**** Fee-For-Service Pharmacy Provider Notice #188 – September 2014 P&T Changes ****

November 1, 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 September 18, 2014 meeting, and as adopted by the Commissioner of the Department for Medicaid Services of the Cabinet for Health and Family Services by order dated October 10, 2014.

On December 17, 2014, the following changes will be effective:

- **Existing Drug Classes**

Drug Class	The following products will remain **preferred products**:	The following products will become **preferred products**:	The following products will become **non-preferred products** and require prior authorization (PA):	The following products will remain **non-preferred products** and require prior authorization (PA):
Topical Antifungal Agents	clotrimazole solution, cream econazole ketoconazole shampoo nystatin cream, ointment nystatin/triamcinolone cream, ointment	ketoconazole cream nystatin powder	ketoconazole foam	Ciclodan® cream/kit Ciclodan™ solution ciclopirox clotrimazole / betamethasone CNL-8™ Ecoza™ Ertaczo® Exelderm® Extina® Ketodan™ Kuric® Loprox® Lotrimin® Lotrisone® Mentax® Naftin® Nizoral Shampoo® Nyamyc® Nystop® Oxistat® Pediaderm AF® Pedi-Dri® Pedipirox-4™ Penlac® Vusion® Xolegel®

Drug Class	The following products will remain **preferred products**:	The following products will become **preferred products**:	The following products will become **non-preferred products** and require prior authorization (PA):	The following products will remain **non-preferred products** and require prior authorization (PA):
Topical Antiviral Agents	acyclovir ointment			Denavir® Xerese™ Zovirax® cream Zovirax® ointment
Topical Antibiotic Agents	bacitracin ointment bacitracin / zinc ointment Bactroban® cream gentamicin 0.1% cream, ointment neomycin / polymyxin / pramoxine	mupirocin ointment		Altabax™ Bactroban® ointment Centany® mupirocin cream Triple Antibiotic®
Topical Antiparasitic Agents	Eurax® Natroba® permethrin 5% cream Sklice®			Elimite™ lindane malathion Ovide® Prioderm® spinosad Ulesfia®
Topical Psoriasis Agents	calcipotriene	salicylic acid 6% shampoo, gel urea cream		Aluvea® Bensal HP® BP 50% calcipotriene / betamethasone Calcitrene™ calcitriol ointment Cem-Urea® Dovonex® Latrix® Latrix XM® Remeven® Salacyn® lotion, cream salicylic acid cream, lotion, 26% liquid, 27.5% liquid, combo pkg, kit Salex® shampoo, combo pkg, kit Sorilux™ Taclonex® ointment, suspension Taclonex® Scalp Tazorac® Umecta® Kit, foam, emulsion, suspension Umecta® PD suspension, emulsion Uramaxin® Uramaxin® GT urea suspension, gel, lotion, nail film suspension, kit, foam, emulsion Vectical™ X-Viate®

Drug Class	The following products will remain **preferred products**:	The following products will become **preferred products**:	The following products will become **non-preferred products** and require prior authorization (PA):	The following products will remain **non-preferred products** and require prior authorization (PA):
Oral Acne Agents	Amnesteem® Claravis™ Sotret® Zenatane™	Myorisan™	Absorica™	
Otic Antibiotics	Ciprodex® Otic hydrocortisone 1%/neomycin sulfate 5 mg/polymyxin B 10,000 units solution and suspension ofloxacin 0.3% solution		ciprofloxacin 0.2%	Cetraxal® Cipro HC® Otic Coly-mycin® S Cortisporin® solution Cortisporin®-TC
Otic Anti-Infective / Anesthetics / Anti-Inflammatories	acetic acid antipyrine/benzocaine		Acetasol HC® Aralagan® Aurodex® Auroguard® Borofair® Domeboro® chloroxylenol / pramoxine / hydrocortisone Dermotic® fluocinolone 0.01% oil Oto-End 10® Pinnacaine® Trioxin®	acetic acid / hydrocortisone acetic acid in aluminum acetate Neotic® Otic Care® Otozin™ Pramoxine HC® Vosol® HC
Alpha Blockers for BPH	alfuzosin ER doxazosin tamsulosin terazosin			Cardura® Cardura XL® Flomax® Hytrin® Rapaflo™ Uroxatral®
5-Alpha Reductase (5AR) Inhibitors	finasteride 5-Alpha Reductase (5AR) Inhibitors will be approved for a diagnosis of benign prostatic hyperplasia (BPH) via an ICD-9 override.			Avodart® Jalyn® Proscar®
Bladder Relaxants	oxybutynin Toviaz™ VESIcare®		flavoxate	Detrol® Detrol® LA Ditropan® XL Enablex® Gelnique™ Myrbetriq™ oxybutynin ER Oxytrol® Sanctura® Sanctura® XR tolterodine tolterodine ER trospium

- **New Drug Classes**

Drug Class	The following products will have **preferred product Status**:	The following products will have **non-preferred product status**, and require prior authorization (PA):
Oral Psoriasis Agents	Oxsoralean-Ultra® Soriatane®	8-MOP® acitretin methoxsalen
Vaginal Antibiotics	Cleocin® Ovules metronidazole vaginal 0.75% gel	Cleocin® cream clindamycin vaginal 2% cream Clindesse® Metrogel Vaginal® Vandazole®
Irritable Bowel Syndrome	Amitiza® Linzess® Agents will be approved for the following diagnoses: • Irritable Bowel Syndrome with constipation (linaclotide and lubiprostone) or with diarrhea (alosetron); OR • Chronic Idiopathic Constipation after failure of one laxative (linaclotide and lubiprostone); OR • Opioid-Induced Constipation (lubiprostone) if the following are true: o Patient is experiencing chronic, non-cancer pain; and o Patient has tried and failed one laxative.	Lotronex®
Topical Rosacea Agents	metronidazole lotion, cream, gel	Azelex® Finacea® Finacea® Plus MetroCream® MetroGel® MetroGel® Kit MetroLotion® Mirvaso® Noritate® Rosadan® Kit

- **Clinical Criteria Reviews**
  - Tadalafil (Cialis®) Clinical Criteria
    - Tadalafil (Cialis®) will be approved for a diagnosis of benign prostatic hyperplasia (BPH) after trial and failure of both:
      - An alpha blocker for one month; AND
      - A 5-Alpha Reductase Inhibitor for four months.
    - Cialis® should not be used in combination with an alpha blocker.

  - Palivizumab (Synagis®) Clinical Criteria
    - Length of authorization:
      - Authorization will be granted for a maximum of 5 doses during RSV season (five monthly doses of 15 mg/kg IM). Despite differences in onset and offset of RSV infection in some states or regions, only a maximum of 5 doses will be approved during RSV season. If prophylaxis is initiated later in the RSV season, the infant or child will receive less than 5 doses. For example if prophylaxis is initiated in January, the 4th and final dose, will be administered in April. For eligible infants born during RSV season, fewer than 5 monthly doses may be needed.
      - For infants and children < 24 months of age, already on prophylaxis and eligible, one post-op dose can be approved after cardiac bypass or after extracorporeal membrane oxygenation (ECMO).
    - Approval Criteria:
      - Palivizumab will be approved in the following scenarios:

Infant/Child Age at Start of RSV Season	Palivizumab (Synagis®) Criteria
<12 months (1st year of life)	▪ GA <29 wks, 0 d (otherwise healthy); or ▪ CLD of prematurity (GA <32 wks, 0 d and >21% O_2 x first 28 d after birth); or ▪ Anatomic pulmonary abnormalities, or neuromuscular disorder, or congenital anomaly that impairs the ability to clear secretions; or ▪ Profoundly immunocompromised; or ▪ CF with CLD and/or nutritional compromise
≤ 12 months (1st year of life)	▪ CHD (hemodynamically *significant*) with *acyanotic* HD on CHF medications and will require cardiac surgery or moderate to severe PH. For *cyanotic* heart defects consult a pediatric cardiologist
>12 months (2nd year of life)	▪ CLD of prematurity (GA <32 wks, 0 d and >21% O_2 x first 28 d after birth) and medical support (chronic systemic steroids, diuretic therapy, or supplemental O_2) within 6 months before start of 2nd RSV season; or ▪ CF with severe lung disease* or weight for length <10th percentile
<24 months (2nd year of life)	▪ Cardiac transplant during RSV season; or ▪ Already on prophylaxis and eligible: give post-op dose after cardiac bypass or after ECMO; or ▪ Profoundly immunocompromised during the RSV season

GA=gestational age; wks=weeks; d=day; CLD=chronic lung disease; CHD=congenital heart disease; O_2=oxygen; HD=heart disease; CHF=congestive heart failure; PH=pulmonary hypertension; CF=cystic fibrosis; ECMO=extracorporeal membrane oxygenation

*Examples of severe lung disease: previous hospitalization for pulmonary exacerbation in the 1st year of life, abnormalities on chest radiography [chest X-ray], or chest computed tomography [chest CT] that persist when stable

  - Botulinum Toxins Clinical Criteria
    - AbobotulinumtoxinA (Dysport™) OR rimabotulinumtoxinB (Myobloc®) will be approved for a diagnosis of cervical dystonia.
    - IncobotulinumtoxinA (Xeomin®) will be approved for the following diagnoses:
      - Cervical dystonia; OR

- Blepharospasm after trial and failure of onabotulinumtoxinA (Botox®).
- OnabotulinumtoxinA (Botox®) will be approved for the following diagnoses:
  - Blepharospasm ; OR
  - Cervical dystonia; OR
  - Severe primary axillary hyperhidrosis ; OR
  - Strabismus; OR
  - Cerebral Palsy or other spasticity disorders as long as patient has tried ONE other option such as:
    - Muscle relaxants; or
    - Bracing; or
    - Splinting; or
    - Occupational therapy; or
    - Physical therapy; OR
  - Chronic migraines after trial and failure of ALL of the following (unless contraindication or intolerance):
    - Prophylactic therapy with at least two (2) of the following:
      - Beta-blocker; or
      - Amitriptyline; or
      - Valproate; or
      - Topiramate; AND
    - Tried and failed abortive therapy with two triptans; OR
  - Urinary incontinence due to detrusor over activity associated with a neurologic condition (such as spinal cord injury or MS) after trial and failure of or contraindication to an anticholinergic medication; OR
  - Overactive bladder with symptoms of urge urinary incontinence, urgency and frequency after trial and failure of or contraindication to an anticholinergic medication.

- Clonidine Patch Clinical Criteria
  - Clonidine patches will be approved if any one of the following is true:
    - Patient is <15 years old; OR
    - Patient cannot tolerate/absorb PO.

- Phenoxybenzamine (Dibenzyline®) Clinical Criteria
  - Phenoxybenzamine (Dibenzyline®) will be approved for a diagnosis of Pheochromocytoma only.

- Lidocaine Patch (Lidoderm®) Clinical Criteria
  - Lidocaine patches (Lidoderm®) will be approved if any one of the following criteria is met:
    - Diagnosis of Post Herpetic Neuralgia via an ICD-9 override; OR
    - Diagnosis of neuropathic pain and history of one agent in any of the following medication classes in the past 90 days:
      - Tricyclic antidepressant; or
      - Anticonvulsant used for neuropathic pain (i.e. gabapentin, pregabalin); or
      - SNRI.

- Capsaicin Patch (Qutenza®) Clinical Criteria
  - Capsaicin Patch (Qutenza®) will be approved for a diagnosis of postherpetic neuralgia after trial and failure of one of the following agents:
    - Tricyclic antidepressant; OR
    - Anticonvulsant used for neuropathic pain (i.e. gabapentin, pregabalin); OR
    - SNRI.

- Prenatal Vitamins Clinical Criteria
  - Prenatal vitamins will be approved if one of the following is true:
    - Patient is female and currently pregnant; OR
    - Patient is female and actively nursing; OR
    - Patient suffers from a chronic condition associated with wasting (i.e., HIV) or malabsorption.

- Becaplermin (Regranex®) Clinical Criteria
  - Becaplermin (Regranex®) will be approved for a diagnosis of lower extremity diabetic neuropathic ulcers.

- Peginterferon Alfa 2b (Sylatron™) Clinical Criteria
  - Peginterferon Alfa 2b (Sylatron™) will be approved for a diagnosis of melanoma only.

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

* Please note: All dates are subject to change.

Sincerely,
Michael Price
Provider Relations Manager
mprice@magellanhealth.com

Kentucky Medicaid Fee-For-Service Pharmacy Program's Contact Information		
Clinical Support Center	1-800-477-3071 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, Buprenorphine Products, Synagis®, and Zyvox®.**
Pharmacy Support Center	1-800-432-7005 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	1-877-838-5085	Please contact Provider Services if you have

Kentucky Medicaid Fee-For-Service Pharmacy Program's Contact Information		
	Monday – Friday 8:00 am – 4:30 pm	questions about enrollment or when updating your license or bank information.
Member Services	1-800-635-2570	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.