** Fee-For-Service Pharmacy Provider Notice #254 – March 2021 PDL Changes **

May 1, 2021

Please be advised that the Department for Medicaid Services (DMS) is making changes to the Kentucky Medicaid Fee-For-Service (FFS) Pharmacy Preferred Drug List (PDL) based on recommendations and guidance as adopted by the Commissioner of the Department for Medicaid Services of the Cabinet for Health and Family Services by order dated April 1, 2021.

The Kentucky Medicaid FFS Pharmacy and Therapeutics Advisory Committee (Committee) met on March 18, 2021. The necessary quorum was attained, and the expertise, vote, and recommendations were captured within the Committee's official recommendations. DMS, through its Commissioner, reviewed the recommendations and in consultation rendered its final decisions.

On <u>June 1, 2021</u> 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):
Antibiotics: Gastrointestinal (GI)	Firvanq™ CC metronidazole tablets vancomycin capsules CC Xifaxan® CC, QL	neomycin tinidazole		*Alinia®* *Dificid® QL* *Flagyl®* *metronidazole capsules* *nitazoxanide* *paromomycin* *Solosec™ CC, QL* *Tindamax®* *Vancocin®* *vancomycin solution*
Hepatitis C: Direct-Acting Antiviral Agents	Mavyret™ CC, QL sofosbuvir/velpatasvir CC, QL Vosevi™ CC, QL			*Epclusa® CC, QL* *Harvoni® CC, QL* *ledipasvir/sofosbuvir CC, QL* *Sovaldi™ CC, QL* *Viekira Pak® CC, QL* *Zepatier™ CC, QL*
Hepatitis C: Interferons	PEGASYS® ProClick CC, QL PEGASYS® syringe CC, QL			*PEGASYS® vial CC, QL* *PEGIntron™ CC, QL*
Hepatitis C: Ribavirins	ribavirin CC			*Moderiba™ CC* *ribavirin dosepack CC*
Antiretrovirals: HIV/AIDS	abacavir QL abacavir-lamivudine atazanvir QL Atripla® QL Biktarvy® QL Cimduo™ QL	ritonavir tablets Tivicay® tablets QL	*Dovato QL* *Juluca QL* *Norvir® tablets, solution QL* *Prezcobix® QL* *Symtuza™ QL*	*abacavir-lamivudine-zidovudine* *Aptivus®* *Combivir®* *Crixivan®* *didanosine DR QL*

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):
	Complera® QL Delstrigo™ QL Descovy® CC, QL Edurant® efavirenz Emtriva® Evotaz™ QL Genvoya® QL Intelence® Isentress® Kaletra® tablet lamivudine QL lamivudine-zidovudine lopinavir-ritonavir solution Odefsey® QL Pifeltro™ QL Prezista® Selzentry® stavudine capsules QL stavudine solution Stribild® QL Symfi™ QL Symfi Lo™ QL tenofovir disoproxil fumarate tablets QL Triumeq® QL Trizivir® Truvada® CC, QL Tybost® Videx® EC QL zidovudine syrup, tablets		*Temixys™ QL* *Tivicay® suspension QL* *Viread® powder packets*	*efavirenz/emtricitabine/tenofovir disoproxil fumarate* *emtricitabine* *emtricitabine/tenofovir disoproxil fumarate* *Epivir® QL* *Epzicom®* *fosamprenavir* *Fuzeon®* *Invirase®* *Kaletra® solution* *Lexiva®* *nevirapine QL* *nevirapine ER QL* *Norvir® powder packets* *Retrovir® solution* *Reyataz®* *Rukobia® CC, QL* *Sustiva®* *Videx® solution* *Viracept®* *Viramune® QL* *Viramune XR® QL* *Viread® tablets QL* *Zerit® capsules QL* *Ziagen® QL* *zidovudine capsules*
Intranasal Antihistamines and Anticholinergics	azelastine 0.1% ipratropium nasal spray	azelastine 0.15%	*olopatadine*	*Astepro®* *Patanase™*
Intranasal Corticosteroids	fluticasone propionate QL			*azelastine/fluticasone QL* *Beconase AQ® QL* *budesonide QL* *Children's Qnasl™ QL* *Dymista® QL* *flunisolide QL* *Nasonex® QL* *Omnaris™ QL* *Qnasl™ QL* *triamcinolone QL* *Veramyst® QL* *Xhance™ CC* *Zetonna™ QL*

Criteria Review

Clinical Criteria Review:

Gimoti™

Non-prefer in the PDL class: *Anti-Emetics: Other*

Length of Authorization: 8 weeks

- **Gimoti™** (metoclopramide) is a nasally administered dopamine-2 (D2) antagonist indicated for the relief of symptoms in adults with acute and recurrent diabetic gastroparesis.

Criteria for Approval:

- Diagnosis of diabetic gastroparesis; AND
- Prescribed by an endocrinologist, gastroenterologist or other specialist in the diagnosis and treatment of diabetic gastroparesis; AND
- Prescriber attests that patient does NOT meet ANY of the following conditions:
    - History of signs or symptoms of tardive dyskinesia (TD);
    - History of a dystonic reaction to metoclopramide;
    - Known or suspected circumstances where stimulation of gastrointestinal (GI) motility could be dangerous (e.g., GI hemorrhage, mechanical obstruction, or perforation);
    - Known or suspected pheochromocytoma or other catecholamine-releasing paraganglioma;
    - Diagnosis of epilepsy or any other seizure disorder;
    - Hypersensitivity to metoclopramide (e.g., angioedema, bronchospasm);
    - Moderate or severe renal impairment (creatinine clearance [CrCl] < 60 mL/minute);
    - Moderate or severe hepatic impairment (Child-Pugh B or C); AND
- Prescriber attests that each course of treatment, with all dosage forms and routes of administration of metoclopramide, will NOT extend beyond 12 weeks; AND
- Adequate (e.g., 2-4 week) trial and failure of oral (e.g., tablet, solution, orally disintegrating tablet) or injectable (e.g., intramuscular) metoclopramide; OR
- NOT a candidate for oral metoclopramide (e.g., demonstrated or documented erratic absorption of oral medications).

Renewal Criteria (duration 8 weeks)

- Must continue to meet initial authorization criteria; AND
- At least 2 weeks have passed (i.e., drug holiday) since completion of a previous course of metoclopramide treatment of any dosage form; AND
- Demonstrated improvement in signs and symptoms of diabetic gastroparesis (e.g., nausea, vomiting, early satiety, postprandial fullness, bloating, upper abdominal pain); AND
- Prescriber attestation that the patient is being monitored for extrapyramidal symptoms (e.g., tardive dyskinesia, dystonia) or other serious adverse events (e.g., suicidal ideation, fluid retention).

Age Limit: ≥ 18 years

Quantity Limit: 1 bottle (9.8 mL) per 28 days

Consent Agenda

The therapeutic classes in the table below were reviewed; no changes were made to the currently posted status for agents in these classes.

- Absorbable Sulfonamides
- Antibiotics, Inhaled
- Antibiotics, Vaginal
- Antifungals, Oral
- Antihistamines, Minimally Sedating
- Antivirals, Oral
- Bronchodilators, Beta Agonist
- Cephalosporins and Related Antibiotics
- COPD Agents
- Epinephrine, Self-Injected
- Fluoroquinolones, Oral
- Glucocorticoids, Inhaled
- Hepatitis B Agents
- Leukotriene Modifiers
- Macrolides
- Oxazolidinones
- Penicillins
- Pleuromutulins
- Tetracyclines

To review the complete summary of the final PDL selections and new products to market updates and changes, please refer to the "Commissioner's Final Decisions" from March 18, 2021 posted on the provider web portal at: https://kentucky.magellanmedicaid.com(by clicking the Resources/Documents/Committees/P&T tabs).

Thank you for helping Kentucky Medicaid members maintain access to prescription coverage by selecting drugs on the preferred drug list whenever possible. Please contact Magellan Medicaid Administration at kyproviders@magellanhealth.com for any additional information or questions you may have.

Sincerely,

ShaLeigh Hammons, CPhT

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Account Manager I
kyproviders@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.

Kentucky Medicaid Fee-for-Service Pharmacy Program's Contact Information		
Provider Services	1-877-838-5085 Monday – Friday 8:00 a.m. – 4:30 p.m.	Please contact Provider Services if you have questions about enrollment or when updating your license or bank information.
Member Services	1-800-635-2570 Monday – Friday 8:00 a.m. – 5:00 p.m.	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.