An Information Service of the Division of Health Benefits

North Carolina Medicaid Pharmacy Newsletter

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Attention: All Providers

Procedures for Prior Authorization of Synagis® (palivizumab) for Respiratory Syncytial Virus Season 2020/2021

The clinical criteria used by NC Medicaid for the 2020/2021 Respiratory Syncytial Virus (RSV) season are consistent with guidance published by the *American Academy of Pediatrics (AAP): 2018 – 2021 Report of the Committee on Infectious Diseases, 31st Edition*. This guidance for Synagis® use among infants and children at increased risk of hospitalization for RSV infection is available online by subscription. The coverage season is Nov. 1, 2020, through March 31, 2021. Providers are encouraged to review the AAP guidance prior to the start of the RSV season.

Guidelines for Evidenced-Based Synagis Prophylaxis

- Infants younger than 12 months at start of season with a diagnosis of:
  - Prematurity - born before 29 weeks 0 days gestation

- Infants in their first year of life with a diagnosis of:
  - Chronic Lung Disease (CLD) of prematurity (defined as birth at less than 32 weeks 0 days gestation and requiring greater than 21 percent oxygen for at least 28 days after birth),
  - Hemodynamically significant acyanotic heart disease, receiving medication to control congestive heart failure, and will require cardiac surgical procedures
  - Moderate to severe pulmonary hypertension,
  - Neuromuscular disease or pulmonary abnormality that impairs the ability to clear secretions from the upper airway because of ineffective cough.

  Note: Infants in the first year of life with cyanotic heart disease may receive prophylaxis with cardiologist recommendation.

- Infants less than 24 months of age with a diagnosis of:
  - Profound immunocompromise during RSV season
  - CLD of prematurity (see above definition) and continue to require medical support (supplemental oxygen, chronic corticosteroid or diuretic therapy) during the six-month period before start of second RSV season
  - Cardiac transplantation during RSV season

Prior Approval Request

During the Synagis® coverage period, submit all prior approval (PA) requests electronically to www.documentforsafety.org. The web-based program will process PA information in accordance with the guidelines for use. A PA request can be automatically approved based on the information submitted. The program allows a provider to self-monitor the status of a request. Up to five doses can be approved for coverage.

Coverage of Synagis® for congenital heart disease (CHD), neuromuscular disease or congenital anomaly that impairs ability to clear respiratory secretions from the upper airway will terminate when the beneficiary exceeds 12 months of age. Coverage of Synagis® for CLD, profound immunocompromise, or cardiac transplantation will terminate when the beneficiary exceeds 24 months of age.

Dose Authorization
Each Synagis® dose will be individually authorized to promote efficient product distribution. Providers must submit a "**next dose request**" to obtain an authorization for each dose. Providers should ensure the previously obtained supply of Synagis® is administered before submitting a next dose request. Providers will fax each single-dose authorization to the pharmacy distributor of choice.

If an infant received one or more Synagis® doses prior to hospital discharge, the provider should indicate, as part of the request, the most recent date a dose was administered. The number of doses administered by the provider should be adjusted accordingly. If any infant or young child receiving monthly palivizumab prophylaxis experiences a breakthrough RSV hospitalization, coverage of Synagis® will be discontinued.

Pharmacy Distributor Information
Single-dose vial specific authorizations, not to exceed the maximum number of doses approved for the beneficiary, will be issued by NC Medicaid. It is important for the Synagis® distributor to have the appropriate single-dose authorization on hand and a paid point of sale (POS) claim prior to shipping Synagis®. An individual dose authorization is required for each paid Synagis® claim. The drug quantity submitted on the claim must not exceed the quantity indicated on the authorization. Payment for a Synagis® claim will be denied if a dose request was not done by the provider. **Use of a point of sale PA override code is not allowed**.

Synagis® claims processing will begin on Oct. 27, 2020. Payment of a Synagis® claim with a date of service before Oct. 27, 2020, and after March 31, 2021, is not allowed. POS claims should not be submitted by the pharmacy distributor prior to the first billable date of service for the season.

Pharmacy providers should always indicate an accurate days' supply when submitting claims to NC Medicaid. **Submit POS claims for Synagis® doses with multiple vial strengths as a single compound-drug claim. Synagis® doses that require multiple vial strengths that are submitted as separate individual claims are subject to recoupment.** Physicians and pharmacy providers are subject to audits of beneficiary records by NC Medicaid. Maintain Synagis® dose authorizations in accordance with required recordkeeping time frames.

Provider Information
Providers without internet access should contact the Medicaid Outpatient Pharmacy Synagis® Lead at 919-527-7658 or charlene.sampson@dhhs.nc.gov to facilitate submission of a PA request for Synagis®. More information about the Synagis® program is available at www.documentforsafety.org.

Submitting a Request to Exceed Policy
The provider should use the **Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age** to request Synagis® doses exceeding policy or for coverage outside the defined coverage period. **Fax the form to 919-715-1255.** The form is available on the NCTracks Prior Approval web page. Information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage is found on Medicaid's Health Check and EPSDT web page.

Technical Support
Technical support is available Monday to Friday from 8 a.m. to 5 p.m. by calling toll free 1-833-682-2333 or local: 919-600-7590. Technical support can assist with provider registration, user name and password issues, beneficiary searches, and other registry functions.

Outpatient Pharmacy Services
NC Medicaid, 919-527-7658

Influenza Vaccine and Reimbursement Guidelines for 2020-2021 for NC Medicaid and NC Health Choice

For 2020-2021, trivalent (three-component) egg-based vaccines are recommended to contain:

- A/Guangdong-Maonan/SWL1536/2019 (H1N1)pdm09-like virus (updated)
- A/Hong Kong/2671/2019 (H3N2)-like virus (updated)
- B/Washington/02/2019 (B/Victoria lineage)-like virus (updated)

Quadrivalent (four-component) egg-based vaccines, which protect against a second lineage of B viruses, are recommended to contain:

- the three recommended viruses above, plus B/Phuket/3073/2013-like (Yamagata lineage) virus.

For 2020-2021, cell- or recombinant-based vaccines are recommended to contain:

- A/Hawaii/70/2019 (H1N1)pdm09-like virus (updated)
- A/Hong Kong/45/2019 (H3N2)-like virus (updated)
- B/Washington/02/2019 (B/Victoria lineage)-like virus (updated)
- B/Phuket/3073/2013-like (Yamagata lineage) virus

For further details on the 2020-2021 influenza vaccine, visit the Centers for Disease Control (CDC) Flu Season web page.

Billing Codes to be used by Pharmacist for Medicaid Beneficiaries 19 Years of Age or Older

Vaccine CPT Code to Report	CPT Code Description
90653CG	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use
90662CG	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90672CG	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
90674CG	influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5mL dosage, for intramuscular use
90682CG	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
90686CG	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
90688CG	Influenza virus vaccine, quadrivalent (IIV4), split virus, NOT preservative free, 0.5 mL dosage, for intramuscular use
90694CG	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use
90756CG	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use

*The CG modifier must be appended to every vaccine and vaccine administration CPT code used to bill vaccines by pharmacists. The CG modifier identifies a Pharmacy Provider in NCTracks for vaccine claims billing purposes.

Billing Codes to be used by Pharmacists for NC Medicaid Beneficiaries 19 Years of Age and Older

CPT Code(s)	CPT Code Description
90471CG	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **one vaccine** (single or combination vaccine/toxoid)
90472CG (add-on code)*	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); **each additional vaccine.** (Separately list the add-on code(s) for each additional single vaccine and/or combination vaccine/toxoid administered, in addition to the primary procedure)
90473CG	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid). *Do not report 90473 in conjunction with 90471.*

The CG modifier must be appended to every vaccine and vaccine administration CPT code used to bill vaccines by pharmacists. The CG modifier identifies a Pharmacy Provider in NCTracks for vaccine claims billing purposes.

**Providers may bill more than one unit of 90472 as appropriate.*
Detailed information about the regulations regarding pharmacist immunization can be found at Pharmacist Administrated Vaccine and Reimbursement Guidelines published in the October 2016 Medicaid Bulletin. Please note that NDCs are required on vaccine claims.

NDC's Change Each Year for Influenza Vaccines
Providers are required to use appropriate NDCs that correspond to the vaccine used for administration and corresponding CPT code. Note that not all products and NDCs under their respective CPT codes will be covered.

Influenza vaccines are licensed each year with new NDCs, so it is important to report the correct code for the products you are using to avoid having claims deny with edit 00996 (Mismatched NDC) which will require the claim to be resubmitted with the correct NDC. Below are the influenza vaccine procedure (CPT) codes and corresponding NDCs that should be used for the 2020-2021 influenza season:

CPT and NDC codes for the 2020-2021 Influenza Vaccine Products

CPT Codes	NDC codes
90653	Fluad: 70461-0020-03, 70461-0020-04
90662	Fluzone High-Dose: 49281-0120-65, 49281-0120-88
90672	FluMist Quadrivalent: 66019-0307-01, 66019-0307-10
90674	Flucelvax Quadrivalent: 70461-0320-03, 70461-0320-04
90682	Flublok Quadrivalent: 49281-0720-10, 49281-0720-88
90685	Afluria Quadrivalent: 33332-0220-20, 33332-0220-21
90686	Afluria Quadrivalent: 33332-0320-01, 33332-0320-02 Fluarix Quadrivalent: 58160-0885-41, 58160-0885-52 FluLaval Quadrivalent: 19515-0816-41, 19515-0816-52 Fluzone Quadrivalent syringe: 49281-0420-50, 49281-0420-88 Fluzone Quadrivalent vial: 49281-0420-10, 49281-0420-58
90687	Afluria Quadrivalent: 33332-0420-10, 33332-0420-11 Fluzone Quadrivalent: 49281-0633-15, 49281-0633-78
90688	Afluria Quadrivalent: 33332-0420-10, 33332-0420-11 Fluzone Quadrivalent: 49281-0633-15, 49281-0633-78
90694	Fluad Quad: 70461-0120-03, 70461-0120-04
90756	Flucelvax Quadrivalent: 70461-0420-10, 70461-0420-11

GDIT, 1-800-688-6696

*Guidance for immunizing pharmacists regarding the 3rd Amendment of the PREP Act will be forthcoming.

New Preferred Drug List Begins Sept. 1, 2020

Effective Sept. 1, 2020, NC Medicaid will make changes to the North Carolina Medicaid and NC Health Choice Preferred Drug List. Below is a summary list of the changes that will go in to effect:

ANALGESICS

OPIOID ANALGESICS LONG ACTING

- Recommendations: Move Butrans® Patch from Non-Preferred to Preferred and buprenorphine patch (generic for Butrans® Patch) from Preferred to Non-Preferred; move Oxycontin® Tablet from Preferred to Non-Preferred; move Xtampza® ER from Non-Preferred to Preferred; add hydrocodone ER capsule (generic for Zohydro® ER) and tramadol ER capsule (generic for Conzip® Capsule) as Non-Preferred products.

ORALLY DISINTEGRATING / ORAL SPRAY SCHEDULE II OPIODS

- Recommendation: Add Dsuvia™ SLTablet as a Non-Preferred product.

SHORT ACTING SCHEDULE II OPIOIDS

- Recommendations: Add benzhydrocodone-acetaminophen tablet (generic for Apadaz™ Tablet) and morphine oral syringe as Non-Preferred products.

NSAIDS

- Recommendations: Add ketorolac tromethamine nasal spray (generic for Sprix®), Qmiiz™ ODT Tablet, and Relafen™ DS Tablet as Non-Preferred products.

NEUROPATHIC PAIN

- Recommendations: Move pregabalin Capsule/Solution (generic for Lyrica® Capsule/Solution) from Non-Preferred to Preferred; add Drizalma™ Sprinkle and Gabacaine™ Kit as Non-Preferred products; add LidoPure™ Patch and Zilocaine™ Patch as Non-Preferred products with clinical criteria to match current lidocaine patch products.

ANTICONVULSANTS

SECOND GENERATION

- Recommendations: Add Diacomit® Capsule/Powder Pack, lamotrigine ODT (generic for Lamictal® ODT), Nayzilam® Nasal Spray, and Sympazan® Film as Non-Preferred products.

ANTI-INFECTIVES – SYSTEMIC ANTIBIOTICS

PENICILLINS, CEPHALOSPORINS AND RELATED

- Recommendation: Add cefixime capsule (generic for Suprax® Capsule) as a Non-Preferred product.

TETRACYCLINE DERIVATIVES

- Recommendation: Add Minolira™ ER Tablet as a Non-Preferred product.

ANTIFUNGALS

- Recommendation: Add Posaconazole suspension/tablet (generic for Noxafil®) as a Non-Preferred product.

ANTIVIRALS (INFLUENZA)

- Recommendations: Move Tamiflu® Suspension to Non-Preferred and oseltamivir phosphate suspension (generic for Tamiflu®) to Preferred; move oseltamivir phosphate capsule (generic for Tamiflu®) from Non-Preferred to Preferred; Have Xofluza™ process as a "try one Preferred product and fail" exception to the class.

BEHAVIORAL HEALTH

ANTIHYPERKINESIS / ADHD

- Recommendations: Add Adhansia™ XR Capsule, amphetamine ER suspension (generic for Adzenys®), Evekeo® ODT, Jornay PM™ Capsule, Metadate® ER Tablet, and Relexxii™ ER Tablet as Non-Preferred products.

ATYPICAL ANTIPSYCHOTICS ORAL

- Recommendations**:** Add Secuado® Patch as a Non-Preferred product.

CARDIOVASCULAR

ANGIOTENSIN II RECEPTOR BLOCKERS

- Recommendations: Move irbesartan tablet (generic for Avapro®) from Non-Preferred to Preferred, add olmesartan tablet (generic for Benicar® Tablet) as a Non-Preferred product.

ANGIOTENSIN II RECEPTOR BLOCKER DIURETIC COMBINATIONS

- Recommendations: Move irbesartan/HCTZ (generic for Avalide® from Non-Preferred to Preferred, add Olmesartan-amlodipine-HCTZ tablet (generic for Tribenzor® Tablet) and Olmesartan-HCTZ (generic for Benicar® HCT Tablet) as Non-Preferred products.

CHOLESTEROL LOWERING AGENTS

- Recommendation: Add Ezallor™ Capsule as a Non-Preferred product.

DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS

- Recommendation: Add Katerzia™ Suspension as a Non-Preferred product. The product will process as Preferred for ages less than 12.

DIRECT RENIN INHIBITOR

- Recommendation: Add aliskiren tablet (generic for Tekturna® Tablet) as a Non-Preferred product.

ENDOTHELIN RECEPTOR ANTAGONISTS

- Recommendation: Add ambrisentan tablet (generic for Letairis® Tablet) and bosentan tablet (generic for Tracleer® Tablet*)* as Non-Preferred products.

ORAL PULMONARY HYPERTENSION

- Recommendation: Add Alyq® Tablet, sildenafil suspension (generic for Revatio® Suspension), tadalafil tablet (generic for Adcirca® Tablet) as Non-Preferred products. Branded Revatio® suspension will process as Preferred for ages less than 12.

ANTIANGINAL & ANTI-ISCHEMIC

- Recommendation: Move Ranexa® Tablet from Preferred to Non-Preferred, move ranolazine ER tablet (generic for Ranexa® Tablet from Non-Preferred to Preferred.

CENTRAL NERVOUS SYSTEM

ANTIMIGRAINE AGENTS

- Recommendations: Add Reyvow™ Tablet and Tosymra™ Nasal Spray as Non-Preferred products.

ANTI-NARCOLEPSY

- Recommendation: Add Sunosi™ Tablet and Wakix® Tablet as Non-Preferred products.

ANTIPARKINSON & RESTLESS LEG SYNDROME AGENTS

- Recommendation: Add Inbrija™ Inhalation and Nourianz™ Tablet as Non-Preferred products.

MULTIPLE SCLEROSIS

- Recommendation: Add Mavenclad® Tablet, Mayzent® Starter Pack/Tablet, and Vumerity™ Capsule as Non-Preferred products.

SEDATIVE HYPNOTICS

- Recommendation: Add doxepin tablet (generic for Silenor®) and ramelteon tablet (generic for Rozerm® Tablet) as Non-Preferred Not Reviewed products.

ENDOCRINOLOGY

HYPOGLYCEMICS – RAPID ACTING INSULIN

- Recommendations: Add Fiasp® Penfill, insulin aspart U-100 cartridge/FlexPen®/vial (generic for Novolog®) and insulin lispro U-100 KwikPen®/vial (generic for Humalog®) as Non-Preferred products.

HYPOGLYCEMICS – SHORT ACTING INSULIN

- Recommendations: Move Humulin R U500 KwikPen® from Non-Preferred to Preferred, add Myxredlin™ Injection as a Non-Preferred product.

HYPOGLYCEMICS – PREMIXED RAPID COMBINATION INSULIN

- Recommendation: Add insulin aspart protamine-aspart 70/30 U100 FlexPen® / vial (generic for Novolog® Mix 70/30) as a Non-Preferred product.

GLP-1 RECEPTOR AGONISTS AND COMBINATIONS

- Recommendation: Add Rybelsus® Tablet as a Non-Preferred product.

BIGUANIDES AND COMBINATIONS

- Recommendation: Add Riomet® ER Suspension as a Non-Preferred product.

GASTROINTESTINAL

ANTIEMETIC-ANTIVERTIGO AGENTS

- Recommendations: Add Akynzeo® Vial, doxylamine-pyridoxine tablet (generic for Diclegis® Tablet), and fosaprepitant vial (generic for Emend®) as Non-Preferred products.

BILE ACID SALTS

- Recommendation: Move ursodiol capsule (generic for Actigall®) from Non-Preferred to Preferred.

ELECTROLYTE DEPLETERS

- Recommendations: Move Renagel® Tablet and Renvela® Powder Pack from Preferred to Non-Preferred and move sevelamer tablet/powder pack (generic for Renvela® and Renagel®) from Non-Preferred to Preferred.

PROTON PUMP INHIBITORS

- Recommendations: Add lansoprazole ODT (generic for Prevacid® Solutab™) as a Non-Preferred product.

SELECTIVE CONSTIPATION AGENTS

- Recommendation: Add Motegrity™ Tablet as a Non-Preferred product.

ULCERATIVE COLITIS - ORAL

- Recommendations: Add mesalamine DR capsule (generic for Delzicol® Capsule) and mesalamine ER capsule (generic for Apriso® Capsule) as Non-Preferred products.

GENITOURINARY / RENAL

URINARY ANTISPASMODICS

- Recommendations: Add solifenacin tablet (generic for Vesicare® Tablet) as a Non-Preferred product.

GOUT

- Recommendations: Add febuxostat tablet (generic for Uloric® Tablet) and Gloperba® Solution as Non-Preferred products.

HEMATOLOGIC

ANTICOAGULANTS - INJECTABLE

- Recommendations: Move enoxaparin vial (generic for Lovenox®) from Non-Preferred to Preferred, move Lovenox® Vial from Preferred to Non-Preferred.

ANTICOAGULANTS - ORAL

- Recommendations: Add Bevyxxa® Capsule as a Non-Preferred product.

COLONY STIMULATING FACTORS

- Recommendations: Move Neulasta® Syringe/Kit from Preferred to Non-Preferred; move Fulphila™ Syringe/Vial from Non-Preferred to Preferred; move Udenyca™ Syringe from Non-Preferred to Preferred; add Nivestym™ Syringe/Vial and Ziextenzo® Syringe as Non-Preferred products.

HEMATOPOIETIC AGENTS

- Recommendations: Add Reblozyl® Vial as a Non-Preferred product.

OPHTHALMIC

ALLERGIC CONJUNCTIVITIS AGENTS

- Recommendations: Move Pataday® Drops from Preferred to Non-Preferred. Move olopatadine (generic for Pataday®) from Non-Preferred to Preferred.

ANTIBIOTICS

- Recommendations: Move Moxeza® Drops and Vigamox® Drops from Preferred to Non-Preferred; move moxifloxacin ophthalmic solution (generic for Vigamox® Drops and Moxeza®) from Non-Preferred to Preferred.

ANTI-INFLAMMATORY

- Recommendations: Add Dextenza® Insert and loteprednol drops (generic for Lotemax® Drops) as Non-Preferred products.

PROSTAGLANDIN AGONISTS

- Recommendations: Add travoprost drops (generic for Travatan® Z) as a Non-Preferred product.

RHO KINASE MODIFIERS / COMBINATIONS

- Recommendations: Add new PDL category - Rho Kinase Modifiers / Combinations; add Rhopressa® and Rocklatan® Drops as Preferred products in the category.

OSTEOPOROSIS

BONE RESORPTION SUPPRESSION AND RELATED AGENTS

- Recommendation: Add Evenity™ Syringe as a Non-Preferred product.

OTIC

ANTIBIOTICS

- Recommendation: Add ciprofloxacin-fluocinolone drops (generic for Otovel®) as a Non-Preferred product.

RESPIRATORY

BETA ADRENERGIC HANDHELD, SHORT ACTING

- Recommendations: Move Proventil® HFA Inhaler from Preferred to Non-Preferred, add albuterol HFA inhaler (generic for Proventil® HFA Inhaler) and Proair Digihaler™ as Non-Preferred products.
- Unique Category Discussion Points:
    - In March, the State made changes to this category in response to marketplace shortages.
    - After shortages subside, there could be a negative financial impact to the State if the March (i.e. current) PDL placements in this category remain in effect.
    - The recommendation from the state for a vote will implement the proposed recommendations when the marketplace shortages affecting the drugs in the category stabilize.
- Vote: All in favor. None opposed.

ORALLY INHALED ANTICHOLINERGICS / COPD AGENTS

- Recommendations: Add Duaklir® Pressair® as a Non-Preferred product.

INHALED CORTICOSTEROID COMBINATIONS

- Recommendations: Add budesonide/formoterol inhalation (generic for Symbicort®) as a Non-Preferred product.

LOW SEDATING ANTIHISTAMINES

- Recommendations: Add Quzyttir™ Vial as a Non-Preferred product.

TOPICALS

ACNE AGENTS

- Recommendations: Move clindamycin-benzoyl peroxide gel (generic for Benzaclin®) and clindamycin-benzoyl peroxide with pump (generic for Benzaclin®) from Preferred to Non- Preferred; move erythromycin-benzoyl peroxide gel (generic for Benzamycin®) from Non-Preferred to Preferred, move Retin-A® Micro Gel / Micro Gel Pump from Non-Preferred to Preferred; add Aklief® Cream, Amzeeq™ Foam, Avar® Foam, Avar® LS Foam, Clindagel® Gel and Ovace® Foam as Non-Preferred products.

ANDROGENIC AGENTS

- Recommendations: Move Androgel® Pump from Preferred to Non-Preferred and move testosterone pump (generic for Androgel®) from Non-Preferred to Preferred.

ANTIPARASITICS

- Recommendations: Move Sklice® Lotion from Preferred to Non-Preferred.

ANTIVIRAL

- Recommendations: Add acyclovir cream (generic for Zovirax® Cream) as a Non-Preferred product.

IMMUNOMODULATORS – ATOPIC DERMATITIS

- Recommendations: Move Eucrisa® 2% Ointment from Non-Preferred to Preferred; move Protopic® Ointment from Non-Preferred to Preferred

IMMUNOMODULATORS – IMIDAZOQUINOLINAMINES

- Recommendations: Add Condylox® Gel as a Non-Preferred product.

NSAIDS

- Recommendations: Move Voltaren® Gel from Preferred to Non-Preferred; move diclofenac topical gel (generic for Voltaren® Gel) from Non-Preferred to Preferred; add diclofenac epolamine patch (generic for Flector® Patch) and Diclofex™ DC Pack as Non-Preferred products.

PSORIASIS

- Recommendations: Add calcipotriene-betamethasone suspension (generic for Taclonex®) and Duobrii® Lotion as Non-Preferred products.

ROSACEA AGENTS

- Recommendation: Add Finacea® Foam and ivermectin cream (generic for Soolantra®) as Non-Preferred products.

MEDIUM POTENCY STEROIDS

- Recommendation: Add Beser™ Lotion/Kit as a Non-Preferred product.

HIGH POTENCY STEROIDS

- Recommendation: Add halcinonide cream (generic for Halog®) as a Non-Preferred product.

VERY HIGH POTENCY STEROIDS

- Recommendation: Add Tovet™ Foam/Foam Kit as a Non-Preferred Product.

MISCELLANEOUS

ESTROGEN AGENTS COMBINATIONS

- Recommendation: Add Bijuva® Capsule as a Non-Preferred product.

ESTROGEN AGENTS, ORAL / TRANSDERMAL

- Recommendation: Add Dotti™ Patch as a Non-Preferred product.

ESTROGEN AGENTS, VAGINAL PREPARATIONS

- Recommendation: Add Imvexxy® Vaginal Inserts as a Non-Preferred product.

GLUCOCORTICOID STEROIDS, ORAL

- Recommendation: Add Dxevo™ Tablet Pack and Emflaza® Suspension as Non-Preferred products.

IMMUNOMODULATORS, SYSTEMIC

- Recommendation: Add Rinvoq™ ER Tablet and Skyrizi™ syringe as Non-Preferred products.

IMMUNOSUPPRESSANTS

- Recommendation: Add Prograf® Granule Packet as a Preferred product.

MOVEMENT DISORDERS

- Recommendations: Move Austedo™ Tablet from Non-Preferred to Preferred; move Ingrezza® Capsule from Non-Preferred to Preferred thus removing the restriction "Trial and Failure of Preferred" because it is no longer required. Only clinical criteria apply. Move Xenazine® Tablet from Preferred to Non-Preferred and move tetrabenazine tablet from Non-Preferred to Preferred.

SKELETAL MUSCLE RELAXANTS

- Recommendations: Add cyclobenzaprine ER capsule (generic for Amrix® ER Capsule*)* and Norgesic™ Forte Tablet as Non-Preferred products.

DISPOSABLE INSULIN DELIVERY DEVICES

- Recommendations: Add new PDL category – Disposable Insulin Delivery Devices; add Omnipod DASH as a Preferred product in the category.

DIABETIC CONTINUOUS GLUCOSE MONITOR SUPPLIES

- Recommendations: Add a new PDL category - Diabetic Continuous Glucose Monitor Supplies; add Dexcom G5® and G6® Transmitter/Receivers as Preferred and Freestyle Libre™ 14 day Reader as Non-Preferred. Add Dexcom G4®, G5® Platinum Sensor 4 Pack,

and G6® Sensor 3 Pack as Preferred and Freestyle Libre™ 14 day Sensor as Non-Preferred.

Preferred Brands with Non-Preferred Generics on the Preferred Drug List (PDL) *Current as of Sept. 1, 2020*

Brand Name	Generic Name
Actiq 1200 mcg Lozenges	fentanyl citrate 1200 mcg lozenges
Actiq 1600 mcg Lozenges	fentanyl citrate 1600 mcg lozenges
Actiq 200 mcg Lozenges	fentanyl citrate 200 mcg lozenges
Actiq 400 mcg Lozenges	fentanyl citrate 400 mcg lozenges
Actiq 600 mcg Lozenges	fentanyl citrate 600 mcg lozenges
Actiq 800 mcg Lozenges	fentanyl citrate 800 mcg lozenges
Adderall XR 10 mg Capsule	amphetamine salt combo ER 10 mg capsule
Adderall XR 15 mg Capsule	amphetamine salt combo ER 15 mg capsule
Adderall XR 20 mg Capsule	amphetamine salt combo ER 20 mg capsule
Adderall XR 25 mg Capsule	amphetamine salt combo ER 25 mg capsule
Adderall XR 30 mg Capsule	amphetamine salt combo ER 30 mg capsule
Adderall XR 5 mg Capsule	amphetamine salt combo ER 5 mg capsule
Advair Diskus 100-50	fluticasone-salmeterol 100-50
Advair Diskus 250-50	fluticasone-salmeterol 250-50
Advair Diskus 500-50	fluticasone-salmeterol 500-50
Aggrenox Capsule	aspirin-dipyridamole ER capsule
Alphagan P 0.15% Drops	brimonidine P 0.15% Drops
Apriso ER 0.375 Gram Capsule	mesalamine ER 0.375 gram capsule
Aptensio XR 10mg Capsule	methylphenidate ER 10mg capsule
Aptensio XR 15mg Capsule	methylphenidate ER 15mg capsule
Aptensio XR 20mg Capsule	methylphenidate ER 20mg capsule
Aptensio XR 30mg Capsule	methylphenidate ER 30mg capsule
Aptensio XR 40mg Capsule	methylphenidate ER 40mg capsule
Aptensio XR 50mg Capsule	methylphenidate ER 50mg capsule
Aptensio XR 60mg Capsule	methylphenidate ER 60mg capsule
Astepro 0.15% Nasal Spray	azelastine 0.15% nasal spray
Canasa 1,000 mg Suppository	mesalamine 1,000 mg suppository
Catapres-TTS 1 Patch	clonidine 0.1 mg/day patch
Catapres-TTS 2 Patch	clonidine 0.2 mg/day patch
Catapres-TTS 3 Patch	clonidine 0.3 mg/day patch
Cipro 10% Suspension	ciprofloxacin 500 mg/5 ml suspension
Cipro 5% Suspension	ciprofloxacin 250 mg/5 ml suspension
Clobex 0.005% Shampoo	clobetasol 0.005% shampoo
Concerta 18 mg Tablet	methylphenidate ER 18 mg tablet
Concerta 27 mg Tablet	methylphenidate ER 27 mg tablet

Concerta 36 mg Tablet	methylphenidate ER 36 mg tablet
Concerta 54 mg Tablet	methylphenidate ER 54 mg tablet
Copaxone 20 mg/ml Syringe	glatiramer 20 mg/ml syringe
Copaxone 40 mg/ml Syringe	glatiramer 40 mg/ml syringe
Derma-Smoothe-FS Body Oil	fluocinolone 0.01% body oil
Derma-Smoothe-FS Scalp Oil	fluocinolone 0.01% scalp oil
Dermotic Otic Drops	fluocinolone 0.01% otic drops
Diastat 2.5 mg Pedi System	diazepam 2.5 mg rectal gel system
Diastat Acudial 12.5-15-20	diazepam 20 mg rectal gel system
Diastat Acudial 5-7.5-10	diazepam 10 mg rectal gel system
Diclegis Tablet	doxylamine succinate/pyridoxine hcl tablet
Differin 0.1% Cream	adapalene 0.1% cream
Differin 0.3% Gel Pump	adapalene 0.3% gel pump
Dovonex 0.005% Cream	calcipotriene 0.005% cream
E.E.S 200	erythromycin ethyl succinate 200 mg/5 ml
Elidel 1% Cream	picmecrolimus 1% cream
Emend 40 mg Capsule	aprepitant 40 mg capsule
Emend 80 mg Capsule	aprepitant 80 mg capsule
Epiduo Gel	adapalene/benzoyl peroxide gel
Eryped 400mg/5ml suspension	erythromycin 400mg/5ml suspension
Exelon 13.3 mg/24 hr Patch	rivastigmine 13.3 mg/24 hr patch
Exelon 4.6 mg/24 hr Patch	rivastigmine 4.6 mg/24 hr patch
Exelon 9.5 mg/24 hr Patch	rivastigmine 9.5 mg/24 hr patch
Fazaclo 100 mg ODT	clozapine 100 mg ODT
Fazaclo 12.5 mg ODT	clozapine 12.5 mg ODT
Fazaclo 200 mg ODT	clozapine 200 mg ODT
Focalin 10 mg Tablet	dexmethylphenidate 10 mg tablet
Focalin 2.5 mg Tablet	dexmethylphenidate 2.5 mg tablet
Focalin 5 mg Tablet	dexmethylphenidate 5 mg tablet
Focalin XR 5 mg Capsule	dexmethylphenidate ER 5 mg capsule
Focalin XR 10 mg Capsule	dexmethylphenidate ER 10 mg capsule
Focalin XR 15 mg Capsule	dexmethylphenidate ER 15 mg capsule
Focalin XR 20 mg Capsule	dexmethylphenidate ER 20 mg capsule
Focalin XR 25 mg Capsule	dexmethylphenidate ER 25 mg capsule
Focalin XR 30 mg Capsule	dexmethylphenidate ER 30 mg capsule
Focalin XR 35 mg Capsule	dexmethylphenidate ER 35 mg capsule
Focalin XR 40 mg Capsule	dexmethylphenidate ER 40 mg capsule
Gabitril 12 mg Tablet	tiagabine 12 mg tablet
Gabitril 16 mg Tablet	tiagabine 16 mg tablet
Gabitril 2 mg Tablet	tiagabine 2 mg tablet
Gabitril 4 mg Tablet	tiagabine 4 mg tablet
Glyset 100 mg Tablet	miglitol 100 mg tablet
Glyset 25 mg Tablet	miglitol 25 mg tablet

Glyset 50 mg Tablet	miglitol 50 mg tablet
Humalog 100 units/ml Vial	insulin lispro 100units/ml vial
Humalog Kwikpen 100 units/ml	insulin lispro 100units/ml pen
Humalog Kwikpen Mix 75-25	insulin lispro Mix 75-25 pen
Kitabis Pak 300 mg/5 ml	tobramycin pak 300 mg/5 ml
Letairis 5mg Tablet	ambrisentan 5mg tablet
Letairis 10mg Tablet	ambrisentan 10mg tablet
Lialda 1.2 gm Tablet	mesalamine 1.2 gm tablet
Lotemax 0.5% eye drops	loteprednol etabonate eye drops
Methylin 10 mg/5 ml Solution	methylphenidate 10 mg/5 ml solution
Methylin 5 mg/5 ml Solution	methylphenidate 5 mg/5 ml solution
MetroCream 0.75% Cream	metronidazole 0.75% cream
Metrogel Topical 1% Gel	metronidazole topical 1% gel
Metrogel Topical 1% Pump	metronidazole topical 1% gel
Mitigare 0.6 mg capsule	colchicine 0.6 mg capsule
Moxeza 0.5% eye drops	moxifloxacin 0.5% eye drops
Natroba 0.9% Topical Suspension	spinosad 0.9% topical suspension
Nexium DR 10mg Packet	esomeprazole DR 10mg packet
Nexium DR 20mg Packet	esomeprazole DR 20mg packet
Nexium DR 40mg Packet	esomeprazole DR 40mg packet
Niaspan ER 1000 mg Tablet	niacin ER 1000 mg tablet
Niaspan ER 500 mg Tablet	niacin ER 500 mg tablet
Niaspan ER 750 mg Tablet	niacin ER 750 mg tablet
Novolog 100 U/ml Cartridge	insulin aspart 100 U/ml cartridge
Novolog 100 U/ml FlexPen	insulin aspart 100 U/ml pen
Novolog 100 U Vial	insulin aspart 100 U vial
Novolog Mix 70-30 FlexPen	insulin aspart mix 70-30 pen
Novolog Mix 70-30 Vial	insulin aspart mix 70-30 vial
Nuvigil 150 MG Tablet	armodafinil 150 mg tablet
Nuvigil 200 MG Tablet	armodafinil 200 mg tablet
Nuvigil 250 MG Tablet	armodafinil 250 mg tablet
Nuvigil 50 MG Tablet	armodafinil 50 mg tablet
Protopic 0.03% Ointment	tacrolimus 0.03% ointment
Protopic 0.1% Ointment	tacrolimus 0.1% ointment
Provigil 100 mg tablet	modafinil 100 mg tablet
Provigil 200 mg tablet	modafinil 200 mg tablet
Pulmicort 0.25 mg/2 ml	budesonide 0.25 mg/2 ml
Pulmicort 0.5 mg/2 ml	budesonide 0.5 mg/2 ml
Pulmicort 1 mg/2 ml	budesonide 1.0 mg/2 ml
Renagel 800mg Tablet	sevelamer 800mg tablet
Renvela 0.8 gm powder pkt	sevelamer 0.8 gm powder pkt
Renvela 2.4 gm powder pkt	sevelamer 2.4 gm powder pkt
Retin-A 0.025% Cream	tretinoin 0.025% cream

Retin-A 0.05% Cream	tretinoin 0.05% cream
Retin-A 0.1% Cream	tretinoin 0.1% cream
Retin-A Gel 0.01%	tretinoin gel 0.01%
Retin-A Gel 0.025%	tretinoin gel 0.025%
Retin-A Micro 0.04% Gel Tube	tretinoin gel micro 0.04% tube
Retin-A Micro 0.1% Gel Tube	tretinoin gel micro 0.1% tube
Retin-A Micro Pump 0.04% Gel	tretinoin gel micro 0.04% pump
Retin-A Micro Pump 0.1% Gel	tretinoin gel micro 0.1% pump
Sabril Powder Pack	vigabatin powder pack
Suboxone 2 mg-0.5 mg Film	buprenorphine/naloxone 2mg-0.5mg film
Suboxone 4 mg-1 mg Film	buprenorphine/naloxone 4mg-1mg film
Suboxone 8 mg-2 mg Film	buprenorphine/naloxone 8mg-2mg film
Suboxone 12 mg-3 mg Film	buprenorphine/naloxone 12mg-3mg film
Suprax 100 mg/5 ml Suspension	cefixime 100 mg/5 ml suspension
Suprax 200 mg/5 ml Suspension	cefixime 200 mg/5 ml suspension
Supraz 400 mg Capsule	cefixime 400 mg capsule
Symbicort 80-4.5 mcg Inhaler	budesonide-formoterol 80-4.5 mcg inhaler
Symbicort 160-4.5 mcg Inhaler	budesonide-formoterol 160-4.5 mcg inhaler
Symbyax 12-50 Capsule	olanzepine-fluoxetine 12-50 capsule
Symbyax 3-25 Capsule	olanzepine-fluoxetine 3-25 capsule
Symbyax 6-25 Capsule	olanzepine-fluoxetine 6-25 capsule
Symbyax 6-50 Capsule	olanzepine-fluoxetine 6-50 capsule
Tegretol 100 mg/5 ml Suspension	carbamazepine 100 mg/5 ml suspension
Tegretol 200 mg Tablet	carbamazepine 200 mg tablet
Tegretol XR 100 mg Tablet	carbamazepine ER 100 mg tablet
Tegretol XR 200 mg Tablet	carbamazepine ER 200 mg tablet
Tegretol XR 400 mg Tablet	carbamazepine ER 400 mg tablet
Tekturna 150mg Tablet	aliskiren 150mg tablet
Tekturna 300mg Tablet	aliskiren 300mg tablet
TobraDex Eye Drops	tobramycin-dexamethasone drops
Tracleer 125mg Tablet	bosentan 125 mg tablet
Tracleer 62.5mg Tablet	bosentan 62.5 mg tablet
Transderm-Scop 1.5 mg/3 day	scopolamine 1 mg/3 day patch
Travatan Z 0.004% Eye Drop	travoprost 0.004% eye drop
Vagifem 10 mcg Vaginal Tablet	estradiol 10 mcg vaginaI insert
Vesicare 5 mg Tablet	solifenacin succinate 5 mg tablet
Vesicare 10mg Tablet	solifenacin succinate 10 mg tablet
Xopenex HFA 45 mcg Inhaler	Levalbuterol HFA inhaler
Zovirax 5% Cream	acyclovir 5% cream
Zovirax 5% Ointment	acyclovir 5% ointment

As a reminder, if a brand is preferred with a Non-Preferred generic equivalent, "medically necessary" is NOT needed on the face of the prescription in order for the brand product to be covered. Claims for preferred brands with non-preferred generics will be reimbursed with a generic product dispensing fee. Claims for preferred brands with no generic or preferred brands with preferred generics will be reimbursed with a brand dispensing fee.

When a PDL class has a preferred brand with a non-preferred generic, providers requesting prior approval for the non-preferred generic should give a clinical reason why the beneficiary cannot use the brand.

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.

Checkwrite Schedule for September 2020

Electronic Cutoff Schedule	Checkwrite Date
Aug. 27, 2020	Sept. 1, 2020
Sept. 3, 2020	Sept. 9, 2020
Sept. 10, 2020	Sept. 15, 2020
Sept. 17, 2020	Sept. 22, 2020
Sept. 24, 2020	Sept. 29, 2020

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 2020 checkwrite schedules for both DHB and DMH/DPH/ORH can be found under the Quick Links on the right side of the NCTracks Provider Portal home page.

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