

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201843 AUGUST 28, 2018

Pharmacy update approved by Drug Utilization Review Board August 2018

The Indiana Health Coverage Programs (IHCP) announces updates to the mental health utilization edits, SilentAuth automated prior authorization (PA) system, PA criteria, and changes to the Preferred Drug List (PDL) as approved by the Drug Utilization Review (DUR) Board at its August 17, 2018, meeting. These changes apply to the fee-for-service (FFS) pharmacy benefit.



SilentAuth PA enhancement

The IHCP has enhanced its automated PA system to update the criteria for the Opiate Overutilization PA and Duplicate Benzodiazepine Sedative Hypnotic PA. These PA changes will be effective for PA requests submitted on or after December 1, 2018. The PA criteria are posted on the *Pharmacy Prior Authorization Criteria and Forms* page under the [Pharmacy Services](#) quick link at indianamedicaid.com.

PA changes

PA criteria for Agents for the Treatment of Cystic Fibrosis, Synagis, Pulmonary Antihypertensives, Hepatitis C Agents, and Difucid were established and approved by the DUR Board. These PA changes will be effective for PA requests submitted on or after October 1, 2018. The PA criteria are posted on the *Pharmacy Prior Authorization Criteria and Forms* page under the [Pharmacy Services](#) quick link at indianamedicaid.com.

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 dates of service (DOS) on or after October 1, 2018.

Table 1 – Updates to utilization edits effective for DOS on or after October 1, 2018

Name and strength of medication	Utilization edit
Aristada Initio 675 mg	2.4 mL (1 syringe)/180 days; age 18 years and older

Changes to the PDL

Changes to the PDL were made at the August 17, 2018, DUR Board meeting. See [Table 2](#) for a summary of PDL changes. Changes are effective for DOS on or after October 1, 2018, unless otherwise noted.

Table 2 – PDL changes effective for DOS on or after October 1, 2018

Drug class	Drug	PDL status
Beta Adrenergics and Corticosteroids	Trelegy Ellipta	Maintain nonpreferred status; add the following step therapy: <ul style="list-style-type: none"> • Must have tried and failed Anoro Ellipta and Flovent HFA concurrent therapy for at least 30 days
Bronchodilator Agents – Beta Adrenergic and Anticholinergic Combinations	Lonhala Magnair	Nonpreferred; with the following quantity limit: <ul style="list-style-type: none"> • 60 vials (1 kit)/30days
	Anoro Ellipta	Preferred (previously nonpreferred)
	Tudorza Pressair	Preferred (previously nonpreferred)
Nasal Antihistamines/Nasal Anti-Inflammatory Steroids	Dymista	Preferred (previously nonpreferred)
	Azelastine 0.15%	Nonpreferred (previously preferred)
Oral Inhaled Glucocorticoids	Asmanex HFA	Preferred (previously nonpreferred)
Pulmonary Antihypertensives	Adcirca	Preferred (previously nonpreferred)
	Orenitram	Nonpreferred (previously preferred)
Hepatitis C Agents	Epclusa	Preferred (previously nonpreferred)
Ophthalmic Antibiotics	Moxeza	Nonpreferred (previously preferred)
	Gentak ointment	Preferred (previously nonpreferred)
	Ciloxan ointment	Preferred (previously nonpreferred)
Ophthalmic Antibiotics/Corticosteroid Combinations	Prednisolone gatifloxacin bromfenac suspension	Nonpreferred
Otic Antibiotics	Otiprio	Nonpreferred
	Otovel	Preferred (previously nonpreferred)
Topical Antifungals	Luliconazole	Nonpreferred
Alpha Adrenergic Blockers	Doxazosin	Preferred (previously nonpreferred)
Beta Adrenergic Blockers	Coreg CR	Nonpreferred (previously preferred)
	Kaspargo	Nonpreferred
	Levatol	Remove from the PDL
Misc. Cardiac Agents	Entresto	Preferred (previously nonpreferred); remove PA criteria; add the following DUR edit: <ul style="list-style-type: none"> • Must not use ACE-Inhibitor concurrently with Entresto
HMG CoA Reductase Inhibitors	Zypitamag	Nonpreferred
Antimigraine Agents	Aimovig	Nonpreferred; with the following step therapy and quantity limits: <ul style="list-style-type: none"> • Trial and failure of propranolol or topiramate or documented intolerance or contraindication for use • 140 mg (2 injections)/month

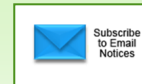
For more information

The mental health utilization edits, PDL, SilentAuth criteria, and PA criteria can be found on the OptumRx website, accessible via 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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