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N.C. Medicaid and N.C. Health Choice Preferred Drug List Changes

Effective **November 1, 2015,** the N.C. Division of Medical Assistance (DMA) will make changes to the N.C. Medicaid and N.C. Health Choice Preferred Drug List (PDL). Please visit our website for the current and future PDL here.

Below are a few highlights of upcoming changes:

- The use of only one rectal Ulcerative Colitis will be required before moving to a non-preferred agent
- New classes are being added:
  - TOPICALS, Rosacea Agents
  - MISCELLANEOUS, Opioid Antagonist
- Update on preferred brands with non-preferred generic equivalents - preferred brands with non-preferred generic equivalents will be updated per the chart below:

Brand Name	Generic Name
Abilify	aripiprazole
Adderall XR	amphetamine salt combo ER
Aggrenox	aspirin-dipyridamole ER
Aldara	imiquimod
Alphagan P	brimonidine
Androgel	testosterone
Avelox	moxifloxacin
Bactroban Cream	mupirocin cream
Baraclude	entecavir
Benzaclin	clindamycin/benzoyl Peroxide
Catapres-TTS	clonidine patches
Cedax	ceftibuten
Celebrex	celecoxib
Cipro Suspension	ciprofloxacin suspension

Copaxone	Glatopa
Derma-Smoothe-FS	fluocinolone 0.01% Oil
Desoxyn	methamphetamine
Dexedrine Spansules	dextroamphetamine spansule
Diastat Accudial/Pedi System	diazepam rectal / system
Differin	adapalene
Diovan	valsartan
Diovan HCT	valsartan / hydrochlorothiazide
Epivir HBV	lamivudine HBV
Epi-Pen	epinephrine
Exforge	amlodipine / valsartan
Exforge HCT	amlodipine / valsartan / HCT
Focalin / Focalin XR	dexmethylphenidate / ER
Gabitril	tiagabine
Hepsera	adefovir
Kadian ER	morphine sulfate ER
Lovenox	enoxaparin
Metadate CD	methylphenidate CD
Methylin Solution	methylphenidate solution
Metrogel Topical	metronidazole gel topical
Natroba	spinosad
Nexium (Rx)	esomeprazole
Orapred ODT	prednisolone ODT
Oxycontin	oxycodone ER

Patanase	olopatadine
Prandin	repaglinide
Provigil	modafinil
Pulmicort 0.25mg/2ml, 0.5mg/2ml	budesonide 0.25mg/2ml, 0.5mg/2ml
Ritalin LA	methylphenidate LA
Rythmol SR	propafenone SR
Symbyax	olanzapine / fluoxetine
Tobradex Drops	tobramycin/dexamethasone drops
Tricor	fenofibrate
Trilipix	fenofibirc acid
Verelan PM	verapamil ER PM
Vivelle-Dot Patch	estradiol patch
Zyvox	linezolid

Change in Coverage for Saline

Effective September 17, 2015, previously covered NDC's for Sodium Chloride Inhalation Solution (3%, 7%, and 0.9%) are no longer rebate eligible and therefore are not coverable in the NC Medicaid Outpatient Pharmacy Program. Sodium Chloride 0.9% is covered by DME policy 5.3.11 Respiratory Devices for the Treatment of Respiratory Disorders other than Obstructive Sleep Apnea (OSA):

Nebulizers
A nebulizer with compressor and related supplies is considered medically necessary when the beneficiary's ability to breathe is severely impaired. Self-contained, ultrasonic nebulizer and related supplies are considered to be medically necessary when:

a. the beneficiary's ability to breathe is severely impaired; and

b. the prescribing physician, physician assistant, or nurse practitioner states that the ultrasonic nebulizer is medically necessary for the beneficiary to receive a smaller particle size than an ordinary nebulizer will provide.

Prior approval is required for an ultrasonic nebulizer. Sterile saline is deemed medically necessary when used with the above equipment and accessories.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Procedure Code(s)** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Nebulizers.*

W4670*	STERILE SALINE, 3 CC VIAL, EACH		0.33

*Indicates PA required

The CMS transmittal detailing this change can be found at:

http://img03.en25.com/Web/FirstDatabankInc/%7b15147345-7ab3-44de-b8ea-b259d39dfb36%7d_CMS_Notification_09-17-2015.pdf

72-hour Emergency Supply Available for Pharmacy Prior Authorization Drugs

Pharmacy providers are encouraged to use the 72-hour emergency supply allowed for drugs requiring prior authorization***. Federal law requires that this emergency supply be available to Medicaid recipients for drugs requiring prior authorization*** (Social Security Act, Section 1927, 42 U.S.C. 1396r-8(d)(5)(B)). Use of this emergency supply will ensure access to medically necessary medications.

The system will bypass the prior authorization requirement if an emergency supply is indicated. Use a "***3***" in the Level of Service field (418-DI) to indicate that the transaction is an emergency fill. ***Note: Copayments will apply and only the drug cost will be reimbursed. There is no limit to the number of times the emergency supply can be used.***

Updated Federal Upper Limit Reimbursement List

The Federal Upper Limit (FUL) reimbursement rate does not cover the cost of certain drugs. Medicaid pharmacy programs are required to reference this reimbursement information when pricing drug claims. To receive adequate reimbursement, pharmacy providers may use the ***DAW1*** override to disregard the FUL reimbursement rate for the drugs listed on the FUL list until the FUL rate has been adjusted to adequately cover the cost of the drug.

As indicated in previous communications, use of the ***DAW1*** override code is monitored. A claim submitted for more than the State Maximum Allowable Cost (SMAC) rate on file may lead to an identifiable overpayment. Any difference between the SMAC rate on

file for the date of service and the actual rate applied to the claim (***if higher***) may be considered an overpayment and subject to recoupment.

Listed below are **ONLY NEW ADDITIONS** since the previous month. The full list is available here.

NDC	NAME
50383074120	ALBUTEROL 5 MG/ML SOLUTION/HI-TECH/AKORN
24208034720	ALBUTEROL 5 MG/ML SOLUTION/VALEANT
00591578201	ATENOLOL-CHLORTHALIDONE 50-25 TAB/ACTAVIS
00378206301	ATENOLOL-CHLORTHALIDONE 50-25 TAB/MYLAN
00472037045	BETAMETHASONE VA 0.1% CREAM/ACTAVIS
51672126901	BETAMETHASONE VA 0.1% CREAM/TARO
51672126906	BETAMETHASONE VA 0.1% CREAM/TARO
00185012801	BUMETANIDE 0.5 MG TAB/SANDOZ
00185012805	BUMETANIDE 0.5 MG TAB/SANDOZ
00093423201	BUMETANIDE 0.5MG TAB/TEVA
66993096159	METRONIDAZOLE 0.75% LOTION/PRASCO
00168027545	METRONIDAZOLE TOPICAL 0.75% GEL/FOUGERA
00713063737	METRONIDAZOLE TOPICAL 0.75% GEL/G&W
00115147446	METRONIDAZOLE TOPICAL 0.75% GEL/GLOBAL
66993096245	METRONIDAZOLE TOPICAL 0.75% GEL/PRASCO
42546070045	METRONIDAZOLE TOPICAL 0.75% GEL/PRUGEN
23155011001	PROPRANOLOL 10 MG TABLET/HERITAGE
23155011010	PROPRANOLOL 10 MG TABLET/HERITAGE
00603548221	PROPRANOLOL 10 MG TABLET/QUALITEST
00603548232	PROPRANOLOL 10 MG TABLET/QUALITEST
43538018245	ROSADAN 0.75% GEL

Electronic Cut-off Schedule	Checkwrite Schedule
October 30, 2015	November 3, 2015
November 6, 2015	November 10, 2015
November 13, 2015	November 17, 2015
November 20, 2015	November 24, 2015

POS claims must be transmitted and completed by 11:59 p.m. on the day of the electronic cut-off date to be included in the next checkwrite.

The 2015 checkwrite schedule is under **Quick Links** on the NCTracks Provider Portal home page.

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