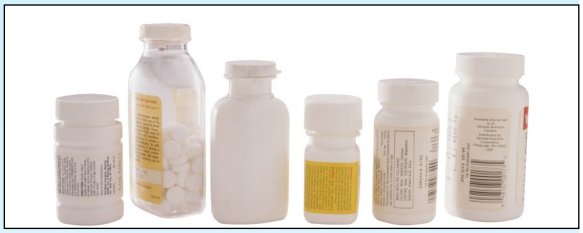
IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201682 NOVEMBER 29, 2016

Pharmacy update approved by Drug Utilization Review Board November 2016

The Indiana Health Coverage Programs (IHCP) announces changes to prior authorization (PA) criteria, enhancements to its SilentAuth automated PA system, updates to the mental health and other utilization edits, and changes to the Preferred Drug List (PDL) as approved by the Drug Utilization Review (DUR) Board at its November 18, 2016, meeting. These changes apply to the fee-for-service (FFS) pharmacy benefit.

PA changes



PA criteria for Buprenorphine/Naloxone and Buprenorphine, growth hormones, and proton pump inhibitors were established and approved by the DUR Board. These PA changes will be effective for PA requests submitted on or after January 1, 2017. The PA criteria are posted on the *Pharmacy Prior Authorization Criteria and Forms* page under the Pharmacy Services quick link at indianamedicaid.com.

SilentAuth PA enhancement

The IHCP has enhanced its automated PA system to update the criteria for the opiate overutilization PA and targeted immunomodulator agents. The goal is to ensure appropriate utilization for IHCP members. These enhancements will be implemented in the IHCP pharmacy claim-processing system for claims with dates of service (DOS) on or after January 1, 2017.

Mental health utilization edits

Utilization edits for mental health medications are reviewed quarterly by the Mental Health Quality Advisory Committee (MHQAC). The DUR Board approved updates to the utilization edits, as recommended by the MHQAC and listed in Table 1. These updates are effective for DOS on or after January 1, 2017.

Table 1 – Updates to mental health utilization edits effective for DOS on or after January 1, 2017

Name and strength of medication	Utilization edit
Latuda 60 mg tabs	1/day; maintain age restriction
Namzaric 7-10 mg caps 24 hour	1/day
Namzaric 21-10 mg caps 24 hour	1/day

Utilization edits

The DUR Board approved an update to utilization edits at its November 18, 2016, meeting; this update is listed in Table 2. The update is effective for DOS on or after January 1, 2017.

Table 2 – Updates to utilization edits effective for DOS on or after January 1, 2017

Name and strength of medication	Utilization edit
Lidocaine and combination lidocaine products ointment/cream/gel	30 grams/90 days

Changes to the PDL

Changes to the PDL were made at the November 18, 2016, DUR Board meeting. See Table 3 for a summary of PDL changes. Changes are effective for DOS on or after January 1, 2017, unless otherwise noted.

Table 3 – Approved changes to the PDL effective for DOS on or after January 1, 2017

Drug Class	Drug	PDL Status
Agents for the Treatment of Opiate Addiction		Maintain all agents at current preferred or nonpreferred statuses until re-reviewed at the February 2017 Therapeutics Committee meeting
Antiemetic/Antivertigo Agents	Sustol	Nonpreferred if the product is covered under the Medicaid program
	Emend suspension	Nonpreferred; add the following step therapy and quantity limit: • Must have tried Emend oral capsules or have inability to swallow or tolerate the capsule formulation • Limited to 3 packets (125 mg each)/Rx
Gastroprotective NSAIDs	Yosprala	Nonpreferred if the product is covered under the Medicaid program
Narcotic Antitussive/ 1st Generation Antihistamine Combinations	Codeine and codeine combination products	Maintain all agents at current preferred or nonpreferred statuses; add PA requirement for members under 18 years of age
Narcotics	Nucynta ER	Preferred (previously nonpreferred); maintain quantity limits
	Codeine and codeine combination products	Maintain all agents at current preferred or nonpreferred statuses; add PA requirement for members under 18 years of age

Table 3 – Approved changes to the PDL effective for DOS on or after January 1, 2017 (Continued)

Drug Class	Drug	PDL Status
Antidiabetic Agents (oral)	Invokamet XR	Nonpreferred; add the following step therapy: • Prescriber must provide documentation that separate components are unsuitable for use
	Jentadueto XR	Nonpreferred; add the following step therapy: • Prescriber must provide documentation that separate components are unsuitable for use
	Jardiance	Nonpreferred (previously preferred)
Growth Hormones	Saizen	Nonpreferred (previously preferred); grandfather current users
	Omnitrope	Preferred (previously nonpreferred)
Insulins – Long Acting	Basaglar	Nonpreferred
Non-Insulin Hypoglycemics	Bydureon	Nonpreferred (previously preferred); grandfather current users
Estrogen, Progesterone, SERMs, or Combinations	Makena	Preferred
	Hydroxyprogesterone caproate	Preferred
Laxatives and Cathartics	Relistor tabs	Nonpreferred; add the following step therapy and quantity limit: • Requires trial of lactulose, sorbitol, or polyethylene glycol within past 90 days **as well as** a diagnosis of opioid-induced constipation • Limited to 3 tabs (450 mg)/day
	Amitiza	Nonpreferred (previously preferred)
	Movantik	Preferred (previously nonpreferred); maintain step therapy and quantity limits
Ulcerative Colitis Agents	Apriso	Preferred
	Asacol	Remove from the Preferred Drug List
Urinary Tract Antispasmodic/ Anti-Incontinence Agents		Remove SilentAuth PA criteria for this drug class
	Enablex	Nonpreferred (previously preferred)
	Trospium	Preferred (previously nonpreferred)

Table 3 – Approved changes to the PDL effective for DOS on or after January 1, 2017 (Continued)

Drug Class	Drug	PDL Status
Targeted Immunomodulators	Humira	Preferred (previously nonpreferred)
	Simponi	Nonpreferred (previously preferred)
	Xeljanz/Xeljanz XR	Preferred (previously nonpreferred)
	Otezla	Preferred (previously nonpreferred)
	Cosentyx	Preferred (previously nonpreferred)
	Enbrel	Nonpreferred (previously preferred)
Ophthalmic Antihistamines	Lastacaft	Preferred (previously nonpreferred)
	Patanol	Nonpreferred (previously preferred)
	Optivar	Remove from the Preferred Drug List
Ophthalmic Anti-Inflammatory Agents	Ilevro	Preferred (previously nonpreferred)
Ophthalmic Anti-Inflammatory Agents/ Immunomodulator-Type	Restasis	Preferred (previously nonpreferred); maintain step therapy, PA criteria, and quantity limits
	Xiidra	Nonpreferred; add the following step therapy, PA criteria, and quantity limits: • Trial of artificial tears within the past 90 days • Diagnosis of keratoconjunctivitis sicca required; initial PA will be for three months and subsequent approvals up to one year • Limited to 60 vials/30 days (12 pouches containing 5 containers) per dispense
Topical Antiparasitics	Natroba	Nonpreferred (previously preferred); maintain quantity limits
	Spinosad	Preferred (previously nonpreferred)

The PDL, SilentAuth criteria, mental health drug utilization edits, and PA criteria can be accessed under the Pharmacy Services quick link at indianamedicaid.com. Notices of the DUR Board meetings and agendas are posted on the FSSA website at in.gov/fssa. Click “FSSA Calendar” on the left side of the page to access the events calendar.

Please direct FFS PA requests and questions about the FFS PDL or this bulletin to the OptumRx Clinical and Technical Help Desk by calling toll-free 1-855-577-6317. Questions regarding pharmacy benefits for members in the Healthy Indiana Plan (HIP), Hoosier Healthwise, and Hoosier Care Connect should be referred to the managed care entity with which the member is enrolled.

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