February 23, 2016: This *Update* has been revised since its original publication. Information under the Clinical Criteria for Pediatric-Covered Indications for Growth Hormone Drugs section has been added in red text on page 10 of the *Update*. This information also may be found in topic #17337 of the Online Handbook.

ForwardHealth
Wisconsin serving you

Update
June 2015

No. 2015-27

Affected Programs: BadgerCare Plus, Medicaid, SeniorCare

To: Blood Banks, Dentists, Federally Qualified Health Centers, Hospital Providers, Nurse Practitioners, Nursing Homes, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

July 2015 Preferred Drug List Review and Other Pharmacy Policy Changes

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List and other pharmacy policy changes effective for dates of service on and after July 1, 2015, unless otherwise noted.

This *ForwardHealth Update* provides information for prescribers and pharmacy providers about changes to the Preferred Drug List (PDL) and other pharmacy policy changes effective for dates of service (DOS) on and after July 1, 2015, unless otherwise noted.

This *Update* provides an overview of the major changes to certain PDL drug classes for BadgerCare Plus, Medicaid, and SeniorCare programs but does not address all of the changes made in PDL drug classes. For additional information about covered drugs on the PDL for BadgerCare Plus, Medicaid, and SeniorCare, providers may refer to the Preferred Drug List Quick Reference on the Pharmacy Resources page of the Providers area of the ForwardHealth Portal at *www.forwardhealth.wi.gov/*.

Changes to Pharmacy-Related Forms and Completion Instructions

Attachment 1 of this *Update* lists the prior authorization (PA) forms and completion instructions that are new or have been revised, renamed, or discontinued as a result of the July 2015 PDL review or as a result of other pharmacy policy changes. Providers should refer to the Forms page of the Portal for current copies of all PA forms and completion instructions. Unless otherwise noted, all forms listed in Attachment 1 are effective July 1, 2015. Additional information regarding changes to clinical criteria or submission options is noted in the applicable drug class section of this *Update*.

Archive Page for Pharmacy-Related Forms and Completion Instructions

Providers may reference the Pharmacy-Related Forms and Completion Instructions link under the Archives section on the Pharmacy Resources page of the Portal for old versions of pharmacy-related forms and completion instructions. These archives are provided for reference purposes only. Providers should refer to the Online Handbook for current policy and procedures and to the Forms page for current forms and completion instructions.

A Brief Overview of the Preferred Drug List

ForwardHealth makes recommendations to the Wisconsin Medicaid Pharmacy PA Advisory Committee on whether certain PDL drugs should be preferred or non-preferred. These recommendations are based primarily on objective evaluations of a drug's relative safety, effectiveness of the drug, clinical outcomes, and the relative cost of the drug (to Wisconsin Medicaid) in comparison with other

therapeutically interchangeable alternative agents in the same drug class.

New drugs are usually added to existing drug classes on the PDL as non-preferred drugs until their next scheduled class review by the Medicaid PA Advisory Committee.

The PDL is not a drug formulary and is not a comprehensive list of covered drugs.

Most drugs and drug classes included on the PDL are covered by BadgerCare Plus, Medicaid, and SeniorCare, but certain drugs may have restrictions (e.g., diagnosis, quantity limits, age limits). Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Non-preferred drugs may be covered with an approved PA request. Most preferred drugs do not require PA except in designated classes identified on the Preferred Drug List Quick Reference. Noncovered drugs (e.g., drugs used for hair loss or cosmetic purposes) are not reimbursed, even with PA.

Prescribers' Responsibilities for Prior Authorization for Preferred Drug List Drugs

Prescribers are encouraged to write prescriptions for preferred drugs.

Prescribers are encouraged to prescribe more than **one** preferred drug before a non-preferred drug is prescribed.

Clinical Criteria for Non-preferred Drugs

Clinical criteria for approval of a PA request for a non-preferred drug are **at least one** of the following, unless drug class-specific clinical criteria have been established and published by ForwardHealth:

- The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least one** of the preferred drugs from the same PDL drug class as the drug being requested.
- There is a clinically significant drug interaction between another drug the member is taking and **at least one** of the preferred drugs from the same PDL drug class as the drug being requested.
- The member has a medical condition(s) that prevents the use of **at least one** of the preferred drugs from the same PDL drug class as the drug being requested.

Alternate Clinical Criteria for Non-preferred Drugs in Eligible Drug Classes Only

The following drug classes have alternate clinical criteria that may be considered if the member does not meet the previously listed clinical criteria for non-preferred drugs:

- Alzheimer's agents drug class (excluding Namenda and Namenda XR® for members who are 44 years of age or younger).
- Anticonvulsants drug class.
- Antidepressants, other drug class.
- Antidepressants, SSRI drug class.
- Antiparkinson's agents drug class.
- Antipsychotics drug class.
- Pulmonary arterial hypertension drug class.

Alternate clinical criteria may be considered if a member does not meet the previously listed clinical criteria for non-preferred drugs. Alternate clinical criteria are **one** of the following:

- The member is new to ForwardHealth (i.e., the member has been granted eligibility for ForwardHealth within the past month) and has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.
- The member had an approved PA issued by ForwardHealth that recently expired for the non-preferred drug, and the member has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.
- The member was recently discharged from an inpatient stay in which the member was stabilized on the non-preferred drug being requested.

Note: Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

Completing a Prior Authorization Form

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber is required to do the following:

- Complete the appropriate PA form for the drug.
- Send the PA form to the pharmacy where the prescription will be filled.
- Include accurate and complete answers and clinical information about the member's medical history on the PA form.
- Provide a handwritten signature and date on the form.

The PA form may be faxed or mailed to the pharmacy, or the member may carry the form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Prescribers are required to retain a completed, signed, and dated copy of the PA form and any supporting documentation. Pharmacy providers may not reuse PA forms from previously approved PA requests for subsequent PA submissions.

Note: If additional information needs to be addressed and can be provided by the pharmacy provider (e.g., medication refill history and compliance), the pharmacy provider should add the information to the Prior Authorization Fax Cover Sheet, F-01176 (12/11), which is available on the Forms page of the Portal, or to the Additional Information section available on most PA forms. The representative for the pharmacy provider should sign and date the entry to clearly identify the information source.

A Pharmacy Provider's Responsibilities for Prior Authorization for Preferred Drug List Drugs

Pharmacy providers should review the Preferred Drug List Quick Reference for the most current list of preferred and non-preferred drugs.

If a member presents a prescription for a non-preferred drug, the pharmacy provider is encouraged to contact the prescriber to discuss preferred drug options. The prescriber may choose to change the prescription to a preferred drug, if medically appropriate for the member, or the prescriber may complete the appropriate PA form.

Pharmacy providers are required to do the following:

- Submit the PA request using the PA form received from the prescriber and using the PA request submission option most appropriate for the drug. Pharmacy providers may submit PA requests using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system (when applicable), on the Portal, by fax, or by mail.
- Retain a completed, signed, and dated copy of the PA form and any supporting documentation received from the prescriber.

Pharmacy providers may not reuse PA forms from previously approved PA requests for subsequent PA submissions.

Note: If additional information needs to be addressed and can be provided by the pharmacy provider (e.g., medication refill history and compliance), the pharmacy provider should add the information to the Prior Authorization Fax Cover Sheet, which is available on the Forms page of the Portal, or to the Additional Information section available on most PA forms. The representative for the pharmacy provider should sign and date the entry to clearly identify the information source.

Changes to the Preferred or Non-preferred Status of Drugs on the Preferred Drug List

On May 13, 2015, the Medicaid PA Advisory Committee met to review new and existing therapeutic drug classes on the PDL.

Providers may refer to Attachment 2 for a table listing all of the drugs that have had a change in their preferred or non-preferred status as a result of this meeting. The updated statuses are effective July 1, 2015. Providers should review the Preferred Drug List Quick Reference on the Portal for a complete list of preferred and non-preferred drugs.

For drugs that previously were preferred and will become non-preferred, pharmacists should work with prescribers to transition members to a preferred drug or to complete the appropriate PA request forms.

As a reminder, new drugs are usually added to existing drug classes on the PDL as non-preferred drugs until the next scheduled class review by the Medicaid PA Advisory Committee; therefore, some drugs listed in the table had not been reviewed previously and were added to the PDL with an interim status of non-preferred. These drugs have now been reviewed and their PDL status resulting from the May 13, 2015, meeting and effective July 1, 2015, are included in in Attachment 2.

For some drugs in in Attachment 2, additional information is provided in the applicable drug class section of this *Update*.

Drug Class Name Change

As a result of the July 2015 PDL review, the irritable bowel syndrome drug classes will be renamed the GI motility, chronic drug class.

Providers may refer to the Preferred Drug List Quick Reference for a list of preferred and non-preferred drugs in each drug class.

Analgesics, Opioids Long-Acting

Zohydro® ER will remain a non-preferred drug.

Providers will be required to use the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request form, F-11075 (09/13), for PA requests for Zohydro® ER. Prior authorization requests received with a requested start date of July 1, 2015, or later must be submitted on the PA/PDL Exemption Request form or the PA request will be returned to the provider. Prior authorization requests for Zohydro® ER may be submitted using the STAT-PA system, on the Portal, by fax, or by mail.

Prior authorization requests previously submitted on the Prior Authorization Drug Attachment (PA/DGA) form, F-11049 (10/13), that have already been approved will be honored until they expire or until the approved days' supply is used up.

Antibiotics, Inhaled

TOBI® inhalation solution will become a non-preferred drug.

Kitabis™ Pak will become a preferred drug.

Bethkis® remains a preferred drug.

Preferred drugs in the antibiotics, inhaled drug class do not require PA.

Note: Studies are not available that indicate continuous alternating inhaled antibiotic therapy provides a better treatment benefit than one inhaled antibiotic every other month. ForwardHealth does not cover antibiotics for continuous alternating inhaled antibiotic therapy.

Tobramycin Solution, TOBI® Inhalation Solution, TOBI® Podhaler™, and Cayston®

Tobramycin solution, TOBI® inhalation solution, TOBI® Podhaler™, and Cayston® are non-preferred drugs in the antibiotics, inhaled drug class.

Prior authorization requests for tobramycin solution, TOBI® inhalation solution, TOBI® Podhaler™, and Cayston® must be completed and signed by the prescriber. Prior authorization requests for tobramycin solution, TOBI® inhalation solution, TOBI® Podhaler™, and Cayston® should be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA and the Prior Authorization Request Form (PA/RF), F-11018 (05/13). Clinical documentation supporting the use of tobramycin solution, TOBI® inhalation solution, TOBI® Podhaler™, or Cayston® must be submitted with the PA request.

Prior authorization requests for tobramycin solution, TOBI® inhalation solution, TOBI® Podhaler™, and Cayston® may be submitted on the Portal, by fax, or by mail. Prior authorization requests for tobramycin solution, TOBI® inhalation solution, TOBI® Podhaler™, and Cayston® may **not** be submitted using the STAT-PA system.

The following indicate how PA requests for tobramycin solution, TOBI® inhalation solution, TOBI® Podhaler™, and Cayston® will be approved when clinical criteria have been met:

- Prior authorization requests will be approved for up to a maximum of a 28-day supply per dispensing.
- Prior authorization requests will be approved with an alternating 28-day treatment schedule of 28 days of tobramycin solution, TOBI® inhalation solution, TOBI® Podhaler™, or Cayston® treatment with 28 days of no inhaled antibiotics/anti-infective agents.
- Prior authorization requests may be approved for up to a maximum of 168 days.

Clinical Criteria for Tobramycin Solution, TOBI® Inhalation Solution, and TOBI® Podhaler™

Clinical criteria that must be documented for approval of a PA request for tobramycin solution, TOBI® inhalation solution, or TOBI® Podhaler™ are **all** of the following:

- The member has cystic fibrosis.
- The member is 6 years of age or older.
- The prescriber has confirmed that the member has a positive sputum culture for Pseudomonas aeruginosa. (Prescribers are required to include a copy of the sputum culture report with all PA requests.)
- The prescriber has confirmed that the member is not colonized with Burkholderia cepacia.
- The member's FEV1 is less than 90 percent predicted. (Prescribers are required to include the member's FEV1, FEV1 predicted, and FEV1 percent predicted, along with the dates taken.)
- The member is not receiving treatment with other inhaled antibiotics/anti-infective agents, including alternating treatment schedules. (Prescribers should provide a history of all inhaled antibiotics/anti-infective agents within the most recent 90-day period.)
- The prescriber has submitted detailed clinical justification for prescribing tobramycin solution, TOBI® inhalation solution, or TOBI® Podhaler™ instead of Bethkis® or Kitabis™ Pak, including clinical information describing why the member cannot use Bethkis® or Kitabis™ Pak and why it is medically necessary that the member receive tobramycin solution, TOBI® inhalation solution or TOBI® Podhaler™ instead of Bethkis® or Kitabis™ Pak.

Clinical Criteria for Cayston®

Clinical criteria that must be documented for approval of a PA request for Cayston® are **all** of the following:

- The member has cystic fibrosis.
- The member is 6 years of age or older.
- The prescriber has confirmed that the member has a positive sputum culture for Pseudomonas aeruginosa. (Prescribers are required to include a copy of the sputum culture report with all PA requests.)
- The prescriber has confirmed that the member is not colonized with Burkholderia cepacia.
- The member's FEV1 is less than 90 percent predicted. (Prescribers are required to include the member's FEV1, FEV1 predicted, and FEV1 percent predicted, along with the dates taken.)
- The member is not receiving treatment with other inhaled antibiotics/anti-infective agents, including

alternating treatment schedules. (Prescribers should provide a history of all inhaled antibiotics/anti-infective agents within the most recent 90-day period.)

- **At least one** of the following is true:
  - ✓ The member has previously used inhaled tobramycin and experienced a clinically significant adverse drug reaction or an unsatisfactory therapeutic response.
  - ✓ The member has a medical condition(s) that prevents the use of inhaled tobramycin.
  - ✓ The member's sputum culture shows resistance to tobramycin.

Prescribers should indicate the specific details about the clinically significant adverse drug reaction(s), the unsatisfactory therapeutic response(s), or the medical condition(s) preventing the member from using inhaled tobramycin.

Antiemetics, Cannabinoids

Dronabinol will become a preferred drug.

Clinical PA is required for all antiemetics, cannabinoids, including preferred drugs.

Marinol®

Effective July 1, 2015, brand name Marinol® will require brand medically necessary (BMN) PA. ForwardHealth will no longer apply a generic copayment and dispensing fee to claims for Marinol®.

Prescribers are required to complete a Prior Authorization/ Brand Medically Necessary Attachment (PA/BMNA) form, F-11083 (01/15), for BMN drugs. In addition to completing the PA/BMNA form, the prescriber is also required to complete the Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids form, F-00194 (07/15), for brand name Marinol®.

For more information about BMN PA requests, providers should refer to the following topics in the Brand Medically Necessary Drugs chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook:

- Titration (topic #2012).
- Brand Medically Necessary Drugs: A Prescriber's Responsibilities (topic #2016).
- Brand Medically Necessary Drugs: Pharmacy Provider's Responsibilities (topic #2017).

Revised Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids Form

ForwardHealth has revised the PA/PDL for Antiemetics, Cannabinoids form, F-00194 (dated 07/15). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section of the Pharmacy Resources page of the Portal. Prior authorization requests received with a requested start date of July 1, 2015, or later must be submitted on the revised form or the PA request will be returned to the provider.

Note: Prior authorization requests that have already been approved for Marinol® may be used to dispense dronabinol until they expire or the approved days' supply is used up; however, previously approved PA requests for Marinol® should not be used to continue to dispense Marinol®. If it is medically necessary for a member to remain on Marinol®, the provider is required to obtain BMN PA.

Prior authorization is required for all antiemetic, cannabinoid drugs. To request PA, prescribers are required to complete and submit the PA/PDL for Antiemetics, Cannabinoids form to the pharmacy where the prescription will be filled. Prior authorization requests for antiemetic, cannabinoid drugs may be submitted on the Portal, by fax, or by mail. Prior authorization requests for antiemetic, cannabinoid drugs may **not** be submitted via STAT-PA.

Prior authorization requests for antiemetic, cannabinoid drugs will be approved for up to a maximum of 183 days.

Clinical Criteria for Dronabinol

Clinical Criteria for Dronabinol for HIV- and AIDS-Related Weight Loss or Cachexia

Clinical criteria for approval of a PA request for dronabinol for the treatment of weight loss or cachexia caused by HIV or AIDS for members who are **not** currently receiving dronabinol are **all** of the following:

- **One** of the following is true:
  - ✓ The member's baseline weight is typically in the normal weight range or above, and either the member's current body mass index (BMI) falls into the underweight range or the member had a 20 percent or greater decrease in weight from baseline in the past six months.
  - ✓ The member's baseline weight is normally in the underweight range and the member has had a 5 percent or greater decrease in weight from baseline.
- The member's daily caloric intake has been optimized.
- The member has been advised about and is following an appropriate dietary plan.

Clinical criteria for approval of a PA request for dronabinol for the treatment of weight loss or cachexia caused by HIV or AIDS for members who are currently receiving dronabinol are **both** of the following:

- The member's BMI is **not** in the overweight or obese range.
- **One** of the following is true:
  - ✓ The member's BMI remains in the underweight range.
  - ✓ The member's BMI has been stabilized in the normal range for less than six months.

Note: Members whose weight has been stabilized in the normal range for at least six months will **not** be granted a dronabinol PA renewal.

Clinical Criteria for Dronabinol for Chemotherapy-Related Nausea and Vomiting

Clinical criteria for approval of a PA request for dronabinol for the treatment of chemotherapy-related nausea and vomiting are **both** of the following:

- **At least one** of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with ondansetron.
  - ✓ There is a clinically significant drug interaction between another drug(s) the member is taking and ondansetron.
  - ✓ The member has a medical condition(s) that prevents the use of ondansetron.
- **At least one** of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with Emend®.
  - ✓ There is a clinically significant drug interaction between another drug(s) the member is taking and Emend®.
  - ✓ The member has a medical condition(s) that prevents the use of Emend®.

Antifungals, Topical

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Jublia® and Kerydin™

Prior authorization requests for Jublia® and Kerydin™ must be completed and signed by the prescriber. Prior authorization requests for Jublia® and Kerydin™ should be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA and the PA/RF.

Prior authorization requests for Jublia® and Kerydin™ may be submitted on the Portal, by fax, or by mail. Prior authorization requests for Jublia® and Kerydin™ may **not** be submitted using the STAT-PA system.

Approved PA requests on file with ForwardHealth dated prior to July 1, 2015, will be honored until they expire or until the approved days' supply is used up.

ForwardHealth has established clinical criteria for Jublia® and Kerydin™.

Clinical Criteria for Jublia® and Kerydin™

Clinical criteria that must be documented for approval of a PA request for Jublia® or Kerydin™ are **both** of the following:

- The member has onychomycosis of the toenails.
- The member has been treated with ciclopirox topical solution for 48 weeks and experienced an unsatisfactory therapeutic response.

In addition to meeting **both** of the above clinical criteria, one of the following must be true:

- The member has been treated with oral terbinafine and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction.
- There is a clinically significant drug interaction between another drug the member is taking and terbinafine.
- The member has a medical condition(s) that prevents the use of oral terbinafine.

Prescribers should indicate the specific details about the unsatisfactory therapeutic response, clinically significant adverse drug reaction, clinically significant drug interaction, or the medical condition(s) preventing the member from using oral terbinafine.

Prior authorization requests for Jublia® and Kerydin™ may be approved for up to a maximum of one year.

Antipsychotics

Generic aripiprazole, an antipsychotic drug, requires PA. Generic aripiprazole is a non-preferred drug that will be reviewed by the Wisconsin Medicaid Pharmacy PA Advisory Committee as part of the PDL review in winter 2015 in the antipsychotics drug class. Until the winter PDL review has occurred, all established clinical criteria for non-preferred drugs and, if applicable, all PA policy for antipsychotic drugs for children 7 years of age and younger will apply. In addition, further PA criteria have been established for generic aripiprazole.

Clinical Criteria for Generic Aripiprazole

In addition to the member meeting established clinical criteria for non-preferred drugs and, if applicable, PA policy for antipsychotic drugs for children 7 years of age and younger, the prescriber is required to also submit detailed clinical justification for prescribing generic aripiprazole instead of brand name Abilify®. This clinical information must document why the member cannot use brand name Abilify®, including why it is medically necessary that the member receive generic aripiprazole instead of brand name Abilify®.

For more information about the clinical criteria for non-preferred drugs, providers should refer to the A Prescribers Responsibilities for Prior Authorization for Preferred Drug List Drugs topic (topic #1987) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Providers should refer to the Prior Authorization for Antipsychotic Drugs for Children 7 Years of Age and Younger topic (topic #16537) in the Services Requiring Prior Authorization chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Submitting Prior Authorization Requests for Generic Aripiprazole

Prior authorization requests for generic aripiprazole must be submitted using the PA/DGA and the PA/PDL Exemption Request.

Prior authorization requests for generic aripiprazole must be completed and signed by the prescriber. Prior authorization requests for generic aripiprazole should be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook)

of the PA/DGA, along with the PA/PDL Exemption Request form and the PA/RF.

Prior authorization requests for generic aripiprazole for children 7 years of age and younger should be submitted using the PA/RF, the PA/DGA, and the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 7 Years of Age and Younger, F-00556 (03/14), in place of the PA/PDL Exemption Request form.

Prior authorization requests for generic aripiprazole may be submitted on the Portal, by fax, or by mail. Prior authorization requests for generic aripiprazole may **not** be submitted using the STAT-PA system.

Growth Hormone

ForwardHealth has revised the clinical criteria for growth hormone drugs.

Submitting Prior Authorization Requests for Growth Hormone Drugs

Prior authorization requests for growth hormone drugs must be submitted on the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs form, F-11092 (10/14). Prior authorization requests for growth hormone drugs may be submitted using the STAT-PA system (for some conditions or indications), on the Portal, by fax, or by mail.

ForwardHealth does not cover growth hormone drugs for the following members and conditions:

- Members with idiopathic short stature, which is a growth failure or short stature not associated with growth hormone deficiency or disease state.
- Pediatric members with growth failure or short stature with closed epiphyses.
- Pediatric members being treated with growth hormone drugs who have growth failure or short stature with a growth rate less than two cm/year.
- Members showing noncompliance with their growth hormone therapy.

Prior authorization requests submitted for these conditions will be returned as noncovered services. Members do not have appeal rights for noncovered services.

If clinical criteria for growth hormone drugs are met, initial PA requests may be approved for up to a maximum of 183 days. Renewal requests may be approved for up to a maximum of one year.

Approved PA requests on file with ForwardHealth dated prior to July 1, 2015, will be honored until they expire or until the approved days' supply is used up.

Clinical Criteria for Serostim®

ForwardHealth covers Serostim® for members with AIDS wasting disease or cachexia.

If clinical criteria for Serostim® are met, initial PA requests for Serostim® will be approved for up to a maximum of one year. Prior authorization requests for Serostim® must be submitted on the PA/PDL for Growth Hormone Drugs and may be submitted to ForwardHealth using the STAT-PA system, on the Portal, by fax, or by mail.

Clinical Criteria for Zorbtive®

ForwardHealth covers Zorbtive® for members with short bowel syndrome with dependence on parenteral nutrition. Members are limited to a 28-day course of the drug to reduce dependence on parenteral nutrition.

Prior authorization requests for Zorbtive® must be submitted on the PA/PDL for Growth Hormone Drugs and may be submitted to ForwardHealth using the STAT-PA system, on the Portal, by fax, or by mail.

Clinical Criteria for Pediatric-Covered Indications for Growth Hormone Drugs

ForwardHealth covers growth hormone drugs for the following indications:

- Growth failure or short stature associated with one of the following congenital conditions:
  - ✓ Noonan's Syndrome.

- ✓ Prader Willi Syndrome.
- ✓ SHOX deficiency.
- ✓ Turner Syndrome.

- Growth failure or short stature associated with chronic renal insufficiency in pre-transplant members. Providers are required to include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment.
- Growth failure or short stature associated with growth hormone deficiency confirmed with at least two appropriate growth hormone stimulation tests demonstrating a growth hormone peak response of less than 10 ng/ml. The member's height must be more than two standard deviations below the mean for chronological age. Providers are required to include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment. The medical workup should include growth velocity, IGF-1, IGF-BP3, and bone age results. If these results are normal, best clinical practice would indicate growth hormone stimulation testing is not necessary since growth hormone deficiency can effectively be excluded without the need for growth hormone stimulation testing. If IGF-1/IGF-BP3 results are low, under-nutrition should be evaluated and addressed before proceeding with growth hormone stimulation testing. Growth hormone stimulation testing can be useful information, but it has not been shown to be by itself a definitive tool for diagnosing growth hormone deficiency. ForwardHealth will consider the entire clinical record for the PA determination decision.
- Members born small for gestational age who are 2 years of age or older with a height that remains more than two standard deviations below the mean for chronological age. Providers are required to include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment.
- Hypothalamic-pituitary structural lesions and evidence of panhypopituitarism involving at least two pituitary hormone deficiencies, not including growth hormone. Providers are required to include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment.

Detailed documentation of the medical work-up and testing includes, at a minimum:

- Medical office notes.
- Growth charts (including growth rate, growth percentiles, and Z-scores).
- Lab testing results.

Additional required documentation to be submitted with the PA request, when applicable, includes the following:

- Bone age results.
- Growth plate results.
- Other image results.
- Growth hormone stimulation results.

Growth hormone stimulation testing should be conducted after an overnight fast, using a well-standardized protocol. Complete testing results must be included with the PA request, including the following:

- The type of stimulation test and the dose of stimulating agent.
- A copy of the medical notes taken during the entire testing procedure.
- The time and results from each blood sample taken.
- The provider interpretation of the testing results.

Note: All growth hormone prescriptions must be written by an endocrinologist or through an endocrinology consultation, except prescriptions written for Serostim® or Zorbtive®.

Clinical Criteria for Adult Covered Indications for Growth Hormone Drugs

ForwardHealth covers growth hormone drugs for the following indications:

- Growth Hormone Deficiency confirmed with an appropriate growth hormone stimulation test:
  - ✓ Providers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment including,

but not limited to, image results, lab testing, and medical office notes.

- ✓ Providers should indicate the type of stimulation test performed, month and year the test was done, and the results of the test. Stimulation testing should be conducted after an overnight fast, using a well-standardized protocol.
- ✓ Additional required information to be submitted includes a copy of the entire testing procedure, including at a minimum: medical office notes, growth hormone levels from each blood sample taken, complete test results, and provider interpretation of results.

- Hypothalamic-pituitary structural lesions and evidence of panhypopituitarism involving at least three pituitary hormone deficiencies, not including growth hormone. Providers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment including, but not limited to, image results, lab testing, and medical office notes.

Note: All growth hormone prescriptions must be written by an endocrinologist or through an endocrinology consultation, except prescriptions written for Serostim® or Zorbtive®.

Hepatitis C Agents

Viekira Pak™ will become a preferred drug.

Harvoni®, Olysio®, and Sovaldi™ will remain non-preferred drugs.

Clinical PA is required for all hepatitis C agents, including preferred drugs.

ForwardHealth has revised the clinical criteria for hepatitis C agents.

Note: The Prior Authorization Drug Attachment for Hepatitis C Agents form, F-01247 (12/14), is currently being revised to better address the revised hepatitis C agents clinical criteria. The revised clinical criteria will be effective for PA requests with a requested start date of July 1, 2015, or later. The revised form will be published at a later date. Until that time, providers should continue to use the current form for PA requests.

Prior authorization requests for hepatitis C agents must be completed and signed by prescribers. Initial PA requests for hepatitis C agents must be submitted on the Prior Authorization Drug Attachment for Hepatitis C Agents form. Renewal PA requests for hepatitis C agents must be submitted on the Prior Authorization Drug Attachment for Hepatitis C Agents Renewal form, F-01248 (12/14).

Note: If additional information needs to be addressed and can be provided by the pharmacy provider (e.g., medication refill history and compliance), the pharmacy provider should add the information to the Prior Authorization Fax Cover Sheet, which is available on the Forms page of the Portal, or to the Additional Information section available on most PA forms. The representative for the pharmacy provider should sign and date the entry to clearly identify the information source.

Prior authorization requests for hepatitis C agents may be submitted on the Portal, by fax, or by mail. Prior authorization requests for hepatitis C agents may not be submitted via STAT-PA.

Approved PA requests on file with ForwardHealth dated prior to July 1, 2015, will be honored until they expire or until the approved days' supply is used up.

Only hepatitis C virus (HCV) treatment prescribed by a board-certified gastroenterologist or a board-certified infectious disease provider for a member who is 18 years of age or older will be considered for review. If the prescriber is a mid-level practitioner, he or she must have a collaborative relationship with a physician board certified in gastroenterology or a physician board certified in infectious disease.

Clinical Information That Must Be Documented on Initial Prior Authorization Requests for All Hepatitis C Agents

For initial PA requests for hepatitis C agents, prescribers should complete the Prior Authorization Drug Attachment for Hepatitis C Agents form and submit the form to the pharmacy where the prescription will be filled. Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Hepatitis C Agents form and a completed PA/RF to ForwardHealth.

The clinical information that must be submitted with all initial PA requests for hepatitis C agents are **all** of the following:

- Lab data (within the last six months), including the following:
  - ✓ Albumin test.
  - ✓ Complete blood count (CBC).
  - ✓ Hepatitis C virus genotype.
  - ✓ Hepatitis C virus-ribonucleic acid (HCV-RNA) level.
  - ✓ International normalized ratio (INR).
  - ✓ Liver function tests (LFTs).
  - ✓ Serum creatinine test.
- Tests (if performed), including the following:
  - ✓ Liver CT scan, ultrasound, or MRI results.
  - ✓ Liver biopsy results.
- Hepatitis C virus clinical data, including the following:
  - ✓ Likely source of the HCV infection.
  - ✓ Current medical records for hepatitis C assessment and treatment.
  - ✓ History of liver transplant or on liver transplant wait list.
- If cirrhotic, documentation of the following clinical assessments:
  - ✓ Child-Turcotte-Pugh (CTP) score.
  - ✓ Hepatocellular carcinoma (HCC) status based on liver CT, ultrasound, or MRI performed within the last six months.
  - ✓ Presence and treatment of ascites, esophageal varices, hepatic encephalopathy, jaundice, and portal hypertension.

  Note: Fibroscan results may be provided as one component of cirrhosis assessment.
- Hepatitis C medication treatment history, including the following:
  - ✓ Details of when treatment occurred.
  - ✓ Medications taken and compliance.
  - ✓ Treatment results. (e.g., null response, partial response, or relapse.)
- From the member's primary care provider, a current history and physical, including complete problem list and medication list.
- Current and past psychosocial history including alcohol and illicit drug use.
- Planned hepatitis C treatment regimen.

If the required documentation is not included on or with the Prior Authorization Drug Attachment for Hepatitis C Agents form, the PA request will be considered incomplete and will be returned to the provider or denied.

Initial PA requests for Hepatitis C agents may be approved for up to a maximum of eight weeks. Depending on the treatment course that has been approved, PA requests may be renewed for additional weeks if the member's HCV-RNA is less than 25 IU/ml.

Note: ForwardHealth does not accept fibrosis staging as determined by calculators or blood assays to differentiate between F2 and F3 or greater Metavir scores. Some examples of fibrosis staging calculators may include AST to Platelet Ratio Index (APRI), Fibrosis-4 (FIB-4), and Non-alcoholic Fatty Liver Disease (NAFLD). Some examples of blood assays may include FibroSURE™ and FIBROSpect®. ForwardHealth does accept liver biopsy results to determine a Metavir score or to determine fibrosis staging.

Renewal Prior Authorization Requests for Hepatitis C Agents

For renewal PA requests for hepatitis C agents, prescribers should complete and sign the Prior Authorization Drug Attachment for Hepatitis C Agents Renewal form and submit the form to the pharmacy where the prescription will

be filled. The member's HCV-RNA levels and a copy of the actual laboratory report are required to be submitted with each renewal PA request for hepatitis C agents. Pharmacy providers are required to submit to ForwardHealth the completed Prior Authorization Drug Attachment for Hepatitis C Agents Renewal form and a completed Prior Authorization Amendment Request, F-11042 (07/12). A PA/RF should **not** be submitted.

Hepatitis C Agents, Viekira Pak™

Viekira Pak™ will become a preferred drug that requires clinical PA.

Prior Authorization Requests That Will Be Considered for Review

Only PA requests for Viekira Pak™ for members whose hepatitis C liver disease has advanced to any of the following stages may be considered for review:

- Compensated cirrhosis (i.e., CTP class A).
- Evidence of bridging fibrosis (e.g., Metavir score of F3 or greater).
- Serious extra-hepatic manifestations of HCV.
- Liver transplant recipients with normal hepatic function and mild fibrosis (e.g., Metavir score less than or equal to F2).

In addition, only PA requests for members who have chronic hepatitis C genotype 1 infection will be considered for review.

Conditions or Circumstances for Which Prior Authorization Requests Will Be Denied

Prior authorization requests for Viekira Pak™ will be denied in the following circumstances:

- The member has acute hepatitis C.
- The member has a significant or uncontrolled concurrent disease (e.g., cardiovascular disease, cancer, depression, diabetes, pulmonary disease, thyroid disease).
- The member has cirrhosis with moderate or severe liver functional compromise (i.e., CTP class B or C). (*Note:* If the member is currently on a liver transplant wait list with an elevated Model for End-Stage Liver Disease [MELD] score, individual circumstances will be considered for review.)
- The member is currently abusing drugs or alcohol.
  - ✓ Members with compensated cirrhosis must be abstinent from alcohol for the six months prior to and during HCV treatment.
  - ✓ Members must no longer be abusing drugs for at least six months prior to HCV treatment.
  - ✓ Active participation in a recovery program is required for members with a recent history of alcohol or drug abuse.
- The member has taken a prior course of therapy with Viekira Pak™.
- The member has not been compliant with approved hepatitis C treatment regimen.

Note: The member's other medications will be evaluated to determine if a significant drug interaction would occur that may result in denial of the PA request.

Hepatitis C, Agents, Harvoni®

Prior Authorization Requests That Will Be Considered for Review

Only PA requests for Harvoni® for members whose hepatitis C liver disease has advanced to any of the following stages and who are clinically ineligible for treatment with Viekira Pak™ due to a medical or medication contraindication may be considered for review:

- Compensated cirrhosis (i.e., CTP class A).
- Evidence of bridging fibrosis (e.g., Metavir score of F3 or greater).
- Serious extra-hepatic manifestations of HCV.

In addition, only PA requests for members who have chronic hepatitis C genotype 1 infection will be considered for review.

For treatment-naive members who have HCV without cirrhosis and an HCV-RNA level less than 6 million IU/ml and who meet the above criteria for PA review

consideration, only eight weeks of Harvoni treatment will be considered for review.

Conditions or Circumstances for Which Prior Authorization Requests Will Be Denied

Prior authorization requests for Harvoni® will be denied in the following circumstances:

- The member does not have a medical or medication contraindication for treatment with Viekira Pak™.
- The member has acute hepatitis C.
- The member has a significant or uncontrolled concurrent disease (e.g., cardiovascular disease, cancer, depression, diabetes, pulmonary disease, thyroid disease).
- The member has cirrhosis with moderate or severe liver functional compromise (i.e., CTP class B or C). (*Note:* If the member is currently on a liver transplant wait list with an elevated MELD score, individual circumstances will be considered for review.)
- The member has received a liver transplant.
- The member is currently abusing drugs or alcohol.
  - ✓ Members with compensated cirrhosis must be abstinent from alcohol for the six months prior to and during HCV treatment.
  - ✓ Members must no longer be abusing drugs for at least six months prior to HCV treatment.
  - ✓ Active participation in a recovery program is required for members with a recent history of alcohol or drug abuse.
- The member has taken a prior course of therapy with Harvoni® or Sovaldi™.
- The member has not been compliant with approved hepatitis C treatment regimen.

Note: The member's other medications will be evaluated to determine if a significant drug interaction would occur that may result in denial of the PA request.

Hepatitis C Agents, Olysio®

Prior Authorization Requests for Use of Olysio® with Pegylated Interferon and Ribavirin That Will Be Considered for Review

Only PA requests for the use of Olysio® with pegylated interferon and ribavirin as a combined treatment for members whose hepatitis C liver disease has advanced to any of the following stages and who are clinically ineligible for treatment with Viekira Pak™ due to a medical or medication contraindication may be considered for review:

- Compensated cirrhosis (i.e., CTP class A).
- Evidence of bridging fibrosis (e.g., Metavir score of F3 or greater).
- Serious extra-hepatic manifestations of HCV.

In addition, only members who have chronic hepatitis C genotype 1 infection will be considered for review. Members with hepatitis C genotype 1a must be screened for the NS3 Q80K polymorphism. If the NS3 Q80K polymorphism is detected, treatment will not be considered for review.

Conditions or Circumstances for Use of Olysio® with Pegylated Interferon and Ribavirin for Which Prior Authorization Requests Will Be Denied

Prior authorization requests for the use of Olysio® with pegylated interferon and ribavirin will be denied in the following circumstances:

- The member does not have a medical or medication contraindication for treatment with Viekira Pak™.
- The member has acute hepatitis C.
- The member has a significant or uncontrolled concurrent disease (e.g., cardiovascular disease, cancer, depression, diabetes, pulmonary disease, thyroid disease).
- The member has cirrhosis with moderate or severe liver functional compromise (i.e., CTP class B or C). (*Note:* If the member is currently on a liver transplant wait list with an elevated MELD score, individual circumstances will be considered for review.)
- The member has received a liver transplant.

- The member is currently abusing drugs or alcohol:
  - ✓ Members with compensated cirrhosis must be abstinent from alcohol for the six months prior to and during HCV treatment.
  - ✓ Members must no longer be abusing drugs for at least six months prior to HCV treatment.
  - ✓ Active participation in a recovery program is required for members with a recent history of alcohol or drug abuse.
- The member has taken a prior course of therapy with a treatment regimen that includes Olysio or any other HCV protease inhibitor.
- The member has not been compliant with approved hepatitis C treatment regimen.

Hepatitis C Agents Olysio® as a Combined Treatment with Sovaldi™

Prior Authorization Requests for Use of Olysio® as a Combined Treatment with Sovaldi™ That Will Be Considered for Review

Only PA requests for the use of Olysio® and Sovaldi™ as a combined treatment for members whose hepatitis C liver disease has advanced to any of the following stages and who are clinically ineligible for treatment with Viekira Pak™ due to a medical or medication contraindication may be considered for review:

- Compensated cirrhosis (i.e., CTP class A).
- Evidence of bridging fibrosis (e.g., Metavir score of F3 or greater).
- Serious extra-hepatic manifestations of HCV.

In addition, only members who have chronic hepatitis C genotype 1 infection will be considered for review. Members with hepatitis C genotype 1a must be screened for the NS3 Q80K polymorphism. If the NS3 Q80K polymorphism is detected, treatment will not be considered for review.

Conditions or Circumstances for Use of Olysio® as a Combined Treatment with Sovaldi™ for Which Prior Authorization Requests Will Be Denied

Prior authorization requests for the use of Olysio® and Sovaldi™ as a combined treatment will be denied in the following circumstances:

- The member does not have a medical or medication contraindication for treatment with Viekira Pak™.
- The member has acute hepatitis C.
- The member has a significant or uncontrolled concurrent disease (e.g., cardiovascular disease, cancer, depression, diabetes, pulmonary disease, thyroid disease).
- The member has cirrhosis with moderate or severe liver functional compromise (i.e., CTP class B or C). (*Note:* If the member is currently on a liver transplant wait list with an elevated MELD score, individual circumstances will be considered for review.)
- The member has received a liver transplant:
- The member is currently abusing drugs or alcohol:
  - ✓ Members with compensated cirrhosis must be abstinent from alcohol for the six months prior to and during HCV treatment.
  - ✓ Members must no longer be abusing drugs for at least six months prior to HCV treatment.
  - ✓ Active participation in a recovery program is required for members with a recent history of alcohol or drug abuse.
- The member has taken a prior course of therapy with Harvoni®, Olysio®, Sovaldi™, or any other protease inhibitor.
- The member has not been compliant with approved hepatitis C treatment regimen.

Note: Use of Olysio® and Sovaldi™ as a combined treatment will only be considered for members who have contraindications to the use of interferon, Harvoni®, ribavirin, and Viekira Pak™. Providers are required to clearly document why the member is unable to take interferon, Harvoni®, ribavirin, and Viekira Pak™.

Hepatitis C, Agents, Sovaldi™

Prior Authorization Requests That Will Be Considered for Review

Only PA requests for Sovaldi™ for members whose hepatitis C liver disease has advanced to any of the following stages may be considered for review (for HCV genotype 1, the member must be clinically ineligible for treatment with Viekira Pak™ due to a medical or medication contraindication):

- Compensated cirrhosis (i.e., CTP class A).
- Evidence of bridging fibrosis (e.g. Metavir score of F3 or greater).
- Serious extra-hepatic manifestations of HCV.

Conditions or Circumstances for Which Prior Authorization Requests Will Be Denied

Prior authorization requests for Sovaldi™ will be denied in the following circumstances:

- The member has HCV genotype 1 and does not have a medical or medication contraindication for treatment with Viekira Pak™.
- The member has acute hepatitis C.
- The member has a significant or uncontrolled concurrent disease (e.g., cardiovascular disease, cancer, depression, diabetes, pulmonary disease, thyroid disease).
- The member has cirrhosis with moderate or severe liver functional compromise (i.e., CTP class B or C). (*Note:* If the member is currently on a liver transplant wait list with an elevated MELD score, individual circumstances will be considered for review.)
- The member has received a liver transplant.
- The member is currently abusing drugs or alcohol:
  - ✓ Members with compensated cirrhosis must be abstinent from alcohol for the six months prior to and during HCV treatment.
  - ✓ Members must no longer be abusing drugs for at least six months prior to HCV treatment.
  - ✓ Active participation in a recovery program is required for members with a recent history of alcohol or drug abuse.
- The member has taken a prior course of therapy with Harvoni® or Sovaldi™.
- The member has not been compliant with the approved hepatitis C treatment regimen.

Hypoglycemics, GLP-1 Agents

Bydureon® and Tanzeum™ will become preferred drugs.

Byetta® will remain a preferred drug.

Preferred drugs in the Hypoglycemics, GLP-1 Agents drug class will no longer require PA.

Revised Prior Authorization Drug/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents Form

ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents form, F-00238 (07/15). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received with a requested start date of July 1, 2015, or later must be submitted on the revised form or the PA request will be returned to the provider.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Prior authorization requests for non-preferred GLP-1 agents must be submitted on the PA/PDL for GLP-1 Agents form.

Prior authorization requests for non-preferred GLP-1 agents may be submitted on the Portal, by fax, or by mail. Prior authorization requests for non-preferred GLP-1 agents may **not** be submitted via STAT-PA.

Prior authorization requests for non-preferred GLP-1 agents may be initially approved for up to a maximum of 183 days. Prior authorization requests may be approved for up to a maximum of one year if the member has been using a non-preferred GLP-1 agent for at least six months and the member has been adherent with treatment.

Clinical Criteria for Non-preferred GLP-1 Agents

ForwardHealth has revised clinical criteria for non-preferred GLP-1 agents.

Clinical criteria for approval of a PA request for a non-preferred GLP-1 agent are **all** of the following:

- The member has type II diabetes mellitus.
- The member is 18 years of age or older.
- The member does not currently have or have a history of pancreatitis.
- The member does not currently have or have a history of gastroparesis.
- The member's HbA1c was measured within the past six months.
- If the member is **not** currently using a GLP-1 agent, his or her most recent HbA1c is 6.5 percent or greater.

Note: Members currently taking a non-preferred GLP-1 agent who have had a previous PA request for that agent approved by ForwardHealth will be allowed to continue to receive PA approval as long as they meet the above requirements. Members are also required to have been adherent with treatment.

For members new to ForwardHealth, or for those who do not have a previously approved GLP-1 PA request, in addition to meeting all of the above clinical criteria, the member must be unable to take or must have previously discontinued treatment with **at least two** preferred GLP-1 agents.

One of the following must be documented for **at least two** of the preferred GLP-1 agents:

- The member has taken the maximum dose of a preferred GLP-1 agent for at least three consecutive months and experienced an unsatisfactory therapeutic response.
- The member experienced a clinically significant adverse drug reaction with a preferred agent.
- The member has a medical condition(s) that prevents the use of a preferred agent.

The following will not be considered as criteria to support the need for a non-preferred GLP-1 agent:

- Non-adherence to previous GLP-1 treatment.
- Member or prescriber preference for the use of a non-preferred GLP-1 agent.
- Member or prescriber preference for a less frequent dosing schedule.

Hypoglycemics, Insulins

Note: The Preferred Drug List Quick Reference provides the most current list of preferred and non-preferred drugs in this drug class.

Toujeo® Solostar

Prior authorization requests for Toujeo® Solostar must be completed and signed by the prescriber. Prior authorization requests for Toujeo® Solostar should be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA and the PA/RF.

Approved PAs requests on file with ForwardHealth dated prior to July 1, 2015, will be honored until they expire or until the approved days' supply is used up.

ForwardHealth has established clinical criteria for Toujeo® Solostar.

Clinical Criteria for Toujeo® Solostar

Clinical criteria that must be documented for approval of a PA request for Toujeo® Solostar are **all** of the following:

- The member has diabetes.
- The prescriber has submitted detailed clinical justification for prescribing Toujeo® Solostar instead of Lantus® or Levemir®, including clinical information why the member cannot use Lantus® or Levemir® and why it is medically necessary that the member receive Toujeo® Solostar instead of Lantus® or Levemir®.

In addition to meeting all of the previous clinical criteria, the following must be submitted:

- A copy of the member's current diabetes treatment regimen.
- A copy of the member's proposed diabetes treatment regimen to include Toujeo® Solostar.

The following will **not** be considered as criteria to support the need for Toujeo® Solostar:

- Non-adherence to previous insulin treatment.
- Member or prescriber preference for the use of Toujeo® Solostar.
- Member or prescriber preference for a smaller injection volume.

If clinical criteria for Toujeo® Solostar are met, initial PA requests may be approved for up to a maximum of 183 days. Renewal requests may be approved for up to a maximum of one year.

Lipotropics, Other

Certain brand name drugs will be preferred over their generic equivalents. Brand name Tricor will become a preferred drug (in addition to other preferred drugs) in the lipotropics, other drug class.

Generic fenofibrate tablets will become a non-preferred drug.

Multiple Sclerosis Agents, Immunomodulators

Aubagio®, Gilenya®, and Copaxone® 40 mg will become preferred drugs.

Extavia® will become a non-preferred drug.

Preferred drugs in the multiple sclerosis agents, immunomodulators drug class do not require PA.

Revised Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators Form

ForwardHealth has revised the Prior Authorization/ Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators form, F-00805 (07/15). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received with a requested start date of July 1, 2015, or later must be submitted on the revised form or the PA request will be returned to the provider.

Prior authorization requests that have already been approved will be honored until they expire or until the approved days' supply is used up.

Prior authorization requests for non-preferred MS agents, immunomodulators must be submitted on the PA/PDL for MS Agents, Immunomodulators form.

Pharmacy providers may submit PA requests for non-preferred MS agents, immunomodulators on the Portal, by fax, or by mail. Prior Authorization requests for non-preferred MS agents, immunomodulators may **not** be submitted using the STAT-PA system.

If clinical criteria for non-preferred MS agents, immunomodulators for treatment of MS are met, initial PA requests may be approved for up to a maximum of 183 days.

Renewal requests may be approved for up to a maximum of one year.

Clinical Criteria for Non-preferred Multiple Sclerosis Interferons

ForwardHealth has revised clinical criteria for non-preferred MS interferons.

Clinical Criteria for Members Currently Being Treated with a Non-preferred Multiple Sclerosis Interferon

Clinical criteria for approval of a PA request for a non-preferred MS interferon for members currently being treated with a non-preferred MS interferon are **all** of the following:

- The member and prescriber are following established monitoring guidelines outlined in the Food and Drug Administration (FDA)-approved patient labeling.
- The member has been adherent with the MS interferon treatment regimen.
- The member's MS is stable and well-controlled, not having disease-progressing symptoms.

In addition to all of the above clinical criteria, one of the following must be true:

- The member is new to ForwardHealth (i.e., the member has been granted eligibility for ForwardHealth within the past month) and has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response. *(Note:* Medical records must be provided to demonstrate the member meets this criterion.)
- The member had an approved PA issued by ForwardHealth that recently expired for the non-preferred drug, and the member has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.

Note: Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

Clinical Criteria for Members Not Currently Being Treated with a Non-preferred Multiple Sclerosis Interferon

Clinical criteria for approval of a PA request for a non-preferred MS interferon for members not currently being treated with a non-preferred MS interferon are that the member must experience an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to **at least two** preferred MS interferons.

Prior authorization requests must include detailed documentation regarding why the member has previously discontinued preferred MS interferon treatments.

Note: Medical records must be provided to demonstrate the member meets this criterion.

The following will **not** be considered as criteria to support the need for a non-preferred MS interferon:

- Non-adherence to previous MS treatment.
- Member or prescriber preference for the use of a non-preferred MS interferon.
- Member or prescriber preference for a less frequent dosing schedule.

Clinical Criteria for Non-preferred Oral Multiple Sclerosis Immunomodulators

ForwardHealth has revised clinical criteria for non-preferred oral MS immunomodulators.

Clinical Criteria for Members Currently Being Treated with a Non-preferred Oral Multiple Sclerosis Immunomodulator

Clinical criteria for approval of a PA request for a non-preferred oral MS immunomodulator for members currently being treated with a non-preferred oral MS immunomodulator are **all** of the following:

- The member and prescriber are following established monitoring guidelines outlined in the FDA-approved patient labeling.
- The member has been adherent with the oral agent treatment regimen.

- The member's MS is stable and well-controlled, without disease-progressing symptoms.

In addition to all of the above clinical criteria, one of the following must be true:

- The member is new to ForwardHealth (i.e., the member has been granted eligibility for ForwardHealth within the past month) and has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response. (*Note:* Medical records must be provided to demonstrate the member meets this criterion.)
- The member had an approved PA issued by ForwardHealth that recently expired for the non-preferred drug, and the member has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.

Note: Starting a member on a medication by using manufacturer-provided samples or manufacturer patient assistance programs will not be considered as previous medication history for PA review.

Clinical Criteria for Members Not Currently Being Treated with a Non-preferred Oral Multiple Sclerosis Immunomodulator

Clinical criteria for approval of a PA request for a non-preferred oral MS immunomodulator for members not currently being treated with a non-preferred oral MS immunomodulator are **all** of the following:

- The member is unable to take Aubagio® due to **one** of the following:
  - ✓ The member experienced a clinically significant adverse drug reaction.
  - ✓ There is a clinically significant drug interaction with another drug the member is taking.
  - ✓ The member has a medical condition(s) that prevents use of the drug.
- The member is unable to take Gilenya® due to **one** of the following:
  - ✓ The member experienced a clinically significant adverse drug reaction.
  - ✓ There is a clinically significant drug interaction with another drug the member is taking.
  - ✓ The member has a medical condition(s) that prevents use of the drug.

Prior authorization requests must include detailed documentation regarding why the member is unable to take or has previously discontinued treatment with both Aubagio® and Gilenya®.

Note: Medical records must be provided to demonstrate the member meets these criterion.

The following will not be considered as criteria for use of a non-preferred oral MS immunomodulator:

- Non-adherence to previous MS treatment.
- Member or prescriber preference for the use of a non-preferred oral MS immunomodulator.

Proton Pump Inhibitors

Lansoprazole capsules will become a preferred drug.

Rabeprazole tablets will become a non-preferred drug.

Revised Prior Authorization Drug/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets Form

ForwardHealth has revised the Prior Authorization/ Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets form, F-11078 (07/15). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Completion Instructions archive page linked under the Archives section on the Pharmacy Resources page of the Portal. Prior authorization requests received with a requested start date of July 1, 2015, or later must be submitted on the revised form or the PA request will be returned to the provider.

Clinical Criterion for Non-preferred Proton Pump Inhibitor Capsules and Tablets

ForwardHealth has revised the clinical criteria for non-preferred PPI capsules and tablets.

Prior authorization requests previously submitted on the PA/PDL for PPI Capsules and Tablets form that have already been approved will be honored until they expire or until the approved days' supply is used up.
The clinical criterion for approval of a PA request for a non-preferred PPI capsule or tablet is that the member has experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least two** preferred PPI capsules or tablets.

Stimulants and Related Agents

Vyvanse® for the Treatment of Binge Eating Disorder

The use of Vyvanse® for the treatment of Binge Eating Disorder (BED) requires clinical PA.

Prior authorization requests for Vyvanse® should be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA and the PA/RF.

Clinical Criteria for Vyvanse® for the Treatment of Binge Eating Disorder

ForwardHealth has established clinical criteria for Vyvanse for the treatment of BED.

Clinical criteria that must be documented for approval of a PA request for Vyvanse® for the treatment of BED are **all** of the following:

- The member is 18 years of age or older.
- The member has experienced at least three binge days per week for the last two weeks.
- The member is participating in at least one weekly intervention, including, but not limited to, the following:
  - ✓ Psychotherapy (individual or group).
  - ✓ Nutritional counseling.
  - ✓ Monitored exercise program. (*Note:* The name and telephone number of the individual monitoring the intervention[s] must be included on the PA form.)
- The member's BMI is between 25 and 45.
- The member is not currently taking an anti-obesity drug.
- The member has not had bariatric surgery.
- The member does not have a history of drug abuse or drug diversion.

Prior authorization requests should also include clinical documentation of the diagnostic work-up for BED, as well as all past and current BED treatments that have been attempted (both pharmacologic and non-pharmacologic).

Prior authorization requests may be approved for up to a maximum of 84 days.

Pharmacy Policy Changes

Anti-obesity Drugs

Prior authorization requests for the following anti-obesity drugs may be submitted on the Prior Authorization Drug Attachment for Anti-obesity Drugs, F-00163 (01/15):

- Benzphetamine.
- Diethylpropion.
- Phendimetrazine.
- Phentermine.
- Belviq®.
- Contrave®.
- Evekeo™.
- Qysmia®.
- Saxenda®.
- Xenical®.

Anti-obesity drugs are covered for dual eligibles enrolled in a Medicare Part D Prescription Drug Plan (PDP).

A 34-day supply is the maximum amount of any anti-obesity drug that may be dispensed each month.

Clinical Criteria for Anti-obesity Drugs

Clinical criteria for approval of a PA request for anti-obesity drugs require **one** of the following:

- The member has a BMI greater than or equal to 30.
- The member has a BMI greater than or equal to 27 but less than 30 **and** two or more of the following risk factors:
  - ✓ Coronary heart disease.
  - ✓ Dyslipidemia.
  - ✓ Hypertension.
  - ✓ Sleep apnea.
  - ✓ Type II diabetes mellitus.

In addition, **all** of the following must be true:

- The member is 16 years of age or older. (*Note:* Members need only to be 12 years of age or older to take Xenical®.)
- The member is not pregnant or nursing.
- The member does not have a history of an eating disorder (e.g., anorexia, bulimia).
- The member has not had bariatric surgery.
- The prescriber has evaluated and determined that the member does not have any medical or medication contraindications to treatment with the anti-obesity drug being requested.
- For controlled substance anti-obesity drugs, the member does not have a medical history of substance abuse or misuse.
- The member has participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will continue to follow the treatment plan while taking an anti-obesity drug.

PA requests for anti-obesity drugs will not be renewed if a member's BMI is below 24.

ForwardHealth does not cover the following:

- Brand name (i.e., innovator) anti-obesity drugs if an FDA-approved generic equivalent is available.
- Any brand name innovator phentermine products.
- Over-the-counter (OTC) anti-obesity drugs.

ForwardHealth will return PA requests for the previously listed drugs as noncovered services.

Submitting Prior Authorization Requests for Anti-obesity Drugs

Prescribers or their designees are required to request PA for anti-obesity drugs using one of the following options:

- Drug Authorization and Policy Override (DAPO) Center.
- ForwardHealth Portal.
- Fax.
- Mail.

A prescriber, or his or her designees, should have all PA information completed before calling the DAPO Center to obtain PA.

Prescribers are required to retain a copy of the PA form and any supporting documentation.

If a prescriber or his or her designee chooses to submit a paper PA request for anti-obesity drugs by fax or mail, the following must be completed and submitted to ForwardHealth:

- A PA/RF.
- A Prior Authorization Drug Attachment for Anti-obesity Drugs.
- Supporting documentation, as appropriate.

The Prior Authorization Fax Cover Sheet is available on the Forms page of the Portal for providers submitting the forms and documentation by fax.

Prescribers are reminded that they are required to sign and date each PA request form when submitting the request on paper.

ForwardHealth has revised the list of anti-obesity drugs that may be submitted on the Prior Authorization Drug Attachment for Anti-obesity Drugs to include Evekeo™ and Saxenda®, which are new anti-obesity drugs available in the marketplace that have been approved by the FDA.

ForwardHealth has established clinical criteria for Evekeo™ and Saxenda®.

Clinical Criteria for Evekeo™

If clinical criteria for anti-obesity drugs are met, initial PA requests for Evekeo™ will be approved for up to a maximum of one month. The maximum length of continuous drug therapy for Evekeo™ is one month.

After the member has completed one month of Evekeo™ treatment, the member must wait six months before PA can be requested for any controlled substance anti-obesity drug. ForwardHealth allows only two weight loss attempts with Evekeo™ during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

Refer to the Prior Authorization for Anti-obesity Drugs topic (topic #7837) in the Services Required Prior Authorization chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook for more information regarding clinical criteria for anti-obesity drugs.

Clinical Criteria for Saxenda®

If clinical criteria for anti-obesity drugs are met, initial PA requests for Saxenda® will be approved for up to a maximum of six months. If the member meets a weight loss goal of at least 5 percent of his or her weight from baseline, PA may be requested for an additional six months of treatment. Prior authorization requests for Saxenda® may be approved for up to a maximum treatment period of 12 continuous months of drug therapy.

If the member does not meet a weight loss goal of at least 5 percent of his or her weight from baseline during the initial six-month approval, or if the member has completed 12 months of continuous Saxenda® treatment, the member must wait six months before PA can be requested for Saxenda®.

ForwardHealth allows only two weight loss attempts with Saxenda® during a member's lifetime. Additional PA requests will not be approved. ForwardHealth will return additional PA requests to the provider as noncovered services. Members do not have appeal rights for noncovered services.

Refer to the Prior Authorization for Anti-obesity Drugs topic (topic #7837) of the Online Handbook for more information regarding clinical criteria for anti-obesity drugs.

Iron Products

Effective for DOS on and after May 1, 2015, age restrictions will no longer apply to ferrous sulfate and ferrous gluconate.

Kalydeco®

Kalydeco® (ivacaftor) requires clinical PA. Prior authorization requests for Kalydeco® must be submitted using Section VI (Clinical Information for Drugs with Specific Criteria Addressed in the Online Handbook) of the PA/DGA and the PA/RF.

Prior authorization requests for Kalydeco® may be submitted on the Portal, by fax, or by mail. Prior authorization requests for Kalydeco® may **not** be submitted using the STAT-PA system.

Clinical Criteria for Kalydeco®

ForwardHealth has revised the clinical criteria for Kalydeco®.

Prior authorization requests previously submitted for Kalydeco® that have already been approved will be honored until they expire or until the approved days' supply is used up.

Clinical criteria that must be documented for approval of a PA request for Kalydeco® are **all** of the following:

- The member has cystic fibrosis.
- The member is 2 years of age or older.
- The prescriber has confirmed that the member has a gene mutation consistent with the FDA-approved indications for use of Kalydeco®. (*Note:* A copy of the test results must be included with an initial PA request.)

- The prescriber has confirmed that the member does not have a homozygous F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
- The prescriber has confirmed that liver function is being monitored by periodic testing. (*Note:* A copy of the test results completed within the last 90 days must be included with initial and renewal PA requests.)

Prior authorization requests for Kalydeco® may be approved for up to a maximum of one year.

Copayment and Dispensing Fee for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copayment and dispensing fee to a brand name drug when a drug that previously required BMN PA moves to a preferred drug on the PDL and the available generic equivalents are non-preferred drugs.

This does not include brand name drugs that were preferred over generic equivalents because the generic equivalents are new to the marketplace and not yet cost-effective when compared with brand pricing (i.e., a Maximum Allowed Cost rate has not been established).

For drugs determined to be included in this policy, ForwardHealth will automatically apply the generic copayment when a specific brand name drug is preferred over a generic equivalent. Providers do not need to indicate a National Council for Prescription Drug Programs Dispense as Written code on claims to ensure the generic copayment deduction. In addition, ForwardHealth will automatically apply a generic dispensing fee to claims for which a specific brand name drug is preferred over the generic equivalent.

The following table includes the most current list of drugs for which this policy applies. Drugs shown in bold letters are drugs that have been added to this list, effective for DOS on and after July 1, 2015. This list is available on the Preferred Drug List Quick Reference on the Portal. Providers are encouraged to review the list closely to identify future changes.

Drug Class	Drug Name	Effective Date
Acne Agents	Differin® cream	January 1, 2012
	Differin® 0.1% gel	January 1, 2012
Anticonvulsants	Depakote® Sprinkle	January 1, 2012
	Tegretol XR® 200 mg	January 1, 2012
	Tegretol XR® 400 mg	January 1, 2012
Antihypertensive, Miscellaneous	Catapres-TTS®	January 1, 2014
Immunomodulators, Topical	Aldara™	January 1, 2014
Lipotropics, Other	**Tricor®**	July 1, 2015
Migraine Agents, Injectable	Imitrex® injection	July 1, 2012
Migraine Agents, Other	Imitrex® nasal spray	July 1, 2012
Ophthalmics Antibiotic/Steroid Combinations	Tobradex® suspension	January 1, 2012
Ophthalmics, Glaucoma — Other	Alphagan® P 0.15%	January 1, 2012
Stimulants and Related Agents	Adderall XR®	January 1, 2012
	Dexedrine® Spansule	January 1, 2014

Revisions to the Diagnosis Restricted Drugs Data Table

ForwardHealth has revised the Diagnosis Restricted Drugs data table on the Pharmacy Resources page of the Portal. The revised data table provides a list of diagnosis-restricted drugs effective July 1, 2015. The revised table also has a new, more user-friendly format, which includes the addition of check boxes for each drug class indicating whether the

diagnosis code must be submitted on the claim form, the PA request, or both. The updated data table is available on the Pharmacy Resources page of the Portal.

In most cases, data tables are revised monthly, so providers should refer to the Portal frequently for the most current information.

For more information about diagnosis-restricted drug policy, providers may refer to the Prior Authorization/Drug Attachment topic (topic #15937) in the Forms and Attachments chapter and the Diagnosis-Restricted Drugs topic (topic #15537) in the Diagnosis-Restricted Drugs chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook. For more information on submitting claims for diagnosis-restricted drugs, providers should refer to the Claims for Diagnosis-Restricted Drugs topic (topic #4403) in the Submission chapter of the Claims section of the Pharmacy service area of the Online Handbook.

Reminder

The following information is a reminder for providers of current policy. The following policy remains unchanged.

Place of Service Codes for Members Residing in a Long-Term Care Facility

Place of service (POS) codes identify the place where a drug or service is dispensed or administered. A POS code is required for all federal legend drugs, OTC drugs, and diabetic supplies. When providers submit compound and noncompound claims to ForwardHealth, it is important that they use the appropriate POS code.

Note: If a member resides in a nursing facility and the drug or service is dispensed or administered in that facility, the provider should use POS code 32 (Nursing Facility) as the appropriate POS. However, if the member does not reside in a nursing home and the drug or service was not dispensed or administered in that facility, the provider is required to use the most appropriate POS code. For instance, if a member resides in assisted living, rather than in a nursing home, POS code 13 (Assisted Living Facility) should be used, **not** POS code 32. If a member resides in a group home, POS code 14 (Group Home) should be used, **not** POS code 32. For more information about pharmacy POS codes, providers should refer to the Place of Service Codes topic (topic #12817) in the Codes chapter of the Covered and Noncovered section of the Pharmacy service area of the Online Handbook.

ICD-10 Code Set Project

In response to the Centers for Medicare and Medicaid Services mandate that all Health Insurance Portability and Accountability Act of 1996-covered entities implement the *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) and *International Classification of Diseases, 10th Revision, Procedure Coding System* (ICD-10-PCS) code sets by October 1, 2015, ForwardHealth is analyzing ICD-10 impacts and preparing for the transition to ICD-10. As a result, ForwardHealth has revised the following pharmacy-specific resources:

- ForwardHealth Portal Compound and Noncompound Drug Claim User Guide. The updated user guide is available for download on the ForwardHealth Portal.
- Pharmacy drug PA form completion instructions. ForwardHealth has revised the completion instructions for several of the drug PA forms. Refer to Attachment 3 for a list of the PA completion instructions that have been revised. These revisions are limited to removing specific *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code set references from the completion instruction language. The previous versions of these completion instructions will be removed from the Forms page of the Portal; however, they will not be placed on the Pharmacy-Related Forms and Completion Instructions archive page.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy for members enrolled in Medicaid and BadgerCare Plus who receive pharmacy services on a fee-for-service basis only. Pharmacy services for Medicaid members enrolled in the Program of All Inclusive Care for the Elderly (PACE) and the Family

Care Partnership are provided by the member's managed care organization. Medicaid and BadgerCare Plus HMOs must provide at least the same benefits as those provided under fee-for-service.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our website at *www.forwardhealth.wi.gov/*.

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ATTACHMENT 1
Changes to Pharmacy Prior Authorization Forms and Completion Instructions

The following table lists the pharmacy prior authorization forms and completion instructions that are new or have been revised, renamed, or discontinued as a result of the July 2015 Preferred Drug List review or as a result of other pharmacy policy changes. Providers should refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for current copies of these forms and completion instructions. Unless otherwise noted, all form changes listed are effective July 1, 2015. The old versions of these forms and completion instructions will be moved to the Pharmacy-Related Forms and Completion Instructions archive page that is linked under the Archives section on the Pharmacy Resources page of the Portal. Additional information regarding changes to clinical criteria or submission options is noted under the applicable drug classes in this *ForwardHealth Update*.

Form Name	Form Number	Revised, Renamed, Discontinued, or New	Effective Date
Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids	F-00194	Revised	07/01/15
Completion Instructions	F-00194A	Revised	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents	F-00238	Revised	07/01/15
Completion Instructions	F-00238A	Revised	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators	F-00805	Revised	07/01/15
Completion Instructions	F-00805A	Revised	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Capsules and Tablets Completion	F-11078	Revised	07/01/15
Completion Instructions	F-11078A	Revised	07/01/15

ATTACHMENT 2
Changes to the Preferred or Non-preferred Status of Drugs on the Preferred Drug List

The following table lists drugs that have had a change in their preferred or non-preferred status as a result of the July 2015 Preferred Drug List (PDL) review. The updated statuses are effective July 1, 2015. Drugs that have not been previously reviewed by the Medicaid Prior Authorization (PA) Advisory Committee are marked with an asterisk (*). The complete Preferred Drug List Quick Reference can be referenced on the Pharmacy Resources page of the Providers area of the ForwardHealth Portal at *www.forwardhealth.wi.gov/*.

Drug Class	Drug Name	Status Effective July 1, 2015
Acne Agents	benzoyl peroxide cleanser	Non-preferred
	benzoyl peroxide gel	Non-preferred
	sulfacetamide/sulfur cleanser	Preferred
Analgesics, Narcotics Long	fentanyl (37.5, 62.5, 87.5 MG)*	Non-preferred
	hydromorphone ER*	Non-preferred
	Hysingla ER*	Non-preferred
	oxycodone ER*	Non-preferred
Androgenic Agents	Testim	Non-preferred
	testosterone gel *	Non-preferred
	testosterone gel packet*	Non-preferred
	testosterone gel pump*	Non-preferred
Angiotesin Modulator Combination	amlodipine/valsartan*	Non-preferred
	amlodipine/valsartan/HCTZ*	Non-preferred
	trandolapril/verapamil*	Non-preferred
Anitbiotics, Inhaled	Kitabis Pak*	Preferred
	TOBI	Non-preferred
	tobramycin solution*	Non-preferred
Antibiotics, Vaginal	Nuvessa*	Non-preferred
Anticoagulants	Savaysa*	Non-preferred
	Xarelto Dose Pack*	Preferred
Antiemetic/Antivertigo Agents	Akynzeo*	Non-preferred
	Diclegis	Preferred
	dronabinol	Preferred
Antifungals, Oral	griseofulvin tablets	Non-preferred

Drug Class	Drug Name	Status Effective July 1, 2015
Antifungals, Topical	ciclopirox solution	Preferred
	clotrimazole-betamethasone lotion	Non-preferred
	Jublia*	Non-preferred
	Kerydin*	Non-preferred
	nystatin-triamcinolone cream	Non-preferred
	nystatin-triamcinolone ointment	Non-preferred
Antiparasitics, Topical	malathion	Non-preferred
Antivirals, Oral	Sitavig*	Non-preferred
Antivirals, Topical	Zovirax Ointment	Preferred
	acyclovir ointment	Non-preferred
Beta-Blockers	acebutolol	Non-preferred
	labetolol	Preferred
	Sotylize*	Non-preferred
Bone Resorption Suppression and Related Agents	raloxifene*	Non-preferred
Calcium Channel Blockers	diltiazem capsule ER*	Preferred
GI Motility, Chronic	Movantik*	Preferred
Hepatitis C Agents	Harvoni*	Non-preferred
	Viekira Pak*	Preferred
Hypoglycemics, Incretin Mimetics/Enhancers	Bydureon	Preferred
	Bydureon Pens*	Preferred
	Glyxambi*	Non-preferred
	Tanzeum*	Preferred
	Trulicity*	Non-preferred
Hypoglycemics, Insulin and Related Agents	Toujeo Solostar Pen*	Non-preferred
	Afrezza Cartridge*	Non-preferred
Hypoglycemics, SGLT2	Invokamet*	Non-preferred
	Invokana	Preferred
	Jardiance*	Non-preferred
Lipotropics, Other	fenofibrate tablet	Non-preferred
	omega-3 acid ethyl esters*	Non-preferred
	Tricor	Preferred
Multiple Sclerosis Agents	Aubagio	Preferred
	Copaxone Syringe	Preferred
	Extavia Kit	Non-preferred
	Extavia Vial	Non-preferred
	Gilenya	Preferred
	Plegridy*	Non-preferred
PAH Agents Oral and Inhaled	Orenitram ER*	Non-preferred
	Revatio Suspension*	Non-preferred
Penicillins	amoxicillin ER tablet*	Non-preferred

Drug Class	Drug Name	Status Effective July 1, 2015
Phosphate Binders	Auryxia*	Non-preferred
Platelet Aggregation Inhibitors	Zontivity*	Non-preferred
Proton Pump Inhibitors	esomeprazole Strontium*	Non-preferred
	lansoprazole capsules	Preferred
	rabeprazole tablets	Non-preferred
Tetracyclines	tetracycline	Non-preferred
	doxycycline hyclate tablet DR*	Non-preferred

* Drug was not previously reviewed. For more information, refer to the Changes to the Preferred or Non-preferred Status of Drugs on the Preferred Drug List section of this *ForwardHealth Update*.

ATTACHMENT 3
Changes to Pharmacy Prior Authorization Form Completion Instructions as a Result of *International Classification of Diseases, 10th Revision* (ICD-10)

The table below lists the pharmacy prior authorization drug form completion instructions that have been revised as a result of the *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) and *International Classification of Diseases, 10th Revision, Procedure Coding System* (ICD-10-PCS) code set implementation. These revisions are limited to removing specific ICD code set identifiers. The previous versions of these completion instructions will be removed from the Forms page of the Portal. They will not be placed on the Pharmacy-Related Forms and Completion Instructions Archives page.

Form Name	Form Number	Effective Date
Attestation to Administer Alpha Hydroxyprogesterone Caproate (17P) Compound Injections and Makena Injections Completion Instructions	F-00286A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Non-steroidal Anti-inflammatory Drugs (NSAIDS) Including Cyclo-oxygenase Inhibitors Completion Instructions	F-11077A	07/01/15
Compound Drug Claim Completion Instructions	F-13073A	07/01/15
Noncompound Drug Claim Completion Instructions	F-13072A	07/01/15
Expedited Emergency Supply Request Completion Instructions	F-00401A	07/01/15
Prior Authorization/Drug Attachment (PA/DGA) Completion Instructions	F-11049A	07/01/15
Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 7 Years of Age and Younger Completion Instructions	F-00556A	07/01/15
Prior Authorization Drug Attachment for Blood Glucose Meters and Test Strips Completion Instructions	F-00239A	07/01/15
Prior Authorization Drug Attachment for Lipotropics, Omega-3 Acids Completion Instructions	F-00162A	07/01/15
Prior Authorization/"J" Code Attachment (PA/JCA) Completion Instructions	F-11034A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions	F-11075A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ulcerative Colitis Completion Instructions	F-00694A	07/01/15

Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA) and Polyarticular Juvenile RA Completion Instructions	F-11308A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonists Drugs for Ankylosing Spondylitis Completion Instructions	F-11304A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonists Drugs for Crohn's Disease Completion Instructions	F-11305A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonists Drugs for Plaque Psoriasis Completion Instructions	F-11306A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonists Drugs for Psoriatic Arthritis Completion Instructions	F-11307A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Fentanyl Mucosal Agents Completion Instructions	F-00281A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Other Completion Instructions	F-00280A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Proton Pump Inhibitor (PPI) Orally Disintegrating Tablets Completion Instructions	F-00433A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Stimulants and Related Agents Completion Instructions	F-11097A	07/01/15
Prior Authorization/Preferred Drug List (PA/PDL) for Symlin Completion Instructions	F-00080A	07/01/15
Prior Authorization/Enteral Nutrition Product Attachment (PA/ENPA) Completion Instructions	F-11054A	07/01/15
Prior Authorization / Preferred Drug List (PA/PDL) for Migraine Agents, Injectable Completion Instructions	F-00622A	07/01/15
STAT-PA System Instructions	F-11055	07/01/15