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| Arkansas Department of Human Services | Division of Medical Services | [Great Seal of the State of Arkansas](http://dhsshare/DHS%20Graphics/!arkseal2.jpg) |
| P.O. Box 1437, Slot S295 • Little Rock, AR 72203-1437  501-683-4120 • Fax: 501-683-4124  TDD/TTY: 501-682-6789 |

MEMORANDUM

TO: Arkansas Medicaid Prescribers and Interested Parties

FROM: Suzette Bridges, P.D., Division of Medical Services Pharmacy Program Suzette Bridges - initials

DATE: May 21, 2014

SUBJ: **AR Medicaid** **DUR Board edits approved at the April 16, 2014 meeting:**

**Changes To Existing Prior Authorization (PA) Criteria Or Edits:** C-II stimulants; Cuvposa® (glycopyrrolate) oral solution; Noxafil® (posaconazole) oral suspension; Proton Pump Inhibitors (PPI)

**Clinical edits through the Manual Review PA Process:** Noxafil® (posaconazole) DR tablet and Noxafil® (posaconazole) inj.; glycopyrrolate 0.2 mg/ml vials and Cuvposa® (glycopyrrolate) oral solution; Sovaldi® (sofosbuvir) tablet; Olysio® (simeprevir) capsule; Otrexup® (methotrexate) auto injector; clonidine HCl PF vials; Aptiom® (eslicarbazepine acetate) tablet; Zohydro® (hydrocodone) ER capsule; Fycompa® (perampanel) tablet; Fosrenol® chew tablets; Velphoro® chew tablet; Renvela® powder packets

**Clinical edits added through point-of-sale (POS) edit system:** Lupaneta® (leuprolide/norethindrone acet) kit 3.5-5 mg 1 month inj. and 11.25-5 mg 3 month inj.

**AEVCS edits (Dose-op edits, Cumulative Quantity, Daily Dose edits, Age edits, or Gender edits):** Afinitor® (everolimus) disperz tablets; Vimpat® (lacosamide) tablets

All criteria for the point of sale (POS) clinical edits can be viewed on the Medicaid website at <https://www.medicaid.state.ar.us/Download/provider/pharm/PACriteria.pdf>.

All drug claim edits, such as quantity edits, dose edits, age edits, or gender edits, can be viewed on the Medicaid website at <https://www.medicaid.state.ar.us/Download/provider/pharm/ClaimEdits.xls>.

**ICD-10 implementation deadline has been postponed by CMS to Oct. 1, 2015.**

**The following edits will be effective July 8, 2014 unless otherwise stated.**

(Reimbursement rates listed in this memo have been rounded to 2 decimals)

1. **CHANGES TO EXISTING PRIOR AUTHORIZATION (PA) CRITERIA OR EDITS:**
   1. **C-II Stimulants**

The C-II Stimulants belong to a drug class that is included on the Medicaid Preferred Drug List (PDL). Please view the Medicaid website for the PDL list of preferred and non-preferred drugs in this drug class. <https://www.medicaid.state.ar.us/Download/provider/pharm/PDL.xls>

Maximum daily dose and quantity edits for the C-II stimulants have been revised and are listed in the chart below. In addition to the revised allowed daily dose and quantity edits, the following point-of-sale prior approval criteria have also been revised:

* + - The criterion that allows concurrent therapy for children <18 years of age for both a long-acting agent and a short-acting agent as a “booster” dose has been amended. The new criterion will allow only one tablet per day for the booster dose of the short-acting agent if there is an overlap in the days’ supply between the long-acting agent and the short-acting agent.
    - For adolescents age 13 years through 17 years and adults age 18 years and older who meet the adult ADD/ADHD or narcolepsy criteria, a once daily dose of 72 mg for methylphenidate extended release tablets (e.g., Concerta®) may be requested through the manual review PA process by submitting a letter explaining the medical necessity for the high dose.
    - Focalin IR is included in the criteria with other short-acting IR formulation C-II stimulants.
    - Criteria that were developed to allow for doses that are not commercially available for Daytrana patch and Adderall XR have been removed.

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| --- | --- | --- | --- | --- |
| **Amphetamine Salts, Dex-Amphetamine, and Lis-dexamfetamine Agents** | | | | |
| **Immediate Release Amphetamine Salts Medicaid Max Daily Dose = 40 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAX CUMULATIVE QTY** |
| Mixed Amphetamine Salts (e.g., Adderall) 5 mg Tablet | 10 mg | 2 | | 62 |
| Mixed Amphetamine Salts (e.g., Adderall) 7.5 mg Tablet | 15 mg | 2 | | 62 |
| Mixed Amphetamine Salts (e.g., Adderall) 10 mg Tablet | 20 mg | 2 | | 62 |
| Mixed Amphetamine Salts (e.g., Adderall) 12.5 mg Tablet | 25 mg | 2 | | 62 |
| Mixed Amphetamine Salts (e.g., Adderall) 15 mg Tablet | 30 mg | 2 | | 62 |
| Mixed Amphetamine Salts (e.g., Adderall) 20 mg Tablet | 40 mg | 2 | | 62 |
| Mixed Amphetamine Salts (e.g., Adderall) 30 mg Tablet | 30 mg | 1 | | 31 |
|  | | | | |
| **Amphetamine Salts EXTENDED RELEASE Medicaid Max Daily Dose = 30 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAX CUMULATIVE QTY** |
| Adderall XR® 5 mg Capsule | 5 mg | 1 | | 31 |
| Adderall XR® 10 mg Capsule | 10 mg | 1 | | 31 |
| Adderall XR® 15 mg Capsule | 15 mg | 1 | | 31 |
| Adderall XR® 20 mg Capsule | 20 mg | 1 | | 31 |
| Adderall XR® 25 mg Capsule | 25 mg | 1 | | 31 |
| Adderall XR® 30 mg Capsule | 30 mg | 1 | | 31 |
|  | | | | |
| **Immediate Release Dextroamphetamine Medicaid Max Daily Dose = 40 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAX CUMULATIVE QTY** |
| Zenzedi® (Dextroamphetamine) Tablet 2.5 mg | 5 mg | 2 | | 62 |
| Dextroamphetamine (E.G., Dexedrine®, Zenzedi®) Tablet 5 mg | 10 mg | 2 | | 62 |
| Zenzedi® (Dextroamphetamine) Tablet 7.5 mg | 15 mg | 2 | | 62 |
| Dextroamphetamine (E.G., Dexedrine®, Zenzedi®) Tablet 10 mg | 20 mg | 2 | | 62 |
| Dextroamphetamine (E.G., Dexedrine®, Zenzedi®) Tablet 15 mg | 30 mg | 2 | | 62 |
| Dextroamphetamine (E.G., Dexedrine®, Zenzedi®) Tablet 20 mg | 40 mg | 2 | | 62 |
| Dextroamphetamine (E.G., Dexedrine®, Zenzedi®) Tablet 30 mg | 30 mg | 1 | | 31 |
|  | | | | |
| **Dextroamphetamine IR Oral Solution (PROCENTRA®) 5 mg/5 ml solution--No Change to Existing Quantity Edits Medicaid Max Daily Dose = 15 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAXIMUM CUMULATIVE QTY** |
| Dextroamphetamine IR Oral Solution (Procentra®) 5 mg/5 ml Soln | 15 mg | 15 ml per day | | 465 ml |
|  | | | | |
| **Dextroamphetamine EXTENDED RELEASE Medicaid Max Daily Dose = 40 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAX CUMULATIVE QTY** |
| Dextroamphetamine (e.g., Dexedrine®) Capsule 5 mg | 5 mg | 1 | | 31 |
| Dextroamphetamine (e.g., Dexedrine®) Capsule 10 mg | 40 mg | 4 | | 124 |
| Dextroamphetamine (e.g., Dexedrine®) Capsule 15 mg | 30 mg | 2 | | 62 |
| **Vyvanse (lis-dexamfetamine) EXTENDED RELEASE -- No Changes to Existing Quantity Edits. Medicaid Max Daily Dose = 70 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAX CUMULATIVE QTY** |
| Vyvanse® 20 mg Capsule | 20 mg | 1 | | 31 |
| Vyvanse® 30 mg Capsule | 30 mg | 1 | | 31 |
| Vyvanse® 40 mg Capsule | 40 mg | 1 | | 31 |
| Vyvanse® 50 mg Capsule | 50 mg | 1 | | 31 |
| Vyvanse® 60 mg Capsule | 60 mg | 1 | | 31 |
| Vyvanse® 70 mg Capsule | 70 mg | 1 | | 31 |
|  | | | | |
| **Methamphetamine HCl Medicaid Max Daily Dose = 10 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAX CUMULATIVE QTY** |
| Desoxyn® (Methamphetamine) 5mg Tablet | 10 mg | 2 | | 62 |
|  | | | | |
| **Methylphenidate Agents** | | | | |
| **Immediate Release Methylphenidate Medicaid Max Daily Dose = 60 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAX CUMULATIVE QTY** |
| Methylin 2.5 mg Chewable Tablet | 5 mg | 2 | | 62 |
| Methylin 5 mg Chewable Tablet | 10 mg | 2 | | 62 |
| Methylin 10 mg Chewable Tablet | 60 mg | 6 | | 186 |
| Methylphenidate 5 mg Swallow Tablet | 10 mg | 2 | | 62 |
| Methylphenidate 10 mg Swallow Tablet | 20 mg | 2 | | 62 |
| Methylphenidate 20 mg Swallow Tablet | 60 mg | 3 | | 93 |
| Methylin 5 mg/5 ml Solution | 30 mg | 30 ml | | 480 ml |
| Methylin 10 mg/5 ml Solution | 60 mg | 30 ml | | 960 ml |
|  | | | | |
| **Methylphenidate Tablets (e.g., Metadate® ER or Ritalin® SR) EXTENDED RELEASE Medicaid Max Daily Dose = 60 mg** | | | | |
| **DRUG NAME (Metadate® ER or Ritalin® SR = 8 HR DURATION)** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAX CUMULATIVE QTY** |
| Metadate (Methylphenidate) ER or Ritalin SR 10 mg Tablet | 10 mg | 1 | | 31 |
| Metadate (Methylphenidate) ER or Ritalin SR 20 mg Tablet | 60 mg | 3 | | 93 |
|  | | | | |
| **Methylphenidate Tablets (e.g., Concerta®) EXTENDED RELEASE Medicaid Max Daily Dose = 54 mg** | | | | |
| **DRUG NAME (Concerta® = 12 HR DURATION)** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAX CUMULATIVE QTY** |
| Methylphenidate Sa (E.G. Concerta®) 18 mg Tablet SA | 18 mg | 1 | | 31 |
| Methylphenidate Sa (E.G. Concerta®) 27 mg Tablet SA | 27 mg | 1 | | 31 |
| Methylphenidate Sa (E.G. Concerta®) 36 mg Tablet SA | 36 mg | 1 | | 62 |
| Methylphenidate Sa (E.G. Concerta®) 54 mg Tablet SA | 54 mg | 1 | | 31 |
|  | | | | |
| **Methylphenidate Capsules (e.g., Metadate CD™) EXTENDED RELEASE Medicaid Max Daily Dose = 60 mg** | | | | |
| **DRUG NAME (Metadate CD = 9-12 HR DURATION)**  (The extended-release capsules are comprised of both immediate-release (IR) and extended-release (ER) beads such that 30% of the dose is provided by the IR component and 70% of the dose is provided by the ER component.) | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | | **MEDICAID MONTHLY MAX CUMULATIVE QTY** |
| Metadate CD™ 10 mg Capsule (3 mg IR; 7 mg ER) | 10 mg | 1 | | 31 |
| Metadate CD™ 20 mg Capsule (6 mg IR; 14 mg ER) | 20 mg | 1 | | 31 |
| Metadate CD™ 30 mg Capsule (9 mg IR; 21 mg ER) | 30 mg | 1 | | 31 |
| Metadate CD™ 40 mg Capsule (12 mg IR; 28 mg ER) | 40 mg | 1 | | 31 |
| Metadate CD™ 50 mg Capsule (15 mg IR; 35 mg ER) | 40 mg | 1 | | 31 |
| Metadate CD™ 60 mg Capsule (18 mg IR; 42 mg ER) | 60 mg | 1 | | 31 |
| **Methylphenidate Capsules (e.g., Ritalin® LA) EXTENDED RELEASE Medicaid Max Daily Dose = 60 mg** | | | | |
| **Drug Name** (The extended-release capsules are comparable to two IR doses 4 hours apart) **Ritalin® LA = 9-12 HR DURATION** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | **MEDICAID MONTHLY MAX CUMULATIVE QTY** | |
| Ritalin® La (Methylphenidate) 10 mg Capsule | 10 mg | 1 | 31 | |
| Ritalin® La (Methylphenidate) 20 mg Capsule | 20 mg | 1 | 31 | |
| Ritalin® La (Methylphenidate) 30 mg Capsule | 60 mg | 2 | 62 | |
| Ritalin® La (Methylphenidate) 40 mg Capsule | 40 mg | 1 | 31 | |
|  | | | | |
| **Methylphenidate EXTENDED RELEASE SUSPENSION Medicaid Max Daily Dose = 60 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | **MEDICAID MONTHLY MAX CUMULATIVE QTY** | |
| Quillivant XR™ 25 mg/5 ml, Powder for Reconstitution, 60 ml | 10 mg | 2 ml | 60 ml | |
| Quillivant XR™ 25 mg/5 ml, Powder for Reconstitution, 120 ml | 20 mg | 4 ml | 120 ml | |
| Quillivant XR™ 25 mg/5 ml, Powder for Reconstitution, 150 ml | 25 mg | 5 ml | 150 ml | |
| Quillivant XR™ 25 mg/5 ml, Powder for Reconstitution, 180 ml | 60 mg | 12 ml | 360 ml | |
|  |  |  |  | |
| **Transdermal Methylphenidate EXTENDED RELEASE PATCH Medicaid Max Daily Dose = 30 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | **MEDICAID MONTHLY MAX CUMULATIVE QTY** | |
| Daytrana 10 mg/9 HR Patch | 10 mg | 1 | 31 | |
| Daytrana 15 mg/9 HR Patch | 15 mg | 1 | 31 | |
| Daytrana 20 mg/9 HR Patch | 20 mg | 1 | 31 | |
| Daytrana 30 mg/9 HR Patch | 30 mg | 1 | 31 | |
|  |  |  |  | |
| **Dexmethylphenidate IR Medicaid Max Daily dose = 20 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | **MEDICAID MONTHLY MAX CUMULATIVE QTY** | |
| Focalin 2.5mg Tablet | 5 mg | 2 | 62 | |
| Focalin 5mg Tablet | 10 mg | 2 | 62 | |
| Focalin 10mg Tablet | 20 mg | 2 | 62 | |
|  |  |  |  | |
| **Dexmethylphenidate ER-- No Changes to Existing Quantity Edits. Medicaid Max Daily Dose = 40 mg** | | | | |
| **DRUG NAME** | **MEDICAID MAX DAILY DOSE BY STRENGTH** | **MEDICAID MAX DAILY QUANTITY EDIT** | **MEDICAID MONTHLY MAX CUMULATIVE QTY** | |
| Focalin XR 5mg Capsule | 5 mg | 1 | 31 | |
| Focalin XR 10mg Capsule | 10 mg | 1 | 31 | |
| Focalin XR 15mg Capsule | 15 mg | 1 | 31 | |
| Focalin XR 20mg Capsule | 20 mg | 1 | 31 | |
| Focalin XR 25mg Capsule | 25 mg | 1 | 31 | |
| Focalin XR 30mg Capsule | 30 mg | 1 | 31 | |
| Focalin XR 35mg Capsule | 35 mg | 1 | 31 | |
| Focalin XR 40mg Capsule | 40 mg | 1 | 31 | |

***All calls regarding prior authorization or for a copy of the Statement of Medical Necessity should be directed to the EBRx PA Call Center Toll Free 1-866-250-2518 or Local 501-526-4200, or*** ***Fax 501-526-4188***.

* 1. **Insulin Pens for which a Multi-dose Vial of the Same Formulation exists**

The point-of-sale continuation criteria for the insulin pens have been revised as follows:

1. Claims for all insulin pens for children ≤ 18 yrs of age pay at POS; AND
2. Quantity for all insulin pens for children ≤ 18 yrs of age cannot exceed 15 ml per 31-day supply entered; AND
3. If the child is ≤ 18 years of age and designated as long-term care (LTC) in the Medicaid system, the claims for pens will not pay at POS unless they meet the (POS) continuation criteria below
4. Point of Sale (POS) continuation criteria will apply to all beneficiaries age 19 and older and all LTC-eligible beneficiaries who are “stable and compliant” on the insulin pen formulation. “Stable and compliant” definition was changed in this criterion to ≥ 90 days of the same insulin pen formulation medication in the previous 120 days.

The criteria on the insulin pen formulation applies to all strengths of the following insulin pens: Apridra® (insulin glulisine), Humalog® (insulin lispro), Humalog® Mix 50-50, Humalog® Mix 75-25, Humulin® (insulin human) N, Humulin® R, Lantus® (insulin glargine), Levemir® (insulin detemir), Novolin® (human insulin) 70-30, Novolin® N, Novolin® R, NovoLog® (insulin aspart), NovoLog® Mix 70-30, Relion Humulin® 70-30, Relion Humulin® N, Relion Humulin® R, Relion Novolin® 70-30, and Relion Novolin® N. As new pen formulations that have multidose vials of the same formulation come to market, the pen formulations will be added to the manual review PA list.

* 1. **Glycopyrrolate 0.2 mg/ml vial, and Cuvposa® (glycopyrrolate) 1 mg/5 ml oral solution:**

Cuvposa® (glycopyrrolate) is indicated to reduce chronic severe drooling in patients aged 3 to 16 years with neurologic conditions associated with problem drooling (e.g., cerebral palsy).

The Cuvposa® oral solution manual review PA criteria have been removed and the claims will go through at point-of-sale without a manual review PA. Existing quantity edits will remain in effect.

Manual Review PA will be required for all requests for Glycopyrrolate 0.2 mg/ml vials on a case-by-case basis.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

* 1. **Proton Pump Inhibitor (PPI) point-of-sale approval criteria for preferred agents have been changed:**

Due to the very high cost of pancreatic enzymes, the PPI point of sale criteria has been revised and the requirement of 2 claims of a pancreatic enzyme in previous 75 days has been removed and replaced with the requirement of billing for specific ICD-9 diagnosis codes for Cystic Fibrosis, pancreatic insufficiency, or unspecified disease of pancreas in the previous 2 years of Medicaid diagnosis history.

Point-of-Sale Approval criteria for preferred PPI agents with criteria revised as follows:

* Approve up to 93 days of proton pump inhibitor therapy per year for all recipients age 15 months or older
* Approve treatment beyond 93 days for recipients 15 months or older who have a diagnosis in history for Zollinger-Ellison Syndrome, Barrett’s esophagus, or an endoscopy (Appendix I) in the past 24 months, or diagnosis of CF, or diagnosis of pancreatic insufficiency, or diagnosis of unspecified disease of pancreas in previous 2 years of Medicaid diagnosis history.

***All calls regarding prior authorization or for a copy of the form should be directed to the EBRx PA Call Center Toll Free 1-866-250-2518 or Local 501-526-4200, or*** ***Fax 501-526-4188***.

* 1. **Noxafil® (posaconazole) 40 mg/ml oral suspension:** Noxafil® oral suspension is indicated for prophylaxis of invasive Aspergillus and Candida infections in patients who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy. Noxafil® oral suspension is indicated in patients 13 years of age and older. Noxafil oral suspension is also indicated for the treatment of oropharyngeal candidiasis, including oropharyngeal candidiasis refractory to itraconazole and/or fluconazole.

| **Dosing for Noxafil® Oral Suspension** | |
| --- | --- |
| **Indication** | **Dose and Duration of Therapy** |
| Prophylaxis of invasive *Aspergillus* and *Candida* infections | 200 mg (5 mL) three times a day. The duration of therapy is based on recovery from neutropenia or immunosuppression. |
| Oropharyngeal Candidiasis | Loading dose: 100 mg (2.5 mL) twice a day on the first day. |
|  | Maintenance dose: 100 mg (2.5 mL) once a day for 13 days. |
| Oropharyngeal Candidiasis Refractory to Itraconazole and/or Fluconazole | 400 mg (10 mL) twice a day. Duration of therapy should be based on the severity of the patient's underlying disease and clinical response. |

The reimbursement rate for Noxafil® Oral Suspension is $1,058.25 per 105 ml bottle.

The point-of-sale approval criteria for Noxafil® Oral Suspension for Criterion #3, which is currently for oropharyngeal Candidiasis refractory to itraconazole and/or fluconazole, has been changed and requires at least one paid claim of fluconazole in the past 30 days AND at least one paid claim of itraconazole in the past 30 days.

Criterion 3:

* ≥ 13 years of age, AND
* At least one paid claim for Fluconazole in the past 30 days, **AND**
* At least one paid claim for Itraconazole in the past 30 days.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

1. **CLINICAL EDITS THROUGH MANUAL REVIEW PRIOR APPROVAL (PA) PROCESS:**
   1. **Noxafil® DR 100 mg oral tablet, and Noxafil® 300 mg vial:**

Noxafil® injection and delayed-release tablets are indicated for prophylaxis of invasive Aspergillus and Candida infections in patients who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy. Noxafil® injection is indicated in patients 18 years of age and older. Noxafil® delayed-release tablets are indicated in patients 13 years of age and older. The delayed release tablets and the injection are not indicated for Oropharyngeal Candidiasis Refractory to itraconazole and/or fluconazole.

The reimbursement rates for Noxafil® tablets and injection are as follows: Noxafil® DR 100 mg tablet is $55.43 per 100 mg tablet; Noxafil® 300 mg vial is $509.23 per vial.

| **Dosing for Noxafil® Injection** | |
| --- | --- |
| **Indication** | **Dose and Duration of Therapy** |
| Prophylaxis of invasive *Aspergillus* and *Candida* infections | Loading dose: 300 mg Noxafil injection intravenously twice a day on the first day. |
| Maintenance dose: 300 mg Noxafil injection intravenously once a day, starting on the second day. Duration of therapy is based on recovery from neutropenia or immunosuppression. |

| **Dosing for Noxafil® Delayed-Release Tablets** | |
| --- | --- |
| **Indication** | **Dose and Duration of Therapy** |
| Prophylaxis of invasive *Aspergillus* and *Candida* infections | Loading dose: 300 mg (three 100 mg delayed-release tablets) twice a day on the first day. |
| Maintenance dose: 300 mg (three 100 mg delayed-release tablets) once a day, starting on the second day. Duration of therapy is based on recovery from neutropenia or immunosuppression. |

Manual Review PA will be required for all requests for Noxafil® DR 100 mg tablet and the Noxafil® 300 mg vial and will be reviewed on a case-by-case basis.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

* 1. **Otrexup® (methotrexate) auto inj. 10 mg, 15 mg, 20 mg, 25 mg:** Otrexup® is a folate analog metabolic inhibitor indicated for the management of patients with severe, active rheumatoid arthritis (RA) and polyarticular juvenile idiopathic arthritis (pJIA), who are intolerant of or had an inadequate response to first-line therapy, and symptomatic control of severe, recalcitrant, disabling psoriasis in adults who are not adequately responsive to other forms of therapy. Otrexup® is for once weekly subcutaneous use only. Otrexup® is not indicated for the treatment of neoplastic diseases.

The reimbursement rate for Otrexup® auto inj. 0.4 ml syringe is $142.58.

The reimbursement rate for methotrexate 25 mg/ml vials ranges from about $0.80 per ml to about $1.92 per ml.

Manual Review PA will be required for all requests for Otrexup® auto inj. syringes and will be reviewed on a case-by-case basis. In addition, Otrexup® has a maximum quantity of 4 syringes per month for all strengths (10 mg, 15 mg, 20 mg, and 25 mg).

Methotrexate 25 mg/ml vials do not require a PA.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

* 1. **Clonidine HCl PF vials, 5,000 mcg/10 ml and 1,000 mcg/10 ml:** Clonidine hydrochloride is indicated in combination with opiates for the treatment of severe pain in cancer patients that is not adequately relieved by opioid analgesics alone. Epidural clonidine is more likely to be effective in patients with neuropathic pain than somatic or visceral. The safety of this drug product has only been established in a highly selected group of cancer patients, and only after an adequate trial of opioid analgesia. Other use is of unproven safety and is not recommended.

The reimbursement rate has a wide variance for the 5,000 mcg/10 ml strength, ranging from $9.40 to $22.70 per ml; the 1000 mcg/10 ml strength ranges from $1.92 to $4.54 per ml.

Manual Review PA will be required for all requests for clonidine HCl PF vials and will be reviewed on a case-by-case basis.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

* 1. **Aptiom® (eslicarbazepine acetate) tablet, 200 mg, 400 mg, 600 mg, and 800 mg strengths:** is indicated as adjunctive treatment of partial-onset seizures. The recommended starting dose is 400 mg once daily. After one week, the dose may be increased to 800 mg once daily, which is the recommended maintenance dosage. Some patients may benefit from the maximum recommended maintenance dosage of 1200 mg once daily, although this dosage is associated with an increase in adverse reactions. A maximum dose of 1200 mg daily should only be initiated after the patient has tolerated 800 mg daily for at least a week.

Reimbursement rates are as follows: the 200 mg tablet is $15.47 each ($479.57 / 31 days’ supply); the 400 mg, 600 mg, and 800 mg tablets are $20.62 each ($639.22 / 31 days’ supply, or $1,278.44 for 1,200 mg/day for 31 days’ supply).

Manual Review PA will be required for all requests for Aptiom® tablets and will be reviewed on a case-by-case basis. In addition, a quantity edit is applied for one (1) tablet per day for each strength tablet (200 mg, 400 mg, 800 mg), and a cumulative quantity edit of 31 per 31 days for each strength tablet with the exception of the 600 mg tablet. A quantity of up to 2 tablets once daily will be allowed for the 600 mg tablet and cumulative quantity edit of 62 tablets per 31 days for those patients who may require the 1200 mg daily dose.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

* 1. **Zohydro™ ER (hydrocodone extended release) capsules 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg:** Zohydro™ ER is an opioid agonist indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve Zohydro™ ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. Zohydro™ ER is not indicated as an as-needed (prn) analgesic for opioid-naïve and opioid non-tolerant patients, initiate with 10 mg capsules orally every 12 hours. To convert to Zohydro™ ER from another opioid, use available conversion factors to obtain estimated dose. Increase the dose of Zohydro™ ER in increments of 10 mg every 12 hours every 3 to 7 days as needed to achieve adequate analgesia. Individualize treatment; titrate to effective and tolerable dose. Capsules must be swallowed whole and are not to be chewed, crushed, or dissolved.

The reimbursement rate for Zohydro™ ER is as follows:

10 mg $6.04 each

15 mg $6.45 each

20 mg $6.66 each

30 mg $6.66 each

40 mg $7.07 each

50 mg $7.38 each

Contrary to FDA recommendations, Zohydro™ ER is not in an abuse-deterrent form. It may therefore be preferentially sought for abuse and diversion.

Manual Review PA will be required for all requests for Zohydro™ ER and will be reviewed on a case-by-case basis. In addition, a quantity edit is applied of 2 tablets per day for each strength tablet and a cumulative quantity edit of 62 tablets per 31 days.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

* 1. **Fycompa® (perampanel) tablet 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, 12 mg:** Fycompa®, a non-competitive AMPA glutamate receptor antagonist, is indicated as adjunctive therapy for the treatment of partial-onset seizures with or without secondarily generalized seizures in patients with epilepsy aged 12 years and older. The recommended starting dosage of Fycompa® is 2 mg once daily taken orally at bedtime. Increase dosage by 2 mg per day increments no more frequently than every week to a dose of 4 mg to 8 mg once daily taken at bedtime. In elderly patients, dosage increases during titration are recommended no more frequently than every two weeks. The recommended dose range is 8 mg to 12 mg once daily. A dose of 12 mg once daily resulted in somewhat greater reductions in seizure rates than the dose of 8 mg once daily, but with a substantial increase in adverse reactions. The recommended starting dosage of Fycompa® in the presence of enzyme-inducing AEDs, including phenytoin, carbamazepine, and oxcarbazepine, is 4 mg, and patients should be monitored closely for response. Clinical trials revealed a substantially reduced effect on seizure rates in these patients.

The reimbursement rate of Fycompa® is as follows: the 2 mg tablet is $9.79 each ($303.49 / 31 day- supply); the 4 mg, 6 mg, 8 mg, 10 mg, and 12 mg tablets are all $19.57 each ($606.67 / 31-day supply).

Manual Review PA will be required for all requests for Fycompa ® tablets and will be reviewed on a case-by-case basis. In addition, a quantity edit is applied of one (1) tablet per day on each strength tablet and a cumulative quantity edit of 31 per 31 days for each strength tablet.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

* 1. **Phosphate removing agents: Fosrenol® (lanthanum carbonate) 500 mg, 750 mg, 1000 mg chew tablets; Velphoro® (sucroferric oxyhydroxide) 500 mg chew tablets; Renvela® (sevelamer carbonate) 0.8 gm and 2.4 gm powder packet:**

Calcium acetate (various brands) and Fosrenol (lanthanum carbonate) are phosphate binder agents indicated to reduce serum phosphorus in patients with end stage renal disease (ESRD). Velphoro (sucroferric oxyhydroxide) is a phosphate binder indicated for the control of serum phosphorus levels in patients with chronic kidney disease on dialysis. Renagel® (sevelamer hydrochloride) is indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis. The safety and efficacy of Renagel® in CKD patients who are not on dialysis have not been studied. Renvela® (sevelamer carbonate) is indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis.

The Clinical Journal of the American Society of Nephrology (CJASN) published “Comparative Effectiveness of Calcium-Containing Phosphate Binders in Incident U.S. Dialysis Patients” and stated: “…there is no conclusive support in favor of lowering phosphorus in dialysis patients using oral binder medications. If a provider were compelled to use such a therapy, however, there is currently no hard endpoint evidence in favor of using calcium acetate, sevelamer, or lanthanum instead of the least expensive treatment option, over the-counter calcium carbonate.”

Manual Review PA will be required for all requests for Fosrenol® 500 mg, 750 mg, and 1000 mg chew tablets; Velphoro® 500 mg chew tablets; and Renvela® 0.8 gm and 2.4 gm powder packets, on a case-by-case basis. See chart below for reimbursement rate information and the list of medications available without prior authorization.

|  |  |  |  |
| --- | --- | --- | --- |
| **BRAND DRUG NAME & STRENGTH** | **GENERIC DRUG NAME** | **Reimbursement Rate per each (per ml, tab or cap, or powder packet) (rounded)** |  |
| Phoslyra™ 667 mg/5 ml Solution | CALCIUM ACETATE | $0.17 | No PA Required |
| Eliphos® 667 mg Tablet | CALCIUM ACETATE | $0.49 | No PA Required |
| Calcium Acetate Capsule 667 mg | CALCIUM ACETATE | $0.67 | No PA Required |
| PhosLo® 667 mg Gelcap | CALCIUM ACETATE | $0.82 | No PA Required |
| Renagel® 400 Mg Tablet | SEVELAMER HCl | $2.06 | No PA Required |
| Renagel® 800 Mg Tablet | SEVELAMER HCl | $4.12 | No PA Required |
| Renvela® 800 Mg Tablet | SEVELAMER CARBONATE | $3.30 | No PA Required |
| Fosrenol® 750 Mg Chew Tablet | LANTHANUM CARBONATE | $8.93 | Manual Review PA |
| Fosrenol® 1000 Mg Chew Tablet | LANTHANUM CARBONATE | $8.93 | Manual Review PA |
| Fosrenol® 500 Mg Chew Tab | LANTHANUM CARBONATE | $8.93 | Manual Review PA |
| Velphoro® 500 Mg Chew Tablet | SUCROFERRIC OXYHYDROXIDE | $9.08 | Manual Review PA |
| Renvela® 2.4 Gm Powder Packet | SEVELAMER CARBONATE | $9.90 | Manual Review PA |
| Renvela® 0.8 Gm Powder Packet | SEVELAMER CARBONATE | $9.90 | Manual Review PA |

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

**Hepatitis C**: Arkansas Medicaid is monitoring the evolving therapeutic options for Hepatitis C. Given the regular reporting of new results of several novel agents alone and in combination, the absence of long term clinical outcomes data, and the imminent approval of additional medications, Arkansas Medicaid has adopted a conservative approach to HCV therapy at this time to be revised as new information becomes available. Many factors will be reviewed and prescribers may be asked to provide the medical necessity of urgency for treatment.

The revised HCV Statement of Medical Necessity can be found on the Medicaid Pharmacy Program website and is required for all HCV treatment requests. It is posted on the Medicaid website in the Prescription Drug Program section under Prescription Drug PA forms: <https://www.medicaid.state.ar.us/InternetSolution/provider/forms/pharm/pharmform.aspx>. The Statement of Medical Necessity must be completed for all new and continuation therapy requests. Exceptions to the established criteria, including requests to extend therapy, will be reviewed on a case-by-case basis.

The reimbursement rate for Sovaldi® (sofosbuvir) is $1,032 per tablet; 12 weeks of Sovaldi® treatment = $86,688 in addition to other medications for treatment.

The reimbursement rate for Olysio® (simeprevir) is $815.28 per capsule; 12 weeks of Olysio treatment = $68,483.52 in addition to other medications for treatment.

**HCV manual review PA criteria:**

1. Current treatment for Genotype (GT)-1 of triple therapy of peginterferon + ribavirin + boceprevir (Victrelis®) or telaprevir (Incivek®) will remain available under current criteria.
2. GT-2, GT-3, and GT-4: Current treatment of peginterferon + ribavirin will remain available under current criteria.

**Criteria for approval of Sovaldi® (sofosbuvir):**

1. GT-1: Treatment Naïve AND Stage 4 Cirrhosis patients (liver biopsy required) will be reviewed on a case-by-case basis;
2. GT-1, GT-2, GT-3, GT-4: Pre-transplant patients reviewed on a case-by-case basis (treatment naïve or relapse or non-responder);
3. GT-2 and GT-3: Relapse or non-responder to peginterferon + ribavirin will be reviewed on a case-by-case basis;
4. All Genotypes: Any requests for Sovaldi® due to “ineligible” for or “intolerance” or “allergy” to peginterferon will be reviewed on a case-by-case basis.

**Criteria for approval of Olysio® (simeprevir):**

1. GT-1: medical necessity reviewed on a case-by-case basis (as is telaprevir);
2. Requests for GT-4 will be reviewed on a case-by-case basis.

**The completed HCV Statement of Medical Necessity, and any additional information for exception requests, can be faxed to the Medicaid Pharmacy Program office fax number: 501-683-4124.**

1. **CLINICAL EDITS THROUGH POINT-OF-SALE (POS) EDIT SYSTEM:**
   * + 1. **Lupaneta® (leuprolide/norethindrone acet.) 3.5-5 mg 1 month kit and 11.25-5 mg 3 month kit:**

Lupaneta® Pack kit contains leuprolide acetate for depot suspension and norethindrone acetate tablets. Lupaneta® Kit is indicated for initial management of the painful symptoms of endometriosis and for management of recurrence of symptoms. Duration of use is limited due to concerns about adverse impact on bone mineral density. The initial treatment course of Lupaneta® Pack is limited to six months. A single retreatment course of not more than six months may be administered after the initial course of treatment if symptoms recur. Use of Lupaneta® Pack for longer than a total of 12 months is not recommended. Norethindrone acetate is contraindicated in women with the following conditions: thrombophlebitis, thromboembolic disorders, cerebral apoplexy, or a past history of these conditions; markedly impaired liver function or liver disease and known or suspected carcinoma of the breast.

The reimbursement rates for the Lupaneta® pack kits are as follows:

1 month 3.75/5 mg kit = $884.48

3 month 11.25/5 mg kit = $2,653.51

The Maximum Allowable Cost (MAC) for the single ingredient leuprolide (e.g., Lupron®) injection is as follows:

1 month 3.75 mg = $799.78

3 month 11.25 mg = $1,773.39

Norethindrone 5 mg tablets are available without a PA. The reimbursement rate for the norethindrone 5 mg tablet, as a separate prescription, ranges from $1.13 to $3.53 per tablet.

The FDA approved indications for Lupaneta Pack Kits stated above are the same as the approved indications for the leuprolide injection (e.g., Lupron® Inj.) 3.75 mg-1 month and 11.25 mg-3 month although the duration of total therapy of Lupaneta® Pack for longer than a total of 12 months is not recommended.

The Lupaneta® Pack Kits have been added to the existing point-of-sale prior approval criteria for leuprolide injection (e.g., Lupron® Inj.) 3.75 mg-1 month and 11.25 mg-3 month; however, based on the information in the Lupaneta® kit package insert, regarding length of total therapy, the existing criteria were revised to the following:

* Billed diagnosis of endometriosis or uterine leiomyoma (fibroids) AND
* <12 billed claims of 3.75mg leuprolide injection (which would include Lupaneta®) in the previous 3 year Medicaid history OR
* < 4 billed claims of 11.25mg leuprolide injection (which would include Lupaneta®) in the previous 3 year Medicaid history

The existing denial POS criterion for leuprolide injection will remain:

* Diagnosis of infertility in Medicaid history (3 year look back).

AND the following POS denial criteria for the Lupaneta pack kits were added:

* Diagnosis of infertility in Medicaid history (3 year look back), OR
* Thrombophlebitis, OR
* Thromboembolic disorders, OR
* Cerebral apoplexy in Medicaid history; OR
* Carcinoma of the breast in Medicaid history

In addition, quantity edits have been added to the Lupaneta® 3.75 mg Pack kit to limit to one (1) per month; the Lupaneta® 11.25 mg Pack Kit is limited to one (1) per three (3) months.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information.

1. **AUTOMATED ELIGIBILITY VERIFICATION AND CLAIMS SUBMISSION (AEVCS) EDITS OR CLAIM EDITS (DOSE-OP EDITS, CUMULATIVE QUANTITY, DAILY DOSE EDITS, AGE EDITS, OR GENDER EDITS):**

The following edits were inadvertently left out of the DUR Provider Memo dated Feb. 12, 2014. These edits were implemented on March 18, 2014:

* + - 1. **Afinitor® (everolimus) disperz tablet 2 mg, 3 mg, 5 mg**

The reimbursement rates for Afinitor tablets are as follows:

2 mg disperz tab = $283.84

3 mg disperz tab = $286.69

5 mg disperz tab = $298.39

Quantity edits were added of one (1) tablet per day for all strengths. All requests for doses greater than one tablet per day for dose adjustments will be reviewed on a case-by-case basis.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

* + - 1. **VIMPAT® 50 mg, 100 mg, 150 mg, 200 mg tablet:**

The initial dose should be 50 mg twice daily (100 mg per day). Vimpat® can be increased at weekly intervals by 100 mg/day given as two divided doses up to the recommended maintenance dose of 200 to 400 mg/day, based on individual patient response and tolerability. In clinical trials, the

600 mg daily dose was not more effective than the 400 mg daily dose and was associated with a substantially higher rate of adverse reactions.

The reimbursement rates for Vimpat® are as follows:

50 mg tablet = $5.79; 100 mg tablet= $9.06; 150 mg tablet = $9.59; 200 mg tablet $9.60

Quantity edits were added for two (2) tablets per day for all strengths, and a cumulative quantity edit of 62 tablets per 31 days’ supply for each strength tablet was added.

**HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500** for information**.**

**FRIENDLY REMINDERS:**

1. **Incarcerated Persons:** The Medicaid Pharmacy Program is prohibited by federal regulations, 42 C.F.R. §435.1009 and §435.1010, from paying for drug claims for Medicaid recipients who, on the date the prescription is filled, are incarcerated in a correctional or holding facility for individuals who are prisoners, including juvenile correctional facilities, are detained pending disposition of charges, or are held under court order as material witnesses. If medications are requested for incarcerated Medicaid recipients, *the medications cannot be billed to Medicaid Pharmacy Program* and are subject to recoupment. Pharmacists should contact the correctional facility regarding the facility’s reimbursement procedures for the requested medications.
2. **The ANTIPSYCHOTIC AGENT CRITERIA FOR CHILDREN < 18 YOA** have an **ongoing requirement for labs for metabolic monitoring.** When any provider sends a patient who is less than 18 years of age for the metabolic labs that are required for the antipsychotic agents*, the provider must include* the PCP’s name and Medicaid ID number *on the lab order request form*. *It does* ***not*** *have to be the PCP ordering the labs.* Please refer to the Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual, Section II, 245.000 B.
3. **CHANGES TO INFORMED CONSENT FORM FOR ANTIPSYCHOTIC AGENT PA FOR CHILDREN < 18 YOA:**

For those providers who have not had their own version of the Informed Consent form approved for use with Medicaid PA requests and who use the Medicaid Informed Consent form for antipsychotic agents, the form has been updated (v010914) and is posted on the Medicaid website. As the form is updated and posted on the Medicaid website, *providers are required to use the most current form*. **Effective, Dec. 10, 2013, the old versions will no longer be accepted.**

1. The AR Medicaid Pharmacy Program reimburses for covered outpatient drugs for Medicaid recipients with prescription drug benefits. ***Only medications prescribed to that recipient can be billed using the recipient’s Medicaid ID.***Sanctions may be imposed against a provider for engaging in conduct that defrauds or abuses the Medicaid program. This could include billing a child’s medication to a parent’s Medicaid ID number and vice-versa.
2. EFFECTIVE **Nov. 20, 2013**: PHARMACY CLAIMS WILL DENY AT POINT OF SALE IF THE CLAIM IS SUBMITTED WITH EITHER THE INCORRECT PATIENT NAME OR INCORRECT DATE OF BIRTH. **Prescribers: Please ensure the PATIENT name on the prescription matches the patient’s Medicaid card. Pharmacy providers are encouraged to request the patient’s Medicaid card to verify patient name and date of birth.**
3. *EMERGENCY OVERRIDE*: In an emergency, for those drugs for which a five-day supply can be dispensed, a pharmacy may dispense up to a five-day supply of a drug that requires clinical criteria or is non-preferred. *This provision applies only in an emergency situation and when the HP Enterprise Services Prescription Drug Help Desk is unavailable, Evidence Based Prescription Drug Program Help Desk is unavailable, and the pharmacist is not able to contact the prescribing physician.* To file a claim using this emergency provision, the pharmacy provider will submit a “03” in the Level of Service (418-DI) field. Frequency of the emergency override is limited to once per year per class of drugs for non-LTC beneficiaries and once per 60 days per class for LTC beneficiaries. For any Schedule-II controlled substance filled using the Medicaid Emergency Override process, please refer to the Arkansas State Board of Pharmacy regulations regarding partial fill of a Schedule-II controlled substance.
4. Any reimbursement rates stated in this memorandum (or any previous memorandums) are for **REFERENCE PURPOSES ONLY AND SUBJECT TO CHANGE,** and are in no way a contractual obligation by Arkansas Medicaid. Current Generic Upper Limits (GUL) or Maximum Allowable Cost (MAC) that have been issued at the State and or Federal level, along with State issued Capped Upper Limits (CAP), can be found on the Arkansas Medicaid website: [www.medicaid.state.ar.us](http://www.medicaid.state.ar.us). *EAC is Estimated Acquisition Cost* and, in the absence of a federal or state GUL or MAC, this reimbursement methodology is calculated using AWP-14% for brand agents and AWP-20% for generic agents.
5. Manual Review PA requests and Exceptions to established criteria are reviewed on a case-by-case basis. Prescribers must provide written documentation to substantiate the medical necessity of the request.
6. **FOR ALL PDL DRUGS OR FOR REQUESTS FOR ANTIPSYCHOTIC DRUGS:** Providers requesting a Prior Authorization (PA) for a drug on the PDL or requesting a Prior Authorization (PA) for an antipsychotic medication should contact the **Evidence-based Prescription Drug Program (EBRx) PA Call Center Toll Free 1-866-250-2518 or Local 501-526-4200 or Fax 501-526-4188.** Please include any supporting documentation for the request with the fax, and include recipient ID number, recipient name, and Medicaid Provider ID with your request.
7. **FOR NON-PDL AND NON-ANTIPYSCHOTIC DRUG REQUESTS:** Providers requesting a Prior Authorization (PA) should call the **HP Prescription Drug Help Desk at 1-800-707-3854 or at 1-501-374-6609, extension 500.** For Prior Authorization (PA) requests requiring manual review, you may fax your request to the **HP Help Desk Fax at 501-372-2971 or to the state office Fax at 501-683-4124.** Please include any supporting documentation for the request with the fax, and include recipient ID number, recipient name, and Medicaid provider ID with your request. An approval, denial, or request for additional information will be returned by the close of business the following business day.
8. **The Antenatal & Neonatal Guidelines, Education and Learning System (ANGELS) program has developed a Pediatric Guideline for Strong-Willed Preschoolers (Young Children’s Strong-willed /Noncompliant/ Disruptive Behavior)** that has been peer reviewed and finalized. The guideline covers the problems, etiology, and prevalence of children who have disruptive behavior problems or Oppositional Defiant Disorder (ODD). The guideline indicates that early intervention is important to effectively address disruptive behavior problems and prevent escalation of the problem into the school-aged years. The guideline points out that no medications are indicated for the treatment of disruptive behavior disorders. The most thoroughly researched and validated type of interventions to treat young children’s disruptive behavior are often collectively referred to as Parent Management Training (PMT), Behavioral Parent Training (BPT), or sometimes just as Parent Training (PT). PMT approaches typically involve working with both the parent and child, teaching parents specific parenting skills to improve the parent-child relationship, improve compliance, and decrease disruptive behavior. The complete guideline is available at this link: <http://www.uams.edu/cdh1/peds_guidelines.aspx> Providers are asked to create a user name and password to log in to view any of the available pediatric guidelines on the website.

This advance notice is to provide you the opportunity to contact, counsel, and change patients’ prescriptions.

*If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.*

*If you have questions regarding this transmittal, or you need this material in an alternative format, such as large print, please contact the HP ENTERPRISE SERVICES (FORMERLY CALLED EDS) Provider Assistance Center at 1‑800‑457‑4454 (Toll‑Free) within Arkansas or locally and out-of-state at (501) 376‑2211. Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website:* [*www.medicaid.state.ar.us/*](https://www.medicaid.state.ar.us/InternetSolution/default.aspx)*.*

***ONGOING REMINDER FROM PREVIOUS COMMUNICATIONS:***

**Prescribers are required to monitor children < 18 years of age for metabolic changes every 6 months on an outpatient basis when the child is receiving any antipsychotic agent.**

Acceptable CPT codes for the metabolic monitoring criteria are listed below [reminder, criteria requires CPT codes monitoring for both glucose (group-1) and lipids (group-2)]:

**Group-1 (glucose codes):** Criteria require one of the following CPT codes that contain glucose monitoring in the previous 9 months from claim date of in-process claim:

* 83036 (HbA1c), OR
* 80050 (General Health Panel), OR
* 80069 (Renal Function Panel), OR
* 80047 (Basic Metabolic Panel), OR
* 80048 (Basic Metabolic Panel), OR
* 80053 (Comprehensive metabolic panel ), OR
* 82962 (Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use) OR
* 82948 (Glucose; blood, reagent strip ) OR
* 82947 (Glucose; quantitative, blood),

***AND***, criteria require one of the following lipid panel tests or all of the individual lipid test monitoring codes in previous 9 months from claim date of the in-process claim:

**Group-2 (lipid codes)**

* 80061 (Lipid panel ), OR
* 83701 (High resolution fractionation and quantitation of lipoproteins panel), OR
* 82465 (Cholesterol, serum or whole blood, total ), AND 83718 (HDL cholesterol ), AND 84478 (Triglycerides ), AND 83721 (LDL Cholesterol)

**Please Note:** When any provider sends a patient who is less than 18 years of age for the metabolic labs required for the antipsychotic agents*, the provider must include* the PCP’s name and Medicaid ID number *in the lab order request form*. *It does not have to be the PCP ordering the labs.* Please refer to the Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual, section II, 245.000 B for detailed information pasted below:

**B. The referring physician’s individual provider identification number must also accompany the order.**

1. If the client’s PCP referred the client to the physician ordering the tests, the ordering physician must include with the order the PCP’s individual provider identification number, in addition to his or her own individual provider identification number.

2. The reference facility retains the ordering physician’s provider information with the client’s medical record for the medical necessity audit trail.

3. The reference facility enters the PCP’s provider identification number on its claim(s) to certify PCP referral.

4. If the Medicaid client is exempt from PCP Program requirements, the reference facility submits the individual provider identification number of the ordering physician on its Medicaid claim.