MAGELLAN PHARMACY SOLUTIONS | MAGELLAN MEDICAID ADMINISTRATION

Kentucky UNBRIDLED SPIRIT

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THE NUMBERS LISTED BELOW ARE FOR FEE-FOR-SERVICE SUPPORT

PHARMACY SUPPORT CENTER

1-800-432-7005

24 hours per day/7 days per week
For claim assistance, early refill overrides, and lock-in overrides

CLINICAL SUPPORT CENTER PRIOR AUTHORIZATIONS

1-800-477-3071

24 hours per day/7 days per week

DIABETIC SUPPLY QUESTIONS

Prior Authorization
1-800-477-3071

CLAIM INQUIRY

1-800-432-7005

Please Note: Questions regarding claims prior to October 5, 2010, should be directed to 1-800-807-1232.

PROVIDER SERVICES

1-877-838-5085

M–F, 10:30 a.m.–4:30 p.m. (ET)

Providers should contact Provider Services for inquiries regarding enrollment and changes.

MEMBER SERVICES

1-800-635-2570

M–F, 8:00 a.m.–5:00 p.m. (ET)

Recipients should contact Member Services for medication replacement requests and co-pay and benefit information.

WEBSITES

Kentucky Department for Medicaid Services
http://chfs.ky.gov/dms/Pharmacy.htm

Magellan Medicaid Administration
https://kentucky.magellanmedicaid.com/

ONSITE PROVIDER EDUCATION

For onsite education presentations, please contact Michael Price at kyproviders@magellanhealth.com, *M–F 8:30 a.m.–5:00 p.m.*

This education is free of charge.

Attention LTC Pharmacies: How to Bill a Claim for a Partial Fill

When Long-Term Care (LTC) pharmacies do not dispense the full amount per the prescriber's directions, the pharmacy provider may submit the claim as a partial fill and indicate as such on the claim transaction. The fields listed below should be used in the completion of these partial fill claims.

- **Patient Residence** (NCPDP Field # 384-4X) = 03
- **New/Refill** = "ØØ" – Note: This field is entered differently for partial fills than all other prescriptions. Always enter "ØØ" for each of the 4 partial fills per month.
- **Quantity Dispensed** (NCPDP Field # 442-E7) = the number dispensed for that partial fill's time period.
- **Days' Supply** (NCPDP Field # 4Ø5-D5) = the number of days for which Quantity Dispensed for that partial fill.
- **Dispensing Status** (NCPDP Field # 343-HD) = P (partial fill) or C (completion of partial fill)
- **Days' Supply Intended to be Dispensed** (NCPDP Field # 345-HG) = the total number of days "intended" for the prescription. To calculate, take Days' Supply (from above) and multiply by number of partials in month. ***Example:*** Days' Supply of 7 x 4 partials in month = 28 Days' Supply Intended to be Dispensed.
- **Quantity Intended to be Dispensed** (NCPDP Field # 344-HF) = the total quantity "intended" to be dispensed for the prescription. To calculate, take Quantity Dispensed (from above) and multiply by number of partials in month. ***Example:*** Quantity Dispensed 21 x 4 partials in month = 84 Quantity Intended to be Dispensed.
- **Associated Prescription Date** (NCPDP Field # 457-EP) Note: Leave this "associated" field blank on Partial #1. For all other partial fills of a prescription, use the original prescription date from Partial #1 as the Associated Prescription Date.
- **Associated Prescription Reference Number** (NCPDP Field # 456-EN) Note: Leave this "associated" field blank on Partial #1. For all other partial fills of a prescription, use the original prescription number from Partial #1 as the Associated Prescription Reference Number.

For further clarification, please visit the Kentucky Medicaid Pharmacy Provider Point-of-Sale (POS) Billing Manual at:
https://kentucky.magellanmedicaid.com/Providers/Manuals.asp.

ICD-10 Delay 2015

After a 64-35 Senate vote cleared the measure through Congress, President Barack Obama signed into law legislation to give doctors a temporary delay in the Medicare Payment Formula on Tuesday, April 1, 2014. The law also delays nationwide implementation for the ICD-10 diagnostic codes until 2015.

Introducing the Kentucky Fee-For-Service Web Portal

In June 2014, Kentucky Medicaid will roll out a new Fee-For-Service Web Portal. The Web portal will provide website-based tools such as the following:

- Pharmacy Claims History
- Drug Look-up
- Pharmacy Locator
- Electronic Prior Authorization (PA) submission
- Access to electronic Remittance Advices (RAs)

Please stay tuned for more information about the Web portal as the roll-out date approaches.

Upcoming Preferred Drug List Changes

Please be watching for the upcoming provider communications which outline the Preferred Drug List (PDL) changes as a result of the March 2014 Pharmacy and Therapeutics Advisory Committee (PTAC) meeting.

Vitamin D

On April 11, 2014, generic, over-the-counter (OTC) versions of vitamin D3 were added to the covered OTC list. Branded, OTC versions of vitamin D3 will continue to be non-covered drugs. Vitamin D3 generic, prescription versions were also added to the covered prescription cold, cough, and vitamin products list. Branded, prescription versions of vitamin D3 will continue to be covered as well. **NOTE:** Vitamin D2 will be removed from the prescription cold, cough, and vitamin products list. Prescription versions of vitamin D2 will no longer be covered drugs.

Evidence-Based Guidelines Focus: The Much Anticipated JNC 8 Hypertension Guidelines

The Eighth Joint National Committee (JNC 8) has independently published an update to the 2003 JNC 7 practice guideline for the management of high blood pressure (BP) in adults, based on a systematic review of randomized controlled trials.

The new guidance focuses on three critical questions, as they pertain to adults with hypertension:

- Does initiating antihypertensive pharmacologic therapy at specific BP thresholds improve health outcomes?
- Does treatment with antihypertensive pharmacologic therapy to a specified BP goal lead to improvements in health outcomes?
- Do various antihypertensive drugs or drug classes differ in comparative benefits and harms on specific health outcomes?

Notable differences between the JNC 8 versus the JNC 7 guidelines include:

- JNC 8 does not define the severity stages of hypertension or prehypertension as does JNC 7.
- In patients ≥ 60 years of age who do not have diabetes or chronic kidney disease (CKD), the goal BP level is now < 150/90 mmHg, rather than < 140/90 mmHg.
- In patients 18 to 59 years of age without major comorbidities, and in all ages who have diabetes and/or chronic kidney disease (CKD), the new target BP goal is < 140/90 mmHg versus < 130/80 mmHg.
- First-line treatments are now limited to four classes of medications: thiazide-type diuretics, calcium channel blockers (CCBs), angiotensin-converting enzyme inhibitors (ACEIs), and angiotensin receptor blockers (ARBs). The JNC 7 recommended thiazide-type diuretics as an initial therapy for most patients, either alone or in combination with other agents (e.g., ACEI, ARB, beta blocker, CCB). If the target BP is not achieved with first-line treatment, then use higher doses or use a combination of first-line agents.
- Several medications are now designated as “later-line” alternatives, including beta blockers, alpha-blockers, central alpha2-adrenergic agonists (e.g., clonidine), direct vasodilators (e.g., hydralazine), loop diuretics (e.g., furosemide), aldosterone antagonists (e.g., spironolactone), and peripherally-acting adrenergic antagonists (e.g., reserpine).
- Patients of African descent without CKD should initially be prescribed a CCB and thiazide diuretic, instead of an ACEI.

- Use of ACEIs and ARBs is recommended in all patients with CKD regardless of ethnic background, either as first-line therapy or as an add-on therapy.
- ACEIs and ARBs should not be used concomitantly.
- CCBs and thiazide-type diuretics should be used instead of ACEIs and ARBs in patients > 75 years with impaired kidney function due to the risk of hyperkalemia, increased creatinine, and further renal impairment.

The JNC 8 panel reports that it has not redefined high BP and believes that the 140/90 mmHg definition from JNC 7 remains reasonable. The JNC 8 panel did not reach a unanimous decision to increase the recommended SPB to 150 mmHg for patients ≥ 60 years of age. A minority of panel members believe that the evidence supporting increasing this target was insufficient and inconsistent, and that evidence from trials and observational studies that support a target of 140 mmHg in this age group was not included as part of its review. The panel has concerns that the new threshold could reverse gains in BP treatment achieved in recent decades. A higher BP target would likely lessen the intensity of antihypertensive treatment in certain high-risk groups, including African Americans, those with multiple cardiovascular risk factors (other than diabetes or CKD), and those with clinical cardiovascular disease. This minority, however, did agree that an SBP goal of less than 150 mmHg was a reasonable approach for frail people ≥ 80 years of age. For all persons with hypertension, the potential benefits of a healthy diet, weight control, and regular exercise cannot be overemphasized. These lifestyle treatments can improve BP and even reduce medication needs.

In contrast to JNC 8, the 2013 American Heart Association/American College of Cardiology/Centers for Disease Control and Prevention (AHA/ACC/CDC) hypertension science advisory defines stage 1 hypertension as SBP of 140–159 mmHg or DBP of 90–99 mmHg. The AHA/ACC still endorses the old JNC 7, and is developing a new hypertension guideline, expected in 2015, with hopes of it becoming the national standard.

American Academy of Neurology Updated Guidelines for Stroke Prevention

In February 2014, the American Academy of Neurology (AAN) released updated "Guidelines for Stroke Prevention" in patients with nonvalvular atrial fibrillation (NVAF). This current guideline is endorsed by the World Stroke Organization and replaces guidelines released in September 1998. Major conclusions of the updated guidelines note that in patients with recent cryptogenic stroke, occult NVAF can likely be detected by cardiac rhythm monitoring. Dabigatran, rivaroxaban, and apixaban are probably at least as effective as warfarin in preventing stroke in patients with NVAF and they cause less risk of intracranial hemorrhage. In reducing stroke risk, triflusal with acenocoumarol is probably more effective than acenocoumarol alone. Warfarin is likely more effective than clopidogrel with aspirin in preventing stroke and has less risk of intracranial bleeding. Compared to aspirin alone, clopidogrel plus aspirin likely reduces risk of stroke; however, risk of major hemorrhage is increased. For reducing stroke risk, apixaban is probably more effective than aspirin with a risk of bleeding similar to that of aspirin. Major recommendations from the updated guidelines include that for patients with cryptogenic stroke, clinicians might obtain outpatient cardiac rhythm studies to determine if patients have occult NVAF (Level C) and patients with NVAF and history of TIA/stroke should routinely be offered anticoagulation (Level B). For patients determined to need anticoagulation, patient-specific considerations will guide the selection of anticoagulation therapy.

[1] Magellan Medicaid Administration, Inc. Clinical Alert. 2014. Available at: http://www.MagellanMedicaid.com/news/ClinicalAlerts.asp.