Fee-For-Service Pharmacy Provider Notice #258 – September 2021 PDL and Diabetic Supply List Changes

November 2, 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 September 30, 2021.

The Kentucky Medicaid FFS Pharmacy and Therapeutics Advisory Committee (Committee) met on September 30, 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 December 2, 2021 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):
Antidepressants: Other	bupropion bupropion SR trazodone	Wellbutrin® XL Pharmacies are asked to proactively order branded Wellbutrin® XL for Medicaid members.	*bupropion XL*	*Aplenzin™* *Forfivo XL™* *nefazodone* *Spravato™ CC, QL* *Viibryd™* *Trintellix™* *Wellbutrin®/Wellbutrin® SR*
Antidepressants: SNRIs	venlafaxine	Effexor XR® Pristiq® Pharmacies are asked to proactively order branded Effexor XR® and Pristiq® for Medicaid members.	*desvenlafaxine succinate ER (generic Pristiq®)* *venlafaxine ER capsules*	*desvenlafaxine ER base* *desvenlafaxine fumarate ER* *Fetzima®* *Khedezla™* *venlafaxine ER tablets*
Antidepressants: SSRIs	citalopram escitalopram tablets fluoxetine capsules, solution fluoxetine ER paroxetine sertraline tablets	*Zoloft® oral concentrate* Pharmacies are asked to proactively order branded	*sertraline oral concentrate*	*Brisdelle™ CC* *Celexa®* *escitalopram solution* *fluoxetine 90 mg DR, tablets QL* *fluvoxamine* *fluvoxamine ER*

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):
		Zoloft® oral concentrate for Medicaid members.		*Lexapro™* *paroxetine controlled release* *Paxil ®* *Paxil ® CR* *Pexeva®* *Prozac ®* *Sarafem®* *Zoloft ® Tablets*
Movement Disorders	tetrabenazine	Austedo® CC, QL		*Ingrezza® CC, QL* *Xenazine®*
Stimulants and Related Agents	Adderall XR® CC, QL Concerta® CC, QL atomoxetine CC, QL dexmethylphenidate CC, QL dextroamphetamine CC, QL Focalin XR® CC, QL guanfacine ER CC, QL Methylin® solution CC, QL methylphenidate solution, tablets CC, QL mixed amphetamine salts tablets CC, QL Vyvanse® capsules, chewable tablets CC, QL			*Adderall ® QL* *Adhansia XR™ QL* *Adzenys ER™* *Adzenys XR-ODT™ QL* *amphetamine ER suspension QL* *amphetamine sulfate QL* *Aptensio XR® QL* *clonidine ER QL* *Cotempla XR-ODT™ QL* *Daytrana® QL* *Desoxyn® QL* *Dexedrine ® QL* *dexmethylphenidate ER QL* *dextroamphetamine ER QL* *dextroamphetamine solution QL* *dextroamphetamine sulfate tablets (generic for Zenzedi ®) QL* *Dyanavel ® XR QL* *Evekeo ® QL* *Evekeo ® ODT QL* *Focalin® QL* *Intuniv® QL* *Jornay PM™ QL* *Metadate ® ER QL* *methamphetamine QL* *methylphenidate CD (generic Metadate CD®) QL* *methylphenidate chewable tablets QL* *methylphenidate ER tablets QL* *methylphenidate ER OROS (generic Concerta®) QL* *methylphenidate LA (generic Ritalin LA®) QL* *mixed amphetamine salts ER capsules QL* *Mydayis™ 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):
				ProCentra® QL *QuilliChew ER*™ QL *Quillivant XR*® QL *Relexxii* QL *Ritalin*® QL *Ritalin LA*® QL *Strattera*® QL *Zenzedi* ® QL
Narcolepsy Agents		Provigil® CC, QL Pharmacies are asked to proactively order branded Provigil for Medicaid members.	*modafinil* QL	*armodafinil* QL *Nuvigil* ® QL *Sunosi*™ CC, QL *Wakix*® CC, QL *Xyrem*® CC, QL *Xywav*™ CC, QL

New Products to Market

Drugs Requiring PA	Criteria for Prior Authorization
Qelbree™	Non-prefer in the PDL class: *Stimulants and Related Agents* **Length of Authorization:** 1 year • Viloxazine (Qelbree) is a selective norepinephrine reuptake inhibitor (SNRI) indicated for the treatment of attention deficit hyperactivity disorder (ADHD) in pediatric patients 6 to 17 years of age. **Criteria for Approval**: • Patient has a diagnosis of attention deficit hyperactivity disorder (ADHD) according to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5); **AND** • Patient has a history of trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to 1 preferred agent, unless otherwise specified. **Therapeutic duplication limit:** • Patient is limited to one long-acting and one short-acting CNS agent for ADHD at a time within the quantity/dosing limits. **Age Limit:** None **Quantity Limit**: • 100 mg ER capsule: 30 capsules/30 days • 150 mg ER capsule: 60 capsules/30 days • 200 mg ER capsule: 60 capsules/30 days

Drugs Requiring PA	Criteria for Prior Authorization
	• (Maximum of 400 mg once daily)
Zegalogue®	**Non-prefer in the PDL class:** *Endocrine and Metabolic agents: glucagon agents* **Length of Authorization:** 1 year • Dasiglucagon (Zegalogue) is a glucagon analog and a glucagon receptor agonist that is indicated for the treatment of severe hypoglycemia in pediatric and adult patients with diabetes aged 6 years and older. **Criteria for Approval** • Patient has a history of trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to 1 preferred agent, unless otherwise specified. **Age Limit:** ≥ 6 years **Quantity Limit:** none

Koselugo™	**Non-PDL drug class agent requiring PA -** Oral Oncology
	Length of Authorization: 6 months initial, 6 months renewal
	• Selumetinib (Koselugo) is a mitogen-activated protein kinase kinases 1 and 2 (MEK1/2) inhibitor indicated for the treatment of pediatric patients ≥ 2 years of age with neurofibromatosis type 1 (NF1) who have symptomatic, inoperable plexiform neurofibromas (PN).
	Criteria for Approval
	Initial Approval Criteria
	• Patient is ≥ 2 years of age; AND
	• Patient has a confirmed diagnosis of NF1, as defined by either of the following:
	  ○ Patient has positive genetic testing for NF1 as evidenced by heterozygous pathogenic variants in NF1-gene; OR
	  ○ Patient ≥ 1 of the below diagnostic criteria for NF1 listed below:
	  ▪ ≥ 6 café-au-lait macules (≥ 0.5 cm in pre-pubertal subjects or ≥ 1.5 cm in post-pubertal subjects); OR
	  ▪ Freckling in axilla or groin; OR
	  ▪ Optic glioma; OR
	  ▪ ≥ 2 Lisch nodules; OR
	  ▪ A distinctive bony lesion (dysplasia of the sphenoid bone or dysplasia or thinning of long bone cortex); OR
	  ▪ A first-degree relative with NF1; AND
	• Patient has symptomatic plexiform neurofibromas (PN); AND

Drugs Requiring PA	Criteria for Prior Authorization
	• Patient's PN are inoperable (e.g., PN could not be completely removed without risk for substantial morbidity due to encasement of, or close proximity to, vital structures, invasiveness, or high vascularity of the PN); AND • Left ventricular ejection fraction (LVEF) is within normal limits prior to initiating therapy and will be assessed at regular intervals during treatment; AND • Selumetinib will NOT be used in combination with other MEK inhibitors (e.g., binimetinib, cobimetinib, trametinib). **Renewal Criteria** • Patient must continue to meet the above initial criteria; AND • Patient has documented disease response with treatment, as defined by stabilization of disease or decrease in size of tumor or tumor spread; AND • Patient has NOT experienced any treatment-restricting adverse effects (e.g., cardiomyopathy, ocular toxicities [retinal vein occlusion or retinal pigment epithelial detachment], severe diarrhea, severe skin rashes, rhabdomyolysis, bleeding); AND • LVEF has NOT had an absolute decrease from baseline ≥ 10% and is NOT below the lower limit of normal (LLN). **Age Limit:** ≥ 2 years **Quantity Limit:** 100 MG Daily
Ponvory™	**Non-prefer in the PDL class:** *Multiple Sclerosis agents* **Length of Authorization:** 1 year • Ponesimod (Ponvory), a sphingosine 1-phosphate (S1P) receptor modulator, is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome (CIS), relapsing-remitting disease (RRMS), and active secondary progressive disease (SPMS), in adults. **Criteria for Approval** **Initial Approval Criteria** • Initially prescribed by a neurologist or multiple sclerosis specialist (non-specialist may renew and refill); AND • Patient has a diagnosis of a relapsing form of multiple sclerosis (MS): relapsing remitting MS (RRMS) active secondary progressive MS (SPMS), or clinically isolated syndrome (CIS); AND • Patient has had an inadequate response to, or is unable to tolerate, 1 or more preferred MS agent; AND • NOT used in combination with another MS agent • Patient has a baseline heart rate (HR) ≥ 55 beats per minute (bpm) • If patient is of child-bearing potential, patient is taking effective contraception; • Patient does NOT meet ANY of the following conditions:

Drugs Requiring PA	Criteria for Prior Authorization
	○ Presence of contraindicated cardiovascular comorbidities (e.g., recent heart attack or stroke, heart failure) ○ Presence of Mobitz Type II second- or third-degree atrioventricular (AV) block, sick sinus syndrome, or sinoatrial block (unless treated with a functioning pacemaker) ○ Current systemic or clinically significant local infection ○ Moderate to severe hepatic impairment (Child-Pugh B or C) ○ Use of any other antineoplastic, immunosuppressive or immunomodulating drugs to treat other conditions ○ Prior use of alemtuzumab; AND • Patient has had or will have ALL the following: ○ Screening for clinically significant drug interactions; AND ○ Baseline electrocardiogram (ECG), liver function tests (LFTs) and ophthalmic evaluation; AND ○ Monitoring of respiratory function in patients with baseline respiratory conditions (e.g., pulmonary fibrosis, asthma, chronic obstructive pulmonary disease); AND ○ If pre-existing non-contraindicated cardiac disease (e.g., arrhythmia), cardiology consultation and follow-up will be conducted prior to and during treatment; AND ○ Testing for antibodies to the varicella zoster virus (VZV) OR have received immunization for VZV at least 4 weeks prior to beginning therapy. **Renewal Criteria** • Continue to meet initial approval criteria; AND • Documentation of response to therapy (e.g., progress note). **Age Limit:** ≥18 years **Quantity Limit:** 14-day Starter Pack: 1 pack/14 days, maintenance: 1 tablet (20 mg)/day
Lumakras™	**Non-PDL drug class agent requiring PA –** Oral Oncology **Length of Authorization:** 1 year • Sotorasib (Lumakras) is rat sarcoma proto-oncogene guanosine triphosphatase (RAS GTPase) inhibitor indicated for the treatment of adult patients with Kirsten rat sarcoma viral oncogene homologue (KRAS) G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determined by a United States (US) Food and Drug Administration (FDA)-approved test, who have received at least 1 prior systemic therapy. **Criteria for Approval** **Initial Approval Criteria** • Patient is ≥ 18 years of age; AND • Patient has locally advanced, metastatic, or recurrent (excluding locoregional) disease; AND

Drugs Requiring PA	Criteria for Prior Authorization
	• Patient has presence of Kirsten rat sarcoma viral oncogene homologue (KRAS) G12C-mutation(s) in tumor or plasma specimens as detected by a United States (US) Food & Drug Administration (FDA) or Clinical Laboratory Improvement Amendments (CLIA)-compliant test (Note: if no mutation is detected in a plasma specimen, tumor tissue should be tested); AND • Sotorasib will be used as a single agent; AND • Sotorasib will be used as subsequent therapy after prior treatment with an immune checkpoint inhibitor and/or platinum-based chemotherapy. **Renewal Criteria** • Patient continues to meet indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in above criteria; AND • Absence of unacceptable toxicity from the drug [e.g., interstitial lung disease, hepatotoxicity (AST or ALT > 3 times ULN with total bilirubin > 2 times ULN)]; AND • Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread. **Age Limit:** ≥ 18 years **Quantity Limit:** 240 tablets per 30 days (960 mg daily)
Fotivda™	**Non-PDL drug class agent requiring PA –** Oral Oncology **Length of Authorization:** 1 year • Tivozanib (Fotivda) is a kinase inhibitor indicated for the treatment of adult patients with relapsed or refractory advanced renal cell carcinoma (RCC) following ≥ 2 prior systemic therapies. **Criteria for Approval** **Initial Approval Criteria** • Patient is ≥ 18 years of age; AND • Patient has a diagnosis of renal cell carcinoma (RCC); AND • Patient has relapsed or refractory advanced disease with clear cell histology; AND • Patient has progressed after ≥ 2 prior systemic therapies; AND • Patient's blood pressure is controlled prior to initiation of treatment (note: do NOT administer if systolic >150 mmHg or diastolic > 100 mmHg); AND • Patient must NOT have had a surgical procedure within the preceding 24 days or have a surgical wound that has NOT fully healed; AND • Patient does NOT have unstable or untreated central nervous system (CNS) metastases; AND • Tivozanib will be used as a single agent; AND

Drugs Requiring PA	Criteria for Prior Authorization
	• For females of childbearing potential, a pregnancy test is performed before starting therapy; AND • Prescriber attestation to monitor for standard of practice tests for this condition and/or drug therapy (e.g., blood pressure, proteinuria, thyroid function). **Renewal Criteria** • Patient must continue to meet the above criteria (not including prerequisite therapy); AND • Patient has disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; AND • Patient has NOT experienced any treatment-restricting adverse effects (e.g., severe hypertension, cardiac ischemia, cardiac failure, arterial thromboembolic events, venous thromboembolic events, hemorrhage, severe proteinuria, thyroid dysfunction, impaired wound healing, reversible posterior leukoencephalopathy syndrome [RPLS], tartrazine hypersensitivity). **Age Limit:** ≥ 18 years of age **Quantity Limit:** • 0.89 mg capsule: 21 capsules every 28 days • 1.34 mg capsule: 21 capsules every 28 days • (Maximum dose: 1.34 mg daily for 21 days of a 28-day cycle)
Truseltiq™	**Non-PDL drug class agent requiring PA –** Oral Oncology **Length of Authorization:** 6 months initial, 6 months renewal • Infigratinib (Truseltiq) is a kinase inhibitor indicated for the treatment of adults with previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by a Food and Drug Administration (FDA)-approved test. **Criteria for Approval** **Initial Approval Criteria** • Patient must have cholangiocarcinoma that is unresectable, locally advanced or metastatic; AND • Patient has a susceptible gene mutation rearrangement or fusion in the fibroblast growth factor receptor 2 (FGFR2) gene, as determined by an FDA-approved or CLIA-compliant test; AND • Infigratinib will be used as a single agent; AND • Patient has received at least 1 line of prior therapy which contained gemcitabine; AND • Patient has received a comprehensive ophthalmic examination including optical coherence tomography at baseline and will be repeated periodically (months 1, 3, and every 3 months thereafter) throughout therapy; AND

Drugs Requiring PA	Criteria for Prior Authorization
	• Patient's serum phosphate level is measured at baseline and periodically throughout therapy; AND • Therapy will NOT be used concomitantly with other selective FGFR inhibitors (e.g., erdafitinib, pemigatinib); AND • Female patients of reproductive potential have had a negative pregnancy test prior to infigratinib therapy; AND • Female patients of reproductive potential and male patients with partners of reproductive potential should use effective contraception during therapy and for 1 month following the last dose. **Renewal Criteria** • Patient must continue to meet the above criteria; AND • Patient must have disease response with treatment defined by stabilization of disease or decrease in size of tumor or tumor spread; AND • Patient has NOT experienced any treatment-restricting adverse effects (e.g., retinal pigment epithelial detachment [RPED], severe hyperphosphatemia); AND • Patient's serum phosphate level is ≤ 7.5 mg/dL. **Age Limit:** ≥ 18 years of age **Quantity Limit:** • 25 mg capsule: 63 capsules every 28 days • 100 mg capsule: 21 capsules every 28 days • (Maximum dose: 125 mg daily for 21 days of a 28-day cycle)
Gemtesa™	**Non-prefer in the PDL class:** Bladder relaxants **Length of Authorization: 1 year** • Vibegron (Gemtesa), a selective β3-adrenergic receptor agonist, is indicated for the treatment of overactive bladder (OAB) in adults who have symptoms of urge urinary incontinence, urgency, and urinary frequency. **Criteria for Approval:** **Initial Approval Criteria** • Patient is ≥ 18 years of age; AND • Patient has a diagnosis of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and urinary frequency; AND • Patient must not have hypersensitivity to vibegron or any component of the product; AND • Patient must have an adequate trial and failure of behavioral therapy (bladder training, bladder control strategies, pelvic floor muscle training, and fluid management); AND • Patient has tried and failed at least one month, or has an intolerance, or contraindication to at least two preferred medications. • Patient has tried and failed at least one month of treatment with Myrbetriq.

Drugs Requiring PA	Criteria for Prior Authorization
	Renewal Criteria • Patient has not experienced urinary retention; AND • Patient has experienced disease response as indicated by a reduction in the daily number of micturitions and the average daily number of urge urinary incontinence (UUI) episodes. **Age Limit:** ≥ 18 years of age **Quantity Limit:** 30 tablets per 30 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.

- Alzheimer's Agents
- Angiotensin Modulator Combinations
- Angiotensin Receptor Blockers
- Antianginal & Anti-Ischemic
- Antiarrhythmics, Oral
- Anticoagulants
- Anticonvulsants
- Antidepressants - Tricyclics
- Antiparkinson's Agents
- Antipsychotics
- Anxiolytics
- Beta-Blockers
- Bladder Relaxant Preparations
- BPH Treatments
- Calcium Channel Blockers
- Lipotropics, Other
- Lipotropics, Statins
- Opiate Dependence Treatments
- PAH Agents - Oral and Inhaled
- Platelet Aggregation Inhibitors
- Sedative Hypnotics
- Tobacco Cessation Products

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 September 30, 2021 posted on the provider web portal at: https://kentucky.magellanmedicaid.com(by clicking the Provider/Resources/Documents/Committees/P&T tabs).

Diabetic Supply List Changes

On **October 7, 2021**, the Department for Medicaid Services (DMS) updated the Diabetic Supply Preferred Product list for both Fee-For-Service (FFS) and the Managed Care Organizations (MCOs). The following is a summary of the changes to the list; please see the attached Preferred Diabetic Supply List for a list of products by national drug code (NDC). Products not shown on the Preferred Diabetic Supply List are non-preferred and require prior authorization.

- V-GO disposable insulin pumps have been added to the preferred product list.

Prior authorization of non-preferred BGMs, CGMS and disposable insulin pumps require trial of a preferred product, clinical rationale, or prescriber rationale that the preferred product cannot be used. Non-preferred pen needles and syringes can be authorized on a one-time basis in the case of shortages or outages.

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

ShaLeigh Hammons, CPhT
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.**
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 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.

Kentucky Diabetic Supplies Preferred Product List

Effective October 7, 2021

The following diabetic supplies are available at pharmacy point-of-sale without Prior Authorization (PA):

Continuous Glucose Meters (CGMs) and Components		
Manufacturer	**Product Name**	**NDC***
DEXCOM	DEXCOM G6 TRANSMITTER	08627-0016-01
DEXCOM	DEXCOM G6 SENSOR	08627-0053-03
DEXCOM	DEXCOM G6 RECEIVER	08627-0091-11

*National Drug Code

Traditional Blood Glucose Meters (BGMs)			
Manufacturer	**Product Name**	**NDC***	**Limitation**
ABBOTT DIABETES CARE	FREESTYLE FREEDOM LITE METER	99073-0709-14	1 per year
ABBOTT DIABETES CARE	FREESTYLE INSULINX GLUCOSE SYSTEM	99073-0711-43	
ABBOTT DIABETES CARE	FREESTYLE LITE METER	99073-0708-05	
ABBOTT DIABETES CARE	FREESTYLE PRECISION NEO METER	57599-5175-01	
ABBOTT DIABETES CARE	PRECISION XTRA MONITOR	57599-8814-01	
LIFESCAN	ONE TOUCH ULTRA2 GLUCOSE SYSTEM	53885-0046-01	
LIFESCAN	ONE TOUCH VERIO FLEX SYSTEM KIT	53885-0044-01	
LIFESCAN	ONE TOUCH VERIO REFLECT SYSTEM	53885-0927-01	
Blood Glucose and Ketone Strips			
Manufacturer	**Product Name**	**NDC***	**Limitation**
ABBOTT DIABETES CARE	FREESTYLE INSULINX TEST STRIPS	99073-0712-27	200 per month
ABBOTT DIABETES CARE	FREESTYLE INSULINX TEST STRIPS	99073-0712-31	
ABBOTT DIABETES CARE	FREESTYLE LITE TEST STRIPS	99073-0708-22	
ABBOTT DIABETES CARE	FREESTYLE LITE TEST STRIPS	99073-0708-27	
ABBOTT DIABETES CARE	FREESTYLE TEST STRIPS	99073-0120-50	
ABBOTT DIABETES CARE	FREESTYLE TEST STRIPS	99073-0121-01	
ABBOTT DIABETES CARE	FREESTYLE PRECISION NEO TEST STRIPS	57599-1577-01	
ABBOTT DIABETES CARE	FREESTYLE PRECISION NEO TEST STRIPS	57599-1579-04	
ABBOTT DIABETES CARE	PRECISION XTRA B-KETONE TEST STRIPS	57599-0745-01	
ABBOTT DIABETES CARE	PRECISION XTRA TEST STRIPS	57599-9728-04	
ABBOTT DIABETES CARE	PRECISION XTRA TEST STRIPS	57599-9877-05	
LIFESCAN	ONE TOUCH ULTRA BLUE TEST STRIPS	53885-0244-50	
LIFESCAN	ONE TOUCH ULTRA BLUE TEST STRIPS	53885-0245-10	
LIFESCAN	ONE TOUCH ULTRA BLUE TEST STRIPS	53885-0994-25	
LIFESCAN	ONE TOUCH VERIO TEST STRIPS	53885-0270-25	
LIFESCAN	ONE TOUCH VERIO TEST STRIPS	53885-0271-50	
LIFESCAN	ONE TOUCH VERIO TEST STRIPS	53885-0272-10	

Insulin Pen Needles			
Manufacturer	**Product Name**	**NDC***	**Limitation**
BECTON DICKINSON	BD UF SHORT PEN NEEDLE 8MMX31G	08290-3201-09	200 per month
BECTON DICKINSON	BD UF MINI PEN NEEDLE 5MMX31G	08290-3201-19	
BECTON DICKINSON	BD UF NANO PEN NEEDLE 4MMX32G	08290-3201-22	
BECTON DICKINSON	BD NANO 2 GEN PEN NDL 32GX4MM	08290-3205-50	

BECTON DICKINSON	BD UF MICRO PEN NEEDLE 6MMX32G	08290-3207-49	
BECTON DICKINSON	BD UF ORIG PEN NDL 12.7MMX29G	08290-3282-03	
BECTON DICKINSON	BD AUTOSHIELD DUO NDL 5MMX30G	08290-3295-15	

Insulin Syringes			
Manufacturer	**Product Name**	**NDC***	**Limitation**
BECTON DICKINSON	BD VEO INSULIN SYRINGE 0.3 ML 6MMX31G	08290-3249-09	
BECTON DICKINSON	BD VEO INSULIN SYRINGE 0.3ML 6MMX31G	08290-3249-10	
BECTON DICKINSON	BD VEO INSULIN SYRINGE 0.5 ML 6MMX31G	08290-3249-11	
BECTON DICKINSON	BD VEO INSULIN SYRINGE 1 ML 6MMX31G	08290-3249-12	
BECTON DICKINSON	BD INSULIN SYRINGE U-500 1-2ML 6MMX31G	08290-3267-30	
BECTON DICKINSON	BD INSULIN SYRINGE UF 1 ML 12.7MMX30G	08290-3284-11	N/A
BECTON DICKINSON	BD INSULIN SYRINGE UF 1 ML 8MMX31G	08290-3284-18	
BECTON DICKINSON	BD INSULIN SYRINGE UF 0.3ML 12.7MMX30G	08290-3284-31	
BECTON DICKINSON	BD INSULIN SYRINGE UF 0.3 ML 8MMX31G	08290-3284-38	
BECTON DICKINSON	BD INSULIN SYRINGE UF 0.3 ML 8MMX31G	08290-3284-40	
BECTON DICKINSON	BD INSULIN SYRINGE UF 0.5ML 12.7MMX30G	08290-3284-66	
BECTON DICKINSON	BD INSULIN SYRINGE UF 0.5 ML 8MMX31G	08290-3284-68	

Disposable Insulin Pumps and Components		
Manufacturer	**Product Name**	**NDC***
INSULET	OMNIPOD STARTER KIT	08508-1140-02
INSULET	OMNIPOD DASH 5 PACK POD	08508-2000-05
INSULET	OMNIPOD 5 PACK POD	08508-1120-05
INSULET	OMNIPOD DASH PDM KIT	08508-2000-00
ZEALAND	V-GO 40 DISPOSABLE DEVICE	08560-9400-01
ZEALAND	V-GO 30 DISPOSABLE DEVICE	08560-9400-02
ZEALAND	V-GO 20 DISPOSABLE DEVICE	08560-9400-03

Miscellaneous Supplies			
Manufacturer	**Product Type**	**NDC***	**Limitation**
ALL	Lancets	ALL	200 per month
ALL	Lancing Device	ALL	1 per 6 months
ALL	Normal, Low & High Calibration Solution	ALL	
ALL	Urine Test Tabs or Reagent Strips	ALL	200 per month