**An Information Service of the Division of Medical Assistance**

# North Carolina

# Medicaid Pharmacy

# Newsletter

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## Opioid Dependence Therapy Agents Coverage Changes

Effective Nov. 1, 2017, **Suboxone Film** (the preferred product in this class) will no longer require a prior approval for coverage. The beneficiary must be receiving the medication for a diagnosis of Opioid Dependence and the prescriber must have a special DEA number that begins with "X". The maximum covered daily dose is 24 mg/day.

For coverage of **Bunavail Film** (non-preferred), the beneficiary must be receiving the medication for a diagnosis of opioid dependence and the prescriber must have a special DEA number that begins with "X". The beneficiary must have tried and failed on Suboxone Film or have a documented medical reason why they cannot use Suboxone Film. The maximum covered daily dose is 12.6mg/day.

For coverage of **buprenorphine-naloxone sublingual tablets** (non-preferred), the beneficiary must be receiving the medication for a diagnosis of opioid dependence and the prescriber must have a special DEA number that begins with "X". The beneficiary must have tried and failed on Suboxone Film or have a documented medical reason why they cannot use Suboxone Film. The maximum covered daily dose is 24mg/day.

For coverage of **Zubsolv** (non-preferred), the beneficiary must be receiving the medication for a diagnosis of opioid dependence and the prescriber must have a special DEA number that begins with "X". The beneficiary must have tried and failed on Suboxone Film or have a documented medical reason why they cannot use Suboxone Film. The maximum covered daily dose is 17.1mg/day.

A prior approval is required for coverage of **buprenorphine sublingual tablets** (single ingredient), which are also non-preferred. The prescriber must have a special DEA number that begins with "X" and the beneficiary must be unable to take Suboxone Film. Acceptable reasons include: beneficiaries who are pregnant or nursing, (documentation should be provided with the prior approval request) and beneficiaries with an allergy to naloxone (documentation should be provided with the prior approval request), which includes the following signs and symptoms: rashes, hives, pruritus, bronchospasm, angioneurotic edema and/or anaphylactic shock. Initial requests and renewal requests require documentation as to why the beneficiary cannot use a combination product.

Requests for **buprenorphine** (single ingredient) may be approved for up to nine months during pregnancy and in two month increments thereafter during breast feeding. The maximum daily dose covered is 24 mg/day. Initial requests and renewals require documentation as to why the beneficiary cannot use a combination (buprenorphine-naloxone) product. Requests for buprenorphine (single ingredient) product may be approved for up to 12 months for beneficiaries with a documented allergy to naloxone. The maximum daily dose covered is 24 mg/day. Initial requests and renewal requests require documentation as to why the beneficiary cannot use a combination (buprenorphine-naloxone) product.

## NC Medicaid and N.C. Health Choice Preferred Drug List (PDL) Changes

Effective **Nov. 1, 2017**, the N.C. Division of Medical Assistance (DMA) will implement approved changes to the N.C. Medicaid and N.C. Health Choice Preferred Drug List (PDL).

Below are a few highlights of the changes:

**Opioid Analgesics**

- This class name was updated from "Narcotic Analgesics" to "Opioid Analgesics"
- Opana ER will be removed from the PDL as it has been discontinued from the market

**Anti-Infective-Systemic (Antibiotics - Inhaled)**

- A new PDL drug class has been added. It is "Anti-Infective-Systemic (Antibiotics-Inhaled)." This class requires a trial and failure of only one preferred drug

**Antiviral (Hepatitis C Agents)**

- Mayvret (for 8 weeks of therapy) will be preferred for all genotypes without cirrhosis
- Mayvret ( for 12 weeks of therapy) will be preferred for all genotypes with compensated cirrhosis (Child Pugh A)
- Epclusa Tablet (in combination with ribavirin) will be preferred for all genotypes with decompensated cirrhosis (Child Pugh B and C)
- Vosevi will be preferred for all genotypes previously treated with an HCV regimen containing an NS5A inhibitor or genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor
- Harvoni Tablet will remain preferred until April 30, 2018, only for beneficiaries who start Harvoni therapy prior to Nov. 1, 2017, to allow for completion of the therapy

**Behavioral Health (Antihyperkinesis/ADHD)**

- Metadate CD capsules have been removed from the PDL as they are discontinued
- Clonidine ER tablet (generic for Kapvay), Desoxyn Tablet (methamphetamine HCl), dextroamphetamine ER capsule (generic for Dexedrine Spansules), all methylphenidate ER tablets, Ritalin LA Capsule (methylphenidate 20 mg, 30 mg, 40 mg, 60 mg) will move from preferred to non-preferred
- Quillichew ER Oral (methylphenidate), Vyvanse Chewable Tablets and Aptenzio XR will move from non-preferred to preferred

**Cardiovascular (ACE Inhibitors)**

- Qbrelis Solution (Lisinopril) will be non-preferred, with an age exemption allowed for children less than 12 years of age

**Endocrinology (Growth Hormone)**

- Nutropin AQ Pen / Nuspin (somatropin) will move from preferred to non-preferred status
- Genotropin Cartridge / Miniquick (somatropin) will move from non-preferred to preferred status

**Endocrinology (Hypoglycemics – Injectable)**

- Humalog Kwikpen will move from preferred to non-preferred status (Rapid Acting Insulin)
- Humulin R-U500 Kwikpen will be added as a new non-preferred drug (Short Acting Insulin)
- Humulin N Pen will move from preferred to non-preferred status (Intermediate Acting Insulin)
- Basaglar Kwikpen (insulin glargine) will be added as a new non-preferred drug (Long Acting Insulin)
- Humulin 70/30 Pen will move from preferred to non-preferred status (Combination Insulin)

**Endocrinology (Hypoglycemics – Oral- Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitor and Combinations)**

- Farxiga Tablet (dapagliflozin) and Jardiance Tablet (empagliflozin) will move from non-preferred to preferred status.
- Invokana and Invokamet will move from preferred to non-preferred status
- Added Synjardy XR and Invokamet XR tablet as a new non-preferred product

**Respiratory (COPD Agents)**

- Combivent Respimat Inhalation Spray will move from preferred to non-preferred status.
- Stiolto Respimat Inhalation Spray will move from non-preferred to preferred status

**Topicals (Immunomodulators- Atopic Dermatitis)**

- Eucrisa 2% Ointment will move from non-preferred to preferred status. Clinical criteria continues to apply.

**Topicals (Steroids, Low Potency)**

- Desonide cream/ointment (generic for DesOwen) will move from preferred to non-preferred status with an age exemption allowed for children less than 12 years of age.

These changes could affect pharmacy stocking needs, generic substitution, product substitution, and Point of Sale (POS) overrides. If a brand is Preferred with a Non-Preferred generic equivalent, “brand medically necessary” is NOT needed on the face of the prescription. Below is a chart of preferred brands with non-preferred generics.

As a reminder, a 72-hour emergency supply may be provided if a prescription is awaiting prior authorization. A "3" in the Level of Service field (418-DI) should be used to indicate that the transaction is an emergency fill.

## 2017-2018 NC Medicaid and Health Choice Preferred Drug List
## Preferred Brands with Non-Preferred Generic Alternatives
**Effective 11-1-2017** ***(bold items are newly preferred)***

| Preferred Brand | Non-Preferred Generic |
|---|---|
| Abilify Discmelt | aripiprazole ODT |
| **Actiq Lozenge** | fentanyl citrate lozenge |
| Adderall XR | amphetamine Salt Combo ER |
| Aggrenox | aspirin-dipyridamole ER |
| Alphagan P | brimonidine P |
| Androgel | testosterone |
| Avelox | moxifloxacin |
| Bactroban Cream | mupirocin Cream |
| Benzaclin | clindamycin/benzoyl Peroxide |
| Butrans | buprenorphine |
| Catapres-TTS | clonidine patches |
| Cipro Suspension | ciprofloxacin suspension |
| Derma-Smoothe FS | fluocinolone 0.01% oil |
| Differin | adapalene |
| Diovan | valsartan |
| Diastat Accudial/Pedi System | diazepam rectal/system |
| Emend | aprepitant |
| **Evista** | raloxifene |
| Exelon Patch | rivastigmine patch |
| Exforge | amlodipine / valsartan |
| Exforge-HCT | amlodipine / valsartan / HCT |
| Focalin / Focalin XR | dexmethylphenidate |
| Gabitril | tiagabine |
| Glyset | miglitol |
| Hepsera 10 mg | adefovir |
| Invega ER | paliperidone ER |
| **Kapvay** | clonidine ER |
| Lovenox | enoxaparin |
| **MetroCream** | metronidazole cream |
| **MetroLotion** | metronidazole lotion |
| Metrogel Topical | metronidazole gel topical |
| Methylin Solution | methylphenidate solution |
| Namenda Solution | memantine solution |
| Natroba | spinosad |

| Preferred Brand | Non-Preferred Generic |
|---|---|
| Nexium RX | esomeprazole |
| **Nuvigil** | armodafinil |
| Orapred ODT | prednisolone ODT |
| Oxycontin | cxycodone ER |
| Patanase | olopatadine |
| Provigil | modafinil |
| Pulmicort respules | budesonide respules |
| Renvela powder pkt | sevelamer powder pkt |
| Retin-A Cream/Gel | tretinoin cream/gel |
| Rythmol SR | propafenone SR |
| Seroquel XR | quetiapine |
| Strattera | atomoxetine |
| Suprax Susp | cefixime Susp |
| Symbyax | olanzepine / fluoxetine |
| Tamiflu | oseltamivir |
| Tegretol Tab/ Susp /XR | carbamazepine Tab/ Susp / XR |
| TobraDex Drops | tobramycin / dexamethasone drops |
| Vigamox | moxifloxacin |
| Vivelle-Dot Patch | estradiol patch |
| Voltaren Gel | diclofenac gel |
| **Zetia** | ezetimibe |

## 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 approval**. Federal law requires that this emergency supply be available to Medicaid beneficiaries for drugs requiring prior approval** (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 approval 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.

| Electronic Cutoff Schedule | Checkwrite Schedule |
|---|---|
| November 3, 2017 | November 7, 2017 |
| November 10, 2017 | November 14, 2017 |
| November 17, 2017 | November 21, 2017 |

November 24, 2017 November 28, 2017

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

The 2017 and 2018 DMA checkwrite schedules are posted under **Quick Links** on the NCTracks Provider Portal home page.

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