MAGELLAN PHARMACY SOLUTIONS | MAGELLAN MEDICAID ADMINISTRATION

Fee-For-Service Pharmacy Provider Notice #175 – November 21, 2013 PTAC PDL Changes

February 6, 2014

11013 W. Broad Street
Glen Allen, VA 23060

Dear Kentucky Medicaid Provider:

Please be advised that the Department for Medicaid Services is making changes to the Kentucky Medicaid Fee-For-Service Pharmacy Preferred Drug List (PDL) based on recommendations from the Kentucky Medicaid Fee-For-Service Pharmacy & Therapeutics Advisory Committee at its November 21, 2013 meeting and as adopted by the Commissioner of the Cabinet for Health and Family Services by order dated January 28, 2014.

On March 12, 2014, the following changes will be effective:

- New Products to Market
  - The following product (s) will become **preferred** and require prior authorization (PA):
    - Gilotrif™ (QL = 1 per day)
      - Gilotrif™ will only be approved for a diagnosis of metastatic non-small cell lung cancer (NSCLC) with EGFR exon 19 deletions or exon 21 (L858R) substitution mutations, which have been detected by an FDA-approved test.

- Existing Drug Classes
  - Lipotropics, Statins
    - Lescol XL®, lovastatin and pravastatin will remain **preferred**.
    - Advicor™, Altoprev®, Lescol®, Mevacor® and Pravachol® will remain **non preferred** and require PA.
    - Fluvastatin will become **non preferred** and require PA.
  - Bile Acid Sequestrants
    - Cholestyramine and cholestyramine light will remain **preferred**.
    - Colestid®, colestipol, Questran® and Questran® Light will remain **non preferred** and require PA.
    - WelChol® will become **non preferred** and require PA.
  - Beta Blockers

- Atenolol, bisoprolol, metoprolol tartrate, pindolol, propranolol, propranolol LA and Toprol XL® will remain **preferred**.
- Bystolic™, Corgard®, Inderal®, Innopran XL®, Kerlone®, Levatol®, Lopressor®, metoprolol succinate ER, Sectral®, Tenormin® and Zebeta® will remain **non preferred** and require PA.
- Acebutolol, betaxolol, nadolol, and timolol will become **non preferred** and require PA.

- Beta Blockers + Diuretics
  - Atenolol/chlorthalidone, bisoprolol/HCTZ and propranolol/HCTZ will remain **preferred**.
  - Corzide®, Dutoprol™, Lopressor® HCT, Tenoretic® and Ziac® will remain **non preferred** and require PA.
  - Metoprolol tartrate/HCTZ and nadolol/bendroflumethiazide will become **non preferred** and require PA.
- Calcium Channel Blockers (DHP)
  - Amlodipine, felodipine ER and nifedipine/ER/SA/SR will remain **preferred**.
  - Adalat CC®, Cardene®, Cardene ER®, nisoldipine ER, Norvasc®, Nymalize®, Plendil®, Procardia®, Procardia XL® and Sular® will remain **non preferred** and require PA.
  - Afeditab™ CR, isradipine, nicardipine, Nifediac CC®, Nifedical XL®, nifedipine and nimodipine will become **non preferred** and require PA.
- Ophthalmic Beta Blockers
  - Betimol®, levobunolol and timolol maleate will remain **preferred**.
  - Betagan®, Optipranolol®, Timoptic® and Timoptic XE® will remain **non preferred** and require PA.
  - Betaxolol, Betoptic S®, carteolol, Istalol® and metipranolol will become **non preferred** and require PA.
- Long-Acting $Beta_2$ Adrenergic Agents
  - Foradil® Aerolizer® will remain **preferred**.
  - Arcapta™ Neohaler™, Brovana® and Perforomist™ will remain **non preferred** and require PA.
  - Serevent® Diskus will become **non preferred** and require PA.
- Hypoglycemics, Metformins
  - Glyburide/metformin, metformin and metformin XR will remain **preferred**.
  - Fortamet™, Glucophage®, Glucophage XR®, Glucovance®, Glumetza™, Metaglip™ and Riomet™ will remain **non preferred** and require PA.
  - Glipizide/metformin will become **non preferred** and require PA.
- Bone Resorption Suppression and Related Agents
  - Alendronate, Evista® and Fortical® will remain **preferred**.
  - Actonel®, Actonel with Calcium®, Atelvia™, Binosto®, Boniva®, Didronel®, etidronate, Fosamax®, Fosamax Plus D™, ibandronate, Reclast®, Skelid® and zoledronic acid will remain **non preferred** and require PA.

- Calcitonin-salmon, Forteo™, Miacalcin® and Prolia™ will become **non preferred** and require PA.

- *H. pylori* Treatment
  - Helidac®, Prevpac® and Pylera® will remain **preferred**.
  - Lansoprazole/amoxicillin/clarithromycin and Omeclamox-Pak™ will remain **non preferred** and require PA.
- Oral Antifungals
  - Clotrimazole, fluconazole, flucytosine, griseofulvin suspension, Noxafil®, nystatin, terbinafine and voriconazole will remain **preferred**.
  - Gris-PEG® will become **preferred**.
  - Ancobon®, Diflucan®, ketoconazole, Lamisil®, Lamisil® Granules, Mycelex Troche®, Nizoral®, Onmel™, Oravig™, Sporanox®, Terbinex™ and Vfend® will remain **non preferred** and require PA.
  - Griesofulvin microsized, griesofulvin ultramicrosized and itraconazole will become **non preferred** and require PA.
- Itraconazole Clinical Criteria
  - Itraconazole will be approved for the following diagnoses:
    - Tinea corporis (body ringworm), Tinea cruris (jock itch), or Tinea pedis (athlete's foot):
      - If the patient has NOT had a therapeutic failure on at least one topical antifungal medication, approve after trial and failure of a topical antifungal medication.
      - If the patient has had a failure on at least one topical antifungal medication, approve: itraconazole capsules for once daily dosing for a 4-week continuous course of therapy.
    - Patient can receive itraconazole automatically if diagnosis is Tinea Capitis for up to 4 weeks
    - Onychomycosis (fungal infection of the fingernails or toenails): For the initial treatment of a fingernail or toenail infection (rather than continuation of therapy or retreatment) AND ALSO for retreatment if there has been an interval of 3 months between the initial treatment of fingernail infection and a second treatment or an interval of 6 months between the initial treatment of toenail infection and a second treatment:
      - Fingernail Infection: Approve itraconazole capsules for twice daily dosing for an 8-week continuous course of therapy.
      - Toenail Infection: Approve: itraconazole capsules for once daily dosing for a 12-week continuous course of therapy.
    - For the treatment of a systemic or other serious fungal infection (e.g., esophageal candidiasis, blastomycosis, aspergillosis, cutaneous sporotrichosis), approve the requested quantity for 6 months.

- Antivirals, Herpes
  - Acyclovir, famciclovir and Valtrex® will remain **preferred**.
  - Famvir®, valacyclovir and Zovirax® will remain **non preferred** and require PA.
- Antivirals, Flu
  - Amantadine syrup and tablets, Relenza®, rimantadine and Tamiflu® will remain **preferred**.
  - Amantadine capsules, Flumadine® and Symmetrel® will remain **non preferred** and require PA.
- Sulfonamides, Folate Antagonists
  - Trimethoprim and trimethoprim/sulfamethoxazole will remain **preferred**.
  - Bactrim®, Bactrim DS®, Primsol® and Septra DS® will remain **non preferred** and require PA.
  - Sulfadiazine will become **non preferred** and require PA.
- Hepatitis B Agents
  - Baraclude™, Epivir HBV®, Hepsera® and Tyzeka® will remain **preferred**.
  - Adefovir dipivoxil will remain **non preferred** and require PA.
- Hepatitis C: Interferons
  - PEGASYS® ProClick and PEGASYS® Syringe will remain **preferred** and require PA.
  - Infergen® will remain **non preferred** and require PA.
  - PEGASYS® vial, PEGIntron™ and PEGIntron™ Redipen® will become **non preferred** and require PA.
- Hepatitis C Interferon Clinical Criteria
  - <u>Treatment Naive Patients:</u> After the initial 18 weeks of therapy, interferons will be approved for a diagnosis of Hepatitis C if there is an Early Virologic Response. Early Virologic Response will be defied as either undetectable HCV RNA (<50 IU/mL) or at least a 2 logarithmic drop in HCV RNA levels from baseline at treatment week 12.
    - Limitations on length of therapy is based on product and specific diagnosis:
      - Interferon alfacon-1
        - INF naïve – 24 weeks total therapy
        - INF relapse – 48 weeks total therapy
      - Peginterferon alfa-2a OR 2b
        - Genotype 1, 4, age 2-17 years, OR HIV positive – 48 weeks total therapy
        - Genotype 2, 3 – 24 weeks total therapy
  - <u>Previously Treated or Relapsed Patients:</u> Interferon therapy will only be approved in patients who have previously been treated if:
    - An Early Virologic Response was determined during the previous treatment course; OR
    - Patient was a partial or null responder to treatment with dual therapy consisting of interferon and ribavirin and

        - Patient has diagnosis of genotype 1 Hepatitis C; and
        - The prescriber feels that triple therapy may solicit a response.
    - Limitations on length of therapy are based on product and specific diagnosis:
        - Interferon alfacon-1
            - INF naïve – 24 weeks total therapy
            - INF relapse – 48 weeks total therapy
        - Peginterferon alfa-2a OR 2b
            - Genotype 1, 4, age 2-17 years, OR HIV positive – 48 weeks total therapy
            - Genotype 2, 3 – 24 weeks total therapy
- Hepatitis C: Oral Protease Inhibitors
    - Incivek™ and Victrelis™ will remain **preferred** and require PA.
    - There will not be any non preferred products in this class.
- Hepatitis C: Oral Protease Inhibitors Clinical Criteria
    - Boceprevir (Victrelis™) will be approved for a diagnosis of hepatitis C (CHC) genotype 1 infection after the patient has received 4 weeks of ribavirin and peginterferon therapy if the patient is receiving concurrent therapy with ribavirin and peginterferon.
    - Telaprevir (Incivek™) will be approved for a diagnosis of hepatitis C (CHC) genotype 1 infection if the patient is receiving concurrent therapy with ribavirin and peginterferon.
    - Quantity and Duration Limits:
        - Incivek™: 6 per day; 1 course of oral protease inhibitor therapy per lifetime
        - Victrelis™: 12 per day; 1 course of oral protease inhibitor therapy per lifetime
- Hepatitis C: Ribavirins
    - Ribavirin will remain **preferred** and require PA.
    - Copegus™, Rebetol® and Ribasphere Ribapack™ will remain **non preferred** and require PA.
    - Ribasphere™ will become **non preferred** and require PA.
- Hepatitis C: Ribavirins Clinical Criteria
    - Ribavirins will pay at point-of-sale if there is concurrent interferon therapy in history.
- Progestins for Cachexia
    - Megestrol acetate will remain **preferred**.
    - Megace® and Megace ES® will remain **non preferred** and require PA.
- Pancreatic Enzymes
    - Creon®, pancrelipase and Zenpep® will remain **preferred**.
    - Pancreaze™, Pertzye™, Ultresa™ and Viokace™ will remain **non preferred** and require PA.
- Topical Immunomodulators
    - Elidel® will remain **preferred**.

- Protopic® will remain **non preferred** and require PA.

- Immunosuppressants
  - Azathioprine, cyclosporine, cyclosporine modified, Gengraf®, mycophenolate mofetil, Myfortic®, Rapamune® and tacrolimus will remain **preferred**.
  - Astagraf XL™, Azasan®, CellCept®, Hecoria®, Imuran®, Neoral®, Prograf®, Sandimmune® and Zortress® will remain **non preferred** and require PA.

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

* Please note: All dates are subject to change.

Sincerely,

Kristina Hawkins, PharmD
Director, Clinical Services

Kentucky Medicaid Fee-For-Service Pharmacy Program's Contact Information		
Clinical Support Center	(800) 477-3071 Sunday – Saturday 24 hours a day	Please contact the Clinical Support Center to request a prior authorization (PA) or to check the status of a request. **NOTE: The only drugs that are now required to be submitted via fax are Brand Medically Necessary, Suboxone®/Subutex®, Synagis®, and Zyvox®.**
Pharmacy Support Center	(800) 432-7005 Sunday – Saturday 24 hours a day	Please contact the Pharmacy Support Center when claims assistance is required. Timely filing, lock-in, and early refill (ER) overrides can be obtained through this call center.
Provider Services	(877) 838 – 5085 Monday – Friday 8:00 am – 4:30 pm	Please contact Provider Services if you have questions about enrollment or when updating your license or bank information.
Member Services	(800) 635 – 2570	Please contact Member Services if you are a member or if you as the provider have questions regarding the member's benefits or eligibility coverage dates.