

Pharmacy Update



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HELP SLOW RISING RX COSTS

In order to slow rising drug costs, DOM's Pharmacy Program works to help improve quality and manage costs. In state fiscal year (SFY), 2011, Pharmacy expenditures for Medicaid were over \$308.8M. Prescribers can help slow rising prescription costs in DOM's Pharmacy program by:

Prescribing drugs on the Preferred Drug List or PDL:

In SFY11, MS Medicaid collected over \$10.5M for supplemental rebates for branded drugs on the PDL. Over \$124M was collected for federal rebates for all brand and generic drugs, dispensed in the pharmacy venue as well as for physician administered

drugs.

Being aware that sometimes generic drugs are more costly to Medicaid than their branded counterparts: In the commercial arena, generic drugs are inexpensive in relationship to the costs of

the branded counterparts. Due to federal and supplemental rebates, sometimes branded products are less expensive than

Every time a non-preferred drug is prescribed and/or dispensed, MS Medicaid loses money.

the generic. For a comprehensive list of the PDL, refer to Pharmacy Services' web page at <http://www.medicaid.ms.gov/Pharmacy.aspx>. DOM encourages providers to check the PDL rou-

(Continued on page 2)

MS | DUR

Affix Postage

Per Mississippi Legislature Ruling

PREFERRED BRANDS will not count towards the 2 brand monthly prescription limit as of July 1, 2012. They will however still count toward the 5 prescription limit.

Name
Primary Address
City, State ZIP

MEDICAID UPDATES

Help Slow Rising Rx Costs (continued...)

tinely to stay current with preferred and non-preferred drugs.

Preferring some brands... With disproportionately large brand rebates, net prices of certain brand drugs are significantly less than the generic. As a result, discerning state purchasers/ decision makers must monitor for these “opportunities” or they will inadvertently favor more expensive generics

Some examples where the brand name is preferred over the generic include **ARICEPT, AVAPRO, BENZACLIN GEL, GEODON, LIPITOR, LOVENOX, PLAVIX, and SEROQUEL.** Below is an

example of potential savings from selecting a brand name product when a generic is available.

That is nearly **\$3.5 million dollars in savings** for using the brand name over the generic just from the four drugs used in the example. **Please consider this before submitting PA requests for the generic product when the brand name is preferred.** Please see the preferred drug list on Mississippi Medicaid’s website at <http://www.medicaid.ms.gov/Pharmacy.aspx>.

Every time a non-preferred drug is prescribed and/or dispensed, MS Medicaid loses money.

Examples preferred brands where the generic costs more to Medicaid			
Preferred Brand	Non-preferred generic	Projected savings if all scrips are brand	
		Quarterly Savings	Annual Savings
Aricept	donepezil	\$873,891	\$3,495,564
Benzaclin Gel	clindamycin/benzoyl peroxide		
Lipitor	atorvastatin		
Seroquel	quetiapine		

Medicaid, I Have Questions!

Q: I am receiving a Medicaid POS rejection on Suboxone due to the diagnosis code. Where do I get the correct diagnosis code and how do I input it into my pharmacy software?

A: Now that Suboxone and Subutex prior authorizations are electronic (SmartPA), most claims are receiving a prior authorization without you even noticing. Sometimes, however, there are still reasons why you might receive a rejection. For example, the SmartPA system checks the



beneficiary’s medical claims for a qualifying diagnosis and if the qualifying ICD-9 diagnosis code cannot be found, the claim will reject . The pharmacist must manually enter the ICD9 code in the pharmacy software, typically in the same field used when billing for diabetic supplies. You must obtain the diagnosis code from the prescriber and it must be written on the face of the prescription. Page 7 of this newsletter includes details about the new Suboxone/Subutex criteria and page 8 for inputting the ICD-9 code in your pharmacy software..

MEDICAID RESOURCES

Preferred Drug List Updates

Starting in 2012, DOM's Preferred Drug List, or PDL, will undergo an annual review each autumn. The revisions brought about by this annual review will become effective the following January 1st **with the first such update occurring on January 1, 2013**. Throughout the year, there will be quarterly additions, or deletions. Changes outside of January 1st implementation annual review updates will generally be small. Providers are encouraged to monitor the DOM website frequently for advanced notice of these PDL updates. www.medicaid.ms.gov/Pharmacy.aspx.

72 Hour Emergency Supply

A 72-hour emergency supply should be dispensed any time a PA is not available and the prescribed drug must be filled. If the prescriber cannot be reached or is unable to request the PA, the pharmacy should submit an emergency 72-hour prescription. The 72-hour emergency prescription counts against monthly service limits. A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable (e.g., an albuterol inhaler), as a 72-hour emergency supply. [Click Here](#)

Prescription Services Limit

Currently Mississippi state law limits outpatient prescription drug coverage to five drugs monthly; of the five drugs only two may be a brand name medication. Beneficiaries up to 21 years old may receive more than the monthly limit provided proof of medical necessity. If a pediatric beneficiary has exhausted their monthly service limit, subsequent claims will be denied with the following message: "PA REQUIRED FOR AGE UNDER 21". These edits indicate that the beneficiary may qualify for additional benefits provided the submission of a Children's Medical Necessity prior authorization request. For more information, see www.medicaid.ms.gov/PharmacyForms.aspx.

Flu/ Pneumonia Billing

Influenza and pneumonia immunizations are covered services for Medicaid beneficiaries ages 19 and older who are not residents of long-term care facilities. All immunizations for children age 18 and younger must be handled through the Vaccines for Children Program (VFC). MS Medicaid will reimburse drug ingredient cost and dispensing fee, but no administration fee is paid for immunizations administered in the pharmacy. Please follow [this link](#) for more information.

Medicaid Provider Bulletin

The Mississippi Medicaid Bulletin is a quarterly publication aimed to provide timely information regarding policies that affect Mississippi Medicaid providers. The most recently published bulletins as well as an archive of previously published bulletins may be accessed at www.medicaid.ms.gov/Providers.aspx.

Products with Quantity Limits

A number of products covered by Medicaid have a restricted monthly quantity allowed. An up-to-date list of these products can be located by following the link at <http://www.medicaid.ms.gov/Documents/Pharmacy/QuantityLimitsUpdate7-1-10.pdf>

For assistance resolving issues related prior authorizations or coverage, please contact:



Address:

Sillers Building, 550 High Street, Suite 1000
Jackson, MS 39201-1399

Telephone / Fax

Jackson area: 601-359-5253
Toll free: 1-877-537-0722
Fax: 1-877-537-0720

IMPORTANT INFORMATION

FROM THE MISSISSIPPI DIVISION OF MEDICAID

Synagis Season, 2012-2013

The Mississippi Division of Medicaid (DOM) supports the administration of Synagis® for children meeting the American Academy of Pediatrics (AAP) Redbook 2012 criteria for RSV immunoprophylaxis. **Beginning October 22, 2012**, prior authorization requests may be submitted to DOM's Pharmacy PA unit for administration starting on October 31, 2012.

Up to a total of five doses will be allowed per beneficiary. Be advised that in accordance with AAP's revised guidelines, some beneficiaries may be approved for a maximum of three doses, depending upon gestational and/or chronological age. Synagis® prior authorization criteria and forms may be found at www.medicaid.ms.gov/Pharmacy, go to Prior Authorization, and select Synagis® 2012-2013 PA form and criteria. Keep in mind that PA requests for beneficiaries enrolled in MSCAN are to be submitted to the respective PBM and not to Medicaid. Submission of PAs for MSCAN beneficiaries prolong the process and cause delays for both Medicaid fee for service and coordinated care beneficiaries.

Updated 90 Day Supply Maintenance List (effective 04-01-2012)

Effective April 1, 2012, the Mississippi Division of Medicaid began offering a revised 90 Day Maintenance List of legend medicines which may be written for up to 90 days at a time.

There are several considerations to make before prescribing or recommending a 90 day supply:

- **Patients requiring increased monthly prescription drug coverage will benefit from using medications on the 90 Day List.** Mississippi state law limits monthly fills to five drugs, of which, no more than 2 may be brand for the ambulatory non-institutionalized adult. **Please note: effective July 1, 2012, PREFERRED BRANDS on the PDL count toward the monthly limit of 5 drugs monthly but do not count toward the two brand monthly limit.**
- A 90 day supply for the select maintenance medicines on the list only counts as one (1) fill in one month. This action will "free up" one prescription drug "slot" for months two and three and then the cycle restarts with month four.
- **Ninety (90) day maintenance prescriptions are not appropriate for all patients.** In order to reduce waste, misuse, overuse, and stockpiling, only patients who are "stable" on a particular drug or dose should be given a 90 day supply.

For the most recent version of the **90 Day Maintenance List**, please navigate to the MS Medicaid Pharmacy Services webpage at <http://www.medicaid.ms.gov/Pharmacy.aspx> and select "90 Day Maintenance List, Eff. April 1, 2012" or "90 Day Maintenance List, Disease State Format" from the right column.

IMPORTANT INFORMATION

FROM THE MISSISSIPPI DIVISION OF MEDICAID

ICD-9 Code Requirement at Point-of-Sale

This is a reminder notice to the MS Division of Medicaid (DOM) pharmacy providers regarding ICD-9 requirements at point of sale or POS. Please note that the article in its entirety was published in the June 2012 Provider Bulletin. **Be advised that claims for the drugs below will deny without the validating ICD-9 codes. This includes Suboxone/Subutex. Refer to directions below regarding claim submission.**

ICD-9 Codes at Pharmacy Point of Sale (POS)

Effective July 1, 2012, the Division of Medicaid will accept specific ICD-9 codes in the pharmacy point of sale (POS) system for the following drugs **only**:

- Xarelto –limited to **hip replacement; and knee replacement**
- Effient –limited to **unstable angina; STEMI** (Segment Elevation Myocardial Infarction or heart attack), **NSTEMI** (Non-ST Segment Elevation Myocardial Infarction)
- Brilinta—limited to **unstable angina; STEMI** (Segment Elevation Myocardial Infarction or heart attack), and **NSTEMI** (Non-ST Segment Elevation Myocardial Infarction)
- Suboxone/Subutex—limited to **opioid dependence**

Prescriber must write the validating ICD code on the prescription and no manual prior authorization is required. For the comprehensive list of valid ICD codes at POS, refer to Pharmacy Services' webpage at <http://www.medicaid.ms.gov/Pharmacy.aspx>, and select POS ICD-9 Codes. For other indications for the aforementioned drugs, please submit a prior authorization request.

To process a claim, the pharmacy is to use the following procedure:

- 1) Submit the diagnosis code (**on Rx**) in the field **Diagnosis Code (492-DO)**
- 2) Submit qualifier **Diagnosis Code Qualifier (492-WE) = 01**

Field	Field Name	Values Supported
492-WE	Diagnosis Code Qualifier	Required when Diagnosis used. 01 = ICD-9
492-DO	Diagnosis Code	Required when diagnosis is needed for designated drug coverage.

Postponed: Non-Medicaid Enrolled Prescriber Requirement

The October 1, 2012 implementation date to **deny** pharmacy claims written by non-Medicaid enrolled prescribers **has been temporarily postponed**. Claims will continue to pay until a future date (to be decided). Pharmacy providers submitting prescription claims written by non-Medicaid prescribers will receive this informational message: "**FED LAW REQUIRES ALL MEDICAID PRESCRIBERS ARE ENROLLED AS A MEDICAID PROVIDER. NPI SUBMITTED ON CLAIM MUST BE THE ACTUAL PRESCRIBER ON THE RX. ANY OTHER IS CONSIDERED FRAUD.**" The Affordable Care (AAC) requires that services provided to a Medicaid beneficiary must be provided and/or referred by a Medicaid provider. For additional information, on the AAC and this initiative, please refer to <http://www.cms.gov/CMCSBulletins/downloads/6501-Term.pdf> .

IMPORTANT INFORMATION

FROM THE MISSISSIPPI DIVISION OF MEDICAID

Medicare Part D Changes and Medicaid Drug Coverage

CMS recently announced that effective January 1, 2013, Part D plans will be required to make changes to Part D drug coverage and to include the benzodiazepine drug class in their formularies. Additionally, the barbiturate drug class will also be required to be included in formularies for the indications of epilepsy, cancer, or chronic mental health disorder. Medicaid coverage of these two categories for the fee for service beneficiaries will not change.

Benzodiazepines:

- Since the benzodiazepine drug class becomes a mandatory Medicare Part D drug category on January 1, 2013, Medicaid will no longer cover benzodiazepine drugs for the dually eligible beneficiary.
- Any prior authorizations for the dually eligible beneficiary for benzodiazepines will be closed as of December 31, 2012.
- Medicaid coverage of benzodiazepines fee for service beneficiaries will not change.
- The benzodiazepine drug class is comprised of the following drugs: Ativan or lorazepam, Diastat/Valium or diazepam, Dalmane or flurazepam, Doral or quazepam, Halcion or triazolam, Klonopin or clonazepam, Librium or chlordiazepoxide, Restoril or temazepam, Serax or oxazepam, Tranxene or chlorazepate, and Xanax or alprazolam.

Barbituates:

- Since the barbiturate drug class becomes a mandatory Medicare Part D drug category on January 1, 2013 when used for epilepsy, cancer or chronic mental health disorder, Medicaid will no longer cover barbiturates for these indications.
- For the full dually eligible, Medicaid will cover the barbiturates drug class excluding for epilepsy, cancer, or chronic mental health disorder indications.
- Any prior authorizations for the dually eligible beneficiary for barbiturates used for epilepsy, cancer or chronic mental health disorder will be closed as of December 31, 2012.
- Medicaid coverage of barbiturates for the Medicaid fee for service beneficiaries will not change.
- Medicaid coverage of barbiturates is limited to phenobarbital and Mebaral

It will be very important for the dual eligibles taking these drugs to be attentive when selecting plans during the annual renewal period in October 2012. Be advised that Part D coverage may differ from Medicaid's. Regardless, the benzodiazepine drug class will become a non-covered service for the dually eligible beneficiary and barbiturate coverage is limited to indications other than the Medicare Part D covered indications..

IMPORTANT INFORMATION

FROM THE MISSISSIPPI DIVISION OF MEDICAID

New Suboxone / Subutex Criteria for Treating Opioid Dependence

As of **September 1, 2012**, the Division of Medicaid will not require manual prior authorization (PA) for Suboxone®/Subutex®. Suboxone®/Subutex® will be processed electronically in accordance with new step therapy guidelines as outlined below. This letter outlines the new coverage policies and contains other materials to assist you in managing your Medicaid prescriptions Suboxone®/Subutex®.

- Suboxone®/Subutex® therapy will continue to be approved only for the treatment of opioid dependence.
- Subutex® will only be approved for use during pregnancy.
- As of **September 1, 2012**, there will be a **cumulative 24 months** maximum coverage for each beneficiary – even if more than one physician has been involved in providing Suboxone®/Subutex® therapy for the beneficiary.
- For beneficiaries starting initial therapy, prior authorization will be processed electronically when the prescription is submitted by the pharmacy. **A MANUAL PA WILL NO LONGER BE REQUIRED/ACCEPTED** as long as a diagnosis of opioid dependence is documented in the system and the initial maximum dose is not exceeded. Physicians have been notified that an ICD-9 code for opioid dependence must be written on the prescription in order to facilitate electronic approval for new starts. You must enter the ICD-9 code when submitting a claim for a new start beneficiary to obtain electronic prior authorization.
- A refill gap of 60+ days will be considered to be a discontinuation and will require a restart in treatment. Beneficiaries are only allowed one restart of Suboxone®/Subutex® therapy.

Step Therapy With Maximum Doses

Initial Start of Therapy

Step 1 – maximum daily dose of 24 mg/day for 1 month

Step 2 – maximum daily dose of 16 mg/day for next 4 months

Step 3 – maximum daily dose of 8 mg/day for remainder of time on therapy up to a cumulative 24 months of coverage

Restart of Therapy (only 1 restart allowed per beneficiary)

Step 1 – maximum daily dose of 16 mg/day for 2 months

Step 2 – maximum daily dose of 8 mg/day for remainder of time on therapy up to a cumulative 24 months of coverage

Beneficiaries currently on Suboxone®/Subutex® therapy will be considered to be Initial Starts effective **September 1, 2012**. Maximum daily dose limits will follow those outlined above for Initial Starts. Current beneficiaries will be covered for a cumulative 24 months with the cumulative count beginning on **September 1, 2012**.

SAFETY ALERTS

FDA MedWatch

Juvisync (sitagliptin/simvastatin) contraindicated with strong CYP3A4 inhibitors

Contraindication

[September 2012] The FDA updated the labeling of Juvisync (sitagliptin/simvastatin) to include a contraindication in patients taking strong CYP3A4 inhibitors (e.g., itraconazole, ketoconazole, posaconazole, HIV protease inhibitors, boceprevir, telaprevir, erythromycin, clarithromycin, telithromycin, and nefazodone) due to the increased risk of myopathy and rhabdomyolysis.

Aplenzin (bupropion hydrobromide) contraindicated in patients with seizure disorder

Contraindication

[August 2012] The FDA updated the labeling of Aplenzin (bupropion hydrobromide) to include a contraindication in patients with seizure disorder or conditions that increase the risk of seizures (e.g., arteriovenous malformation, severe head injury, CNS tumor or CNS infection, severe stroke, anorexia nervosa or bulimia, or abrupt discontinuation of alcohol, benzodiazepines, barbiturates, and antiepileptic drugs).

Coartem (artemether/lumefantrine) contraindicated with strong CYP3A4 inducers

Contraindication

[August 2012] The FDA updated the labeling of Coartem (artemether/lumefantrine) to include a contraindication in patients taking strong CYP3A4 inducers such as rifampin, carbamazepine, phenytoin, and St. John's wort due to decreased concentrations of artemether and/orlumefantrine and loss of anti-malarial efficacy.

Clarithromycin use in patients with history of QT prolongation

Contraindication

[July 2012] The FDA updated the labeling of clarithromycin containing products to include a contraindication for use in patients with a history of QT prolongation or ventricular cardiac arrhythmia, including torsades de pointes.

Clarithromycin and the concomitant use with lovastatin and simvastatin

Contraindication

[July 2012] the FDA updated the labeling of clarithromycin containing products to include a contraindication that clarithromycin should not be used concomitantly with HMG-CoA reductase inhibitors (statins) that are extensively metabolized by CYP3A4 (lovastatin or simvastatin), due to increased risk of myopathy including rhabdomyolysis.

For a complete listing of drug safety labeling changes, please visit the FDA MedWatch site at: <http://www.fda.gov/Safety/MedWatch/>



The Mississippi Evidence-Based DUR Initiative (MS-DUR) performs the retrospective drug utilization review (rDUR) for the Mississippi Division of Medicaid. The MS-DUR advises the Mississippi Division of Medicaid Drug Utilization Review Board and provides educational outreach to health care practitioners on drug therapy to improve prescribing and dispensing practices for Mississippi Division of Medicaid beneficiaries. The goal of MS-DUR is to advance the discipline of drug utilization review (DUR) for federal, state, and commercial entities by developing and championing best practices in DUR. The MS-DUR is intended to be an information sharing and education-focused entity, not a punitive program. MS-DUR provides information for health care practitioners serving Mississippi Medicaid beneficiaries to assist with the continued evaluation and management of the patient's medication requirements.

The purpose of this newsletter is to provide new information relevant to providers serving Mississippi Medicaid beneficiaries and to "revoice" some of the information provided in the Mississippi Medicaid Provider Bulletin. You will occasionally receive communication from MS-DUR through Mississippi Medicaid, the Mississippi Pharmacist's Association, or from us directly. We hope this information is helpful to your practice and we value your comments and suggestions. Please email kdnnull@olemiss.edu to provide feedback or to recommend topics for future newsletters. Please contact Medicaid (See Page 3) for assistance resolving issues related to prior authorizations or coverage.

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