

**Affected Programs:** BadgerCare Plus, Medicaid, SeniorCare

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

## July 2018 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 (PDL) and other pharmacy policy changes effective for dates of service on and after July 1, 2018, 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/](http://www.forwardhealth.wi.gov/).

### Changes to Pharmacy-Related Forms and Instructions

Attachment 1 of this *Update* lists the prior authorization (PA) forms and instructions that have been revised as a result of the July 2018 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 instructions. Unless otherwise noted, all forms listed in Attachment 1 are effective July 1, 2018. 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 Instructions

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

### A Brief Overview of the PDL

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 Pharmacy 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.

### ***A Prescriber's Responsibilities for PA for PDL 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.

Prescribers are required to provide clinical information so that pharmacy providers can request and obtain PA. Prescribers are required to complete the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request form, F-11075 (09/13), for non-preferred drugs that do not require a drug- or drug class-specific PA form.

### ***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
- Anticonvulsants drug class
- Antidepressants, other drug class
- Antidepressants, selective serotonin reuptake inhibitor 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 request 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 PA 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 their 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 request 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 PA for PDL 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 request 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 PDL**

On May 9, 2018, the Pharmacy 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, 2018. 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 were previously 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 Pharmacy 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 9, 2018, meeting are effective July 1, 2018, and are included in Attachment 2.

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

## **New Drug Class**

The prenatal vitamins drug class will be added to the PDL on July 1, 2018.

Pharmacy providers should begin working with prescribers to transition members using non-preferred drugs in the prenatal vitamins drug class or request PA for a non-preferred drug if it is medically appropriate for the member. Prescribers are required to complete the PA/PDL Exemption Request form for non-preferred prenatal vitamins.

Prenatal vitamins are available through an expedited emergency supply request, which may be granted for up to a 100-day supply.

For more information about expedited emergency supply drugs, providers may refer to the Emergency Medication Dispensing topic (topic #1399) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook at [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/).

## ***Prenatal Vitamins***

Providers may refer to Attachment 2 for a table listing all of the preferred drugs in the prenatal vitamins drug class.

In the prenatal vitamins drug class on the Preferred Drug List Quick Reference, ForwardHealth lists only the preferred generic and brand name drugs. Non-preferred drugs in the prenatal vitamins drug class will not be listed.

Drugs not listed in the prenatal vitamins drug class on the Preferred Drug List Quick Reference are one of the following:

- Considered to be non-preferred and require PA
- Noncovered (e.g., drugs without signed manufacturer rebate agreements, convenience or combination packaged drugs, and drugs produced under National Drug Codes identified as terminated by the Centers for Medicare and Medicaid Services)

Providers may use the Drug Search Tool on the Portal to determine the most current covered prenatal vitamins and their preferred or non-preferred status.

Convenience and combination packaged drugs are not covered by ForwardHealth. For more information about convenience and combination packaging, providers may refer to the Reimbursement Not Available topic (topic #1928) in the Reimbursement Not Available chapter of the Reimbursement section of the Pharmacy service area of the Online Handbook.

## **Antibiotics, Inhaled**

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

### ***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.

PA requests for tobramycin solution, TOBI Inhalation Solution, TOBI Podhaler, and Cayston must be completed

and signed by the prescriber. PA 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 Prior Authorization/Drug Attachment (PA/DGA) form, F-11049 (07/2016), and the Prior Authorization Request Form (PA/RF), F-11018 (05/13).

PA requests for tobramycin solution, TOBI Inhalation Solution, TOBI Podhaler, and Cayston may be submitted on the Portal, by fax, or by mail (but **not** 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:

- PA requests will be approved for up to a maximum 28-day supply per dispensing.
- PA 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.

#### *Clinical Criteria for Tobramycin Solution, TOBI Inhalation Solution, and TOBI Podhaler*

ForwardHealth has revised the clinical criteria for tobramycin solution, TOBI Inhalation Solution, and TOBI Podhaler.

PA requests 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 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 sputum culture shows susceptibility to tobramycin.
- The member's forced expiratory volume in one second (FEV1) is less than 90 percent predicted. Prescribers are required to include the member's most recent, complete pulmonary function test report.
- The member is not receiving treatment with other inhaled antibiotics/anti-infective agents, including alternating treatment schedules. Prescribers are required to 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.
- The member has been adherent with their prescribed treatment plan for inhaled medications.

Initial and renewal PA requests for tobramycin solution, TOBI Inhalation Solution, and TOBI Podhaler may be approved for up to 168 days.

Renewal PA requests for tobramycin solution, TOBI Inhalation Solution, and TOBI Podhaler require that the member be adherent with their inhaled antibiotic treatment.

#### *Clinical Criteria for Cayston*

ForwardHealth has revised the clinical criteria for Cayston.

PA requests 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 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 sputum culture shows susceptibility to Cayston.
- The member's FEV1 is less than 90 percent predicted. Prescribers are required to include the member's most recent, complete pulmonary function test report.
- The member is not receiving treatment with other inhaled antibiotics/anti-infective agents, including alternating treatment schedules. Prescribers are required to 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.
- The member has been adherent with their prescribed treatment plan for inhaled medications.

*Note:* Prescribers should indicate the specific details about the clinically significant adverse drug reaction(s), the unsatisfactory therapeutic response(s), the medical condition(s) preventing the member from using a preferred antibiotics, inhaled drug, or the member's sputum culture results showing resistance to tobramycin.

Initial and renewal PA requests for Cayston may be approved for up to 168 days.

Renewal PA requests for Cayston require that the member be adherent with their Cayston treatment.

### *Clinical Criteria for Cayston for Continuous Alternating Therapy*

ForwardHealth has established clinical criteria for Cayston for continuous alternating therapy (CAT).

Clinical criteria that must be documented for approval of a PA request for Cayston for CAT 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 sputum culture shows susceptibility to tobramycin and Cayston.
- The member's FEV1 is less than 90 percent predicted. Prescribers are required to include the member's most recent, complete pulmonary function test report.
- The member is experiencing persistent exacerbations or FEV1 decline with no significant improvement while using a single inhaled antibiotic drug or significant worsening of other markers that are being regularly tracked to monitor pulmonary disease progression.
- The prescriber has provided specific treatment goals for the member's CAT.
- The prescriber has provided a history of all inhaled antibiotics/anti-infective agents within the most recent 90-day period.
- The member has been adherent with their prescribed treatment plan for inhaled medications.

*Note:* ForwardHealth will not consider CAT as an initial choice for inhaled antibiotic therapy.

Initial and renewal PA requests for Cayston for CAT may be approved for up to 168 days.

Renewal PA requests for Cayston for CAT require that the member has been adherent with their CAT treatment. Prescribers are required to include documentation with renewal PA requests that clearly demonstrates the member has made progress toward their CAT treatment goals.

## **Antipsychotics**

The December 2017 *Update* (2017-42), titled “January 2018 Preferred Drug List Review and Other Pharmacy Policy Changes,” indicated that the revised PA criteria for antipsychotic drugs for children will include children **8 years of age and younger**.

Originally intended to be effective on and after January 1, 2018, this policy has been updated to be effective on and after July 1, 2018.

To facilitate this transition, ForwardHealth will allow children who turn 8 years of age prior to July 1, 2018, and have a paid claim for an antipsychotic drug from January 1, 2018, through June 30, 2018, to continue taking the same antipsychotic drug without PA.

For children who turn 8 years of age on or after July 1, 2018, antipsychotics PA criteria will apply.

For more information about antipsychotic drugs, providers may refer to the Antipsychotics topic (topic #18457) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

## **Cytokine and Cell Adhesion Molecule Antagonist Drugs**

Since the January 2018 PDL review of the cytokine and cell adhesion molecule (CAM) antagonist drugs drug class by the Pharmacy PA Advisory Committee, new cytokine and CAM antagonist drugs and treatment options have become available.

The cytokine and CAM antagonist drugs drug class will be reviewed by the Pharmacy PA Advisory Committee as part of the January 2019 PDL review. Until the January 2019

PDL review has occurred, the following drug status changes and additions will apply:

- Enbrel Mini will become a preferred drug in the cytokine and CAM antagonist drugs drug class.
- Cimzia will remain a non-preferred drug and will be added to the list of drugs used to treat psoriasis in the cytokine and CAM antagonist drugs drug class.
- Olumiant will become a non-preferred drug used to treat rheumatoid arthritis in the cytokine and CAM antagonist drugs drug class.
- Xeljanz/Xeljanz XR will remain non-preferred drugs and will be added to the list of drugs used to treat psoriatic arthritis in the cytokine and CAM antagonist drugs drug class.
- Xeljanz will remain a non-preferred drug and will be added to the list of drugs used to treat ulcerative colitis in the cytokine and CAM antagonist drugs drug class.

The clinical criteria for which PA requests are considered for cytokine and CAM antagonist drugs have not changed.

For more information about cytokine and CAM antagonist drugs, providers may refer to the Cytokine and Cell Adhesion Molecule Antagonist Drugs topic (topic #16217) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

## **Growth Hormone Drugs Form**

### ***Revised Prior Authorization/Preferred Drug List for Growth Hormone Drugs Form***

ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs form, F-11092 (07/2018). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Instructions archive page linked under the Archives section of the Pharmacy Resources page of the Portal. PA requests submitted on and after July 1, 2018, must be submitted on the revised form, or the PA request will be returned to the provider.

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

## **Growth Hormone Drugs**

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

*Note:* ForwardHealth will consider the entire clinical record for the PA request determination decision.

### ***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 may be approved for up to a maximum of 365 days. PA requests for Serostim must be submitted on the PA/PDL for Growth Hormone Drugs form 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.

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

### ***Clinical Criteria for Growth Hormone Drug Coverage for Children and Adolescents***

ForwardHealth has revised the clinical criteria for growth hormone drug coverage for children and adolescents.

ForwardHealth covers growth hormone drugs for children and adolescents for the following indications:

- The member has a history of panhypopituitarism involving at least two pituitary hormone deficiencies,

not including growth hormone, and a history of hypothalamic-pituitary structural lesion(s).

- The member has a history of cranial irradiation, tumor, or other structural midline lesion, in addition to a decreasing growth velocity and a low insulin-like growth factor-1 (IGF-1) measurement below the age- and gender-specific lower limit of normal with normal thyroid function and adequate nutrition.
- The member has growth failure or short stature associated with one of the following congenital conditions that have a Food and Drug Administration (FDA)-approved indication for growth hormone use:
  - ✓ Noonan syndrome
  - ✓ Prader-Willi syndrome
  - ✓ SHOX gene deficiency disorder
  - ✓ Turner syndrome
- The member has growth failure or short stature associated with chronic renal insufficiency in pre-kidney transplant members.
- A small for gestational age (SGA) member is 2 years of age or older with a height that remains more than two standard deviations below the mean for chronological age and gender on a clinically appropriate growth chart. SGA is defined as infants with a birth weight below the 10th percentile for gestational age. Other causes for short stature must have been excluded, such as the following: growth inhibiting medication, chronic disease, other congenital conditions, thyroid disease, or under-nutrition. ForwardHealth will consider the entire clinical record for the PA request determination decision.
- The member has growth failure or short stature for children and adolescents with growth hormone deficiency including **all** of the following:
  - ✓ The member's height is more than two standard deviations below the mean for chronological age and gender on a clinically appropriate growth chart.
  - ✓ Other causes for short stature must have been excluded, such as the following: growth inhibiting medication, chronic disease, other congenital conditions, thyroid disease, or under-nutrition. If IGF-1 levels are low, insulin-like growth factor-binding protein 3 (IGF-BP3) testing should be considered and under-nutrition should be evaluated



and addressed before proceeding with growth hormone stimulation testing. If the results of the IGF-1/IGF-BP3 and bone age 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 further testing due to recognized limitations of growth hormone stimulation testing and risk of false positive results.

- ✓ The member has failed to respond to at least two validated growth hormone stimulation tests performed using a well-standardized protocol, demonstrating a growth hormone peak response of less than 10 ng/mL after stimulation with a pharmacologic agent such as insulin, arginine, clonidine, or glucagon.

### *Growth Hormone Stimulation Testing Requirements for Children and Adolescents*

Growth hormone stimulation testing should be conducted after an overnight fast, using a well-standardized protocol, and should be conducted for the appropriate duration of time specific to the agents used to ensure the peak growth hormone level is captured. Both stimulation tests can be administered on the same day. When growth hormone stimulation testing has been performed, complete testing results must be submitted with the PA request, including the following:

- Confirmation that the member was fasting
- The type of stimulation test and the dose of stimulating agent
- A copy of the medical notes taken during the entire testing procedure, including vital signs and blood glucose levels
- The time and results from each blood sample taken
- The provider interpretation of the testing results

For members with thyroid deficiency, ForwardHealth only accepts results of the growth hormone stimulation tests that are performed after thyroid deficiency is adequately treated because growth hormone secretion may be subnormal merely as a result of hypothyroidism.

Growth hormone stimulation testing performed in a non-validated or sub-standard manner will not be considered by ForwardHealth to be an acceptable growth hormone stimulation test.

Growth hormone testing can provide useful information, but due to the recognized limitations of growth hormone stimulation testing and the risk of false positive results, ForwardHealth will consider the results of the growth hormone stimulation testing in the context of the entire clinical record for the PA request determination decision.

### *Documentation Requirements for PA Requests for Growth Hormone for Children and Adolescents*

Detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment must be submitted with the PA request, including the following:

- Detailed endocrinology and medical work-up, including medical problem list, current medication list, and medication history
- Height and weight measurements over time plotted on the most clinically appropriate growth chart(s) for age and gender, including growth velocity, growth percentiles, and Z-scores
- Copies of the most recent IGF-1 and IGF-BP3 lab reports
- Bone age results
- Thyroid-stimulating hormone (TSH) level
- Nutrition assessment
- Any other relevant testing, such as advanced imaging of the hypothalamic-pituitary region, if performed

PA requests for growth hormone drugs for children and adolescents must be submitted on the PA/PDL for Growth Hormone Drugs form. PA requests for growth hormone drugs for children and adolescents may be submitted using the STAT-PA system (for congenital conditions), on the Portal, by fax, or by mail.

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

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current endocrinology clinic notes, including clinically appropriate height and weight growth charts for age and gender, the most current IGF-1 and/or IGF-BP3 lab testing results, growth velocity, and the most current bone age report, must be included with the PA request. Renewal PA requests may be approved for up to a maximum of 365 days.

### *Conditions Not Covered for Growth Hormone Treatment for Children and Adolescents*

ForwardHealth does not cover growth hormone treatment for the following conditions or circumstances:

- Member has closed epiphyses.
- Growth velocity is less than 2 cm/year while on growth hormone treatment, or growth velocity does not demonstrate a significant increase while on growth hormone treatment.
- Bone age is greater than 14 years for a female and 16 years for a male.
- Mid-parental height is achieved using the following equation.

Mid-parental height = (father's height + mother's height) ÷ 2, + 2.5 inches (male) or - 2.5 inches (female)

- Therapy is not compliant with prescribed growth hormone therapy.
- Member has idiopathic short stature, which is a growth failure or short stature not associated with growth hormone deficiency or disease state.
- Member is post kidney transplant.

### ***Clinical Criteria for Growth Hormone Drug Coverage for Adults***

ForwardHealth has revised the clinical criteria for growth hormone drug coverage for adults.

ForwardHealth covers growth hormone drugs for adults for the following indications:

- The member has a history of panhypopituitarism during childhood involving at least two other pituitary hormone deficiencies, not including growth hormone,

and treatment with a growth hormone drug during childhood.

- The member has a history of hypopituitarism during childhood involving at least one other pituitary hormone deficiency, not including growth hormone, and treatment with a growth hormone drug during childhood. The diagnosis of growth hormone deficiency must be confirmed with an IGF-1 measurement below the age- and gender-specific lower limit of normal after stopping growth hormone for at least three months and at least one standard appropriate growth hormone stimulation test demonstrating a growth hormone peak response of less than the established adult reference values of the specific stimulation tests performed.
- The member has a history of treatment with a growth hormone drug during childhood without evidence of other pituitary hormone deficiencies. The diagnosis of growth hormone deficiency must be confirmed with an IGF-1 measurement below the age- and gender-specific lower limit of normal after stopping growth hormone treatment for at least three months and at least two standard appropriate growth hormone stimulation tests demonstrating a growth hormone peak response of less than the established adult reference values of the specific stimulation tests performed.
- The member has a history of a head injury, hypothalamic-pituitary structural lesion(s), or cranial irradiation and evidence of panhypopituitarism involving at least three other pituitary hormone deficiencies, not including growth hormone.
- The member has a history of a head injury, hypothalamic-pituitary structural lesion(s), or cranial irradiation and evidence of hypopituitarism with at least one other pituitary hormone deficiency, not including growth hormone. Growth hormone deficiency must be confirmed with an IGF-1 measurement below the age- and gender-specific lower limit of normal and at least one standard appropriate growth hormone stimulation test demonstrating a growth hormone peak response of less than the established adult reference values of the specific stimulation tests performed.
- The member has a history of a head injury, hypothalamic-pituitary structural lesion(s), or cranial

irradiation without evidence of other pituitary hormone deficiencies. Growth hormone deficiency must be confirmed with an IGF-1 measurement below the age- and gender-specific lower limit of normal and at least two standard appropriate growth hormone stimulation tests demonstrating a growth hormone peak response of less than the established adult reference values of the specific stimulation tests performed.

*Note:* For individuals being treated for growth hormone deficiency due to trauma or subarachnoid hemorrhage, growth hormone deficiency must be reconfirmed at one year after the event for therapy to continue. If retesting does not confirm growth hormone deficiency, continued treatment will not be approved.

### *Growth Hormone Stimulation Testing Requirements for Adults*

Growth hormone stimulation testing should not be considered in adults without suggestive history of growth hormone deficiency such as a history of growth hormone deficiency diagnosed in childhood, hypothalamic pituitary disease, or cranial irradiation. In cases where there is suggestive history of growth hormone deficiency and a serum IGF-1 concentration below the age- and gender-specific lower limit of normal, growth hormone stimulation testing may be considered.

Growth hormone stimulation testing should be conducted after an overnight fast, using a well-standardized protocol, and should be conducted for the appropriate duration of time specific to the agents used to ensure the peak growth hormone level is captured. When two growth hormone stimulation tests are required, both stimulation tests can be administered on the same day. When growth hormone stimulation testing has been performed, complete testing results must be submitted with the PA request, including the following:

- Confirmation that the member was fasting
- The type of stimulation test and the dose of the stimulating agent

- A copy of the medical notes taken during the entire testing procedure, including vital signs and blood glucose levels
- The time and results from each blood sample taken
- The provider interpretation of the testing results

For members with thyroid deficiency, ForwardHealth only accepts results of the growth hormone stimulation tests that are performed after thyroid deficiency is adequately treated because growth hormone secretion may be subnormal merely as a result of hypothyroidism.

Growth hormone stimulation testing performed in a non-validated or sub-standard manner will not be considered by ForwardHealth to be an acceptable growth hormone stimulation test.

Growth hormone deficiency in an adult could be considered if the member has failed to respond to validated growth hormone stimulation testing performed using a well-standardized protocol, demonstrating a growth hormone peak response of less than the established level of the agent(s) given. Examples of agents commonly used in adult growth hormone stimulation testing include insulin, glucagon, and arginine. The peak response determining growth hormone deficiency for an adult differs based on the agent used, including the following:

- Insulin tolerance test: A growth hormone peak response of less than 5 mcg/L at every time point during the hypoglycemic phase of the test (If adequate hypoglycemia is not achieved [ $<40$  mg/dL], then growth hormone deficiency cannot be diagnosed.)
- Glucagon test: A growth hormone peak response of less than 3 mcg/L at every time point during testing for members with a body mass index (BMI) less than 25 kg/m<sup>2</sup> or a growth hormone peak response of less than 1 mcg/L at every time point during testing in patients with a BMI greater than or equal to 25kg/m<sup>2</sup>
- Arginine test: A growth hormone peak response of less than 0.4 mcg/L at every time point during testing

Growth hormone testing can provide useful information, but due to the recognized limitations of growth hormone

stimulation testing and the risk of false positive results, ForwardHealth will consider the results of the growth hormone stimulation testing in the context of the entire clinical record for the PA request determination decision.

ForwardHealth does not cover growth hormone drugs for members who do not comply with their prescribed growth hormone therapy.

### *Documentation Requirements for PA Requests for Growth Hormone for Adults*

Detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment must be submitted with the PA request, including the following:

- Detailed endocrinology and medical work-up, including medical problem list, current medication list, and medication history
- Copies of the most recent IGF-1 lab reports
- TSH level
- Nutrition assessment
- Any other relevant testing, such as advanced imaging of the hypothalamic-pituitary region, if performed

PA requests for growth hormone drugs for adults must be submitted on the PA/PDL for Growth Hormone Drugs form. PA requests for growth hormone drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

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

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current endocrinology clinic notes, including the most current IGF-1 lab testing results, must be included with the PA request. Renewal PA requests may be approved for up to a maximum of 365 days.

## **Hypoglycemics, Glucagon-Like Peptide Agents Form**

### ***Revised Prior Authorization/Preferred Drug List for Glucagon-Like Peptide Agents Form***

ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents form, F-00238 (07/2018). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Instructions archive page linked under the Archives section of the Pharmacy Resources page of the Portal. PA requests submitted on and after July 1, 2018, must be submitted on the revised form, or the PA request will be returned to the provider.

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

## **Hypoglycemics, GLP-1 Agents**

Preferred drugs in the hypoglycemics, GLP-1 agents drug class do not require PA.

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

PA requests for non-preferred GLP-1 agents may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

PA requests for non-preferred GLP-1 agents may be initially approved for up to a maximum of 183 days. PA requests may be approved for up to a maximum of 365 days if the member has been using a non-preferred GLP-1 agent for at least 183 days and the member has been adherent with treatment.

### ***Clinical Criteria for Non-Preferred GLP-1 Agents***

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

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

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

- The member is 18 years of age or older.
- The member has type 2 diabetes mellitus.
- The member does not currently have pancreatitis or have a history of pancreatitis.
- The member does not currently have gastroparesis or have a history of gastroparesis.
- The member's hemoglobin A1c (HbA1c) was measured within the past six months.
- If the member is **not** currently using a GLP-1 agent, their 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 request approval as long as they meet the above requirements. Members also are required to have been adherent with treatment.

For members new to ForwardHealth (i.e., members who have been granted eligibility for ForwardHealth within the past month), or for those who do not have a previously approved GLP-1 agent PA request, in addition to meeting all of the above clinical criteria, the member must have previously received 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 GLP-1 agent.

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

- Nonadherence 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

*Note:* ForwardHealth will only consider use of exenatide (Byetta/Bydureon) as one of the preferred GLP-1 agent treatments.

## **Lipotropics, PCSK9 Inhibitors**

Clinical PA is required for all lipotropics, proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors.

PA requests for lipotropics, PCSK9 inhibitors must be completed and signed by the prescriber. PA requests for lipotropics, PCSK9 inhibitors should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form and the PA/RF. Clinical documentation supporting the use of a lipotropics, PCSK9 inhibitor also must be submitted with the PA request.

PA requests for lipotropics, PCSK9 inhibitors may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

The following must be submitted with initial PA requests for PCSK9 inhibitors:

- Medical records demonstrating that the member has clinical atherosclerotic cardiovascular disease (ASCVD), heterozygous familial hypercholesterolemia (HeFH), or homozygous familial hypercholesterolemia (HoFH)
- Current lipid panel lab report
- Documentation of the member's current and previous lipid-lowering drug therapies, including the following:
  - ✓ Drug name and dosage
  - ✓ Dates taken
  - ✓ Lipid panel report prior to and during drug therapy (including dates taken)

- ✓ Reasons for discontinuation if drug therapy was discontinued

### **Conditions for Which PA Requests for Use of Praluent Will Be Considered for Review**

ForwardHealth will only consider PA requests for Praluent to treat the following identified clinical conditions:

- Clinical ASCVD
- HeFH

*Note:* Studies demonstrating reduction in cardiovascular events for PCSK9 inhibitors have only been conducted in patients with established cardiovascular disease taking a regimen of moderate- to high-intensity statins.

#### *Clinical Criteria for Praluent for Members With Clinical ASCVD*

ForwardHealth has revised the clinical criteria for Praluent for members with clinical ASCVD.

Clinical criteria for approval of an initial PA request for Praluent for members with clinical ASCVD are **all** of the following:

- The member has clinical ASCVD, as evidenced by **one** of the following:
  - ✓ The member has coronary artery disease (CAD), which is supported by a history of one of the following:
    - Myocardial infarction (heart attack)
    - Coronary revascularization
    - Angina pectoris
  - ✓ The member has a history of non-hemorrhagic stroke.
  - ✓ The member has symptomatic peripheral arterial disease as evidenced by one of the following:
    - Intermittent claudication with an ankle-brachial index (ABI) of less than 0.85
    - Peripheral arterial revascularization procedure or amputation due to atherosclerotic disease
- The member must have attempted to maximize treatment with statins and ezetimibe prior to requesting Praluent. The member must have taken a maximized statin regimen for **at least three continuous months**

with failure to reach greater than or equal to a 50 percent low-density lipoprotein (LDL) reduction from pre-treatment baseline or LDL less than or equal to 70 mg/dL. If additional lipid lowering is required, ezetimibe 10 mg daily with a maximized statin regimen must be attempted for **at least three continuous months** with failure to reach greater than or equal to a 50 percent LDL reduction or LDL less than or equal to 70 mg/dL.

- The member must continue to take the maximized statin regimen during treatment with Praluent unless one of the following applies:
  - ✓ The member's statin therapy dosing was limited by a rise in transaminases greater than three times the upper limit of normal. Liver function testing (against a timeline of statin dosing) should accompany the PA request.
  - ✓ The member is statin intolerant due to significant skeletal muscle symptoms. Statin intolerance must be established through trials with **at least three** different statins (with one regimen containing pravastatin, fluvastatin, or rosuvastatin) and must include the following documentation:
    - Non-statin causes of significant skeletal muscle-related symptoms (e.g., fibromyalgia, hypothyroidism, recent exercise, vitamin D deficiency) were ruled out.
    - Skeletal muscle-related symptoms resolved after discontinuation of the statin.
    - Skeletal muscle-related symptoms recurred after rechallenged with the original statin at a lower dose.
    - Drug-drug interactions that can increase systemic statin exposure or exacerbate medication-related side effects must have been considered and amended.

If clinical criteria for Praluent for members with clinical ASCVD are met, initial PA requests may be approved for up to a maximum of 120 days. Renewal PA requests may be approved for up to 183 days.

Renewal PA requests for Praluent for members who have clinical ASCVD must meet the clinical criteria for initial PA requests and demonstrate evidence of LDL reduction of at least 30 percent to 50 percent from pre-treatment baseline or a decrease to 100 mg/dL or less. Members also must continue to take the maximized statin regimen during treatment with Praluent.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

### *Clinical Criteria for Praluent for Members With HeFH*

ForwardHealth has revised the clinical criteria for Praluent for members with HeFH.

Clinical criteria for approval of an initial PA request for Praluent for members with HeFH are **all** of the following:

- The member is 18 years of age or older.
- The member has been diagnosed by a specialist in cardiology or lipid management.
- The member has HeFH, as evidenced by clinical documentation that supports a **definitive** diagnosis of HeFH using either World Health Organization (WHO) criteria (Dutch Lipid Clinic Network clinical criteria with a score greater than eight) or Simon Broome diagnostic criteria.
- The member must have attempted to maximize treatment with statins and ezetimibe prior to requesting Praluent. The member must have taken a maximized statin regimen for **at least three continuous months** with failure to reach greater than or equal to a 50 percent LDL reduction from pre-treatment baseline or LDL less than or equal to 100 mg/dL. If additional lipid lowering is required, ezetimibe 10 mg daily with a maximized statin regimen must be attempted for **at least three continuous months** with failure to reach greater than or equal to a 50 percent LDL reduction or LDL less than or equal to 100 mg/dL.

- The member must continue to take the maximized statin regimen during treatment with Praluent unless one of the following applies:
  - ✓ The member's statin therapy dosing was limited by a rise in transaminases greater than three times the upper limit of normal. Liver function testing (against a timeline of statin dosing) should accompany the PA request.
  - ✓ The member is statin intolerant due to significant skeletal muscle symptoms. Statin intolerance must be established through trials with **at least three** different statins (with one regimen containing pravastatin, fluvastatin, or rosuvastatin) and must include the following documentation:
    - Non-statin causes of significant skeletal muscle-related symptoms (e.g., fibromyalgia, hypothyroidism, recent exercise, vitamin D deficiency) were ruled out.
    - Skeletal muscle-related symptoms resolved after discontinuation of the statin.
    - Skeletal muscle-related symptoms recurred after rechallenged with the original statin at a lower dose.
    - Drug-drug interactions that can increase systemic statin exposure or exacerbate medication-related side effects must have been considered and amended.

If clinical criteria for Praluent for members with HeFH are met, initial PA requests may be approved for up to a maximum of 120 days. Renewal PA requests may be approved for up to 183 days.

Renewal PA requests for Praluent for members who have HeFH must meet the clinical criteria for initial PA requests and demonstrate evidence of LDL reduction of at least 30 percent to 50 percent from pre-treatment baseline or a decrease to 130 mg/dL or less. Members also must continue to take the maximized statin regimen during treatment with Praluent.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current

lipid panel report (within the past 30 days) must be included with the PA request.

### ***Conditions for Which PA Requests for Use of Repatha Will Be Considered for Review***

ForwardHealth will only consider PA requests for Repatha to treat the following identified clinical conditions:

- Clinical ASCVD
- HeFH
- HoFH

*Note:* Studies demonstrating reduction in cardiovascular events for PCSK9 inhibitors have only been conducted in patients with established cardiovascular disease taking a regimen of moderate- to high-intensity statins.

#### *Clinical Criteria for Repatha for Members With Clinical ASCVD*

ForwardHealth has revised the clinical criteria for Repatha for members with clinical ASCVD.

Clinical criteria for approval of an initial PA request for Repatha for members with clinical ASCVD are **all** of the following:

- The member has clinical ASCVD, as evidenced by one of the following:
  - ✓ The member has CAD, which is supported by a history of one of the following:
    - Myocardial infarction (heart attack)
    - Coronary revascularization
    - Angina pectoris
  - ✓ The member has a history of non-hemorrhagic stroke.
  - ✓ The member has symptomatic peripheral arterial disease, as evidenced by one of the following:
    - Intermittent claudication with an ABI of less than 0.85
    - Peripheral arterial revascularization procedure or amputation due to atherosclerotic disease
- The member must have attempted to maximize treatment with statins and ezetimibe prior to requesting Repatha. The member must have taken a maximized statin regimen for **at least three continuous months**

with failure to reach greater than or equal to a 50 percent LDL reduction from pre-treatment baseline or LDL less than or equal to 70 mg/dL. If additional lipid lowering is required, ezetimibe 10 mg daily with a maximized statin regimen must be attempted for **at least three continuous months** with failure to reach greater than or equal to a 50 percent LDL reduction or LDL less than or equal to 70 mg/dL.

- The member must continue to take the maximized statin regimen during treatment with Repatha unless one of the following applies:
  - ✓ The member's statin therapy dosing was limited by a rise in transaminases greater than three times the upper limit of normal. Liver function testing (against a timeline of statin dosing) should accompany the PA request.
  - ✓ The member is statin intolerant due to significant skeletal muscle symptoms. Statin intolerance must be established through trials with **at least three** different statins (with one regimen containing pravastatin, fluvastatin, or rosuvastatin) and must include the following documentation:
    - Non-statin causes of significant skeletal muscle-related symptoms (e.g., fibromyalgia, hypothyroidism, recent exercise, vitamin D deficiency) were ruled out.
    - Skeletal muscle-related symptoms resolved after discontinuation of the statin.
    - Skeletal muscle-related symptoms recurred after rechallenged with the original statin at a lower dose.
    - Drug-drug interactions that can increase systemic statin exposure or exacerbate medication-related side effects must have been considered and amended.

If clinical criteria for Repatha for members with clinical ASCVD are met, initial PA requests may be approved for up to a maximum of 120 days. Renewal PA requests may be approved for up to 183 days.

Renewal PA requests for Repatha for members who have clinical ASCVD must meet the clinical criteria for initial PA



requests and demonstrate evidence of LDL reduction of at least 30 percent to 50 percent from pre-treatment baseline or a decrease to 100 mg/dL or less. Members also must continue to take the maximized treatment regimen during treatment with Repatha.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

### *Clinical Criteria for Repatha for Members With HeFH*

ForwardHealth has revised the clinical criteria for Repatha for members with HeFH.

Clinical criteria for approval of an initial PA request for Repatha for members with HeFH are **all** of the following:

- The member is 18 years of age or older.
- The member has been diagnosed by a specialist in cardiology or lipid management.
- The member has HeFH as evidenced by clinical documentation that supports a **definitive** diagnosis of HeFH using either WHO criteria (Dutch Lipid Clinic Network clinical criteria with a score greater than eight) or Simon Broome diagnostic criteria.
- The member must have attempted to maximize treatment with statins and ezetimibe prior to requesting Repatha. The member must have taken a maximized statin regimen for **at least three continuous months** with failure to reach greater than or equal to a 50 percent LDL reduction from pre-treatment baseline or LDL less than or equal to 100 mg/dL. If additional lipid lowering is required, ezetimibe 10 mg daily with a maximized statin regimen must be attempted for **at least three continuous months** with failure to reach greater than or equal to a 50 percent LDL reduction or LDL less than or equal to 100 mg/dL.
- The member must continue to take the maximized statin regimen during treatment with Repatha unless one of the following applies:
  - ✓ The member's statin therapy dosing was limited by a rise in transaminases greater than three times the

upper limit of normal. Liver function testing (against a timeline of statin dosing) should accompany the PA request.

- ✓ The member is statin intolerant due to significant skeletal muscle symptoms. Statin intolerance must be established through trials with **at least three** different statins (with one regimen containing pravastatin, fluvastatin, or rosuvastatin) and must include the following documentation:
  - Non-statin causes of significant skeletal muscle-related symptoms (e.g., fibromyalgia, hypothyroidism, recent exercise, vitamin D deficiency) were ruled out.
  - Skeletal muscle-related symptoms resolved after discontinuation of the statin.
  - Skeletal muscle-related symptoms recurred after rechallenged with the original statin at a lower dose.
  - Drug-drug interactions that can increase systemic statin exposure or exacerbate medication-related side effects must have been considered and amended.

If clinical criteria for Repatha for members with HeFH are met, initial PA requests may be approved for up to a maximum of 120 days. Renewal PA requests may be approved for up to 183 days.

Renewal PA requests for Repatha for members who have HeFH must meet the clinical criteria for initial PA requests and demonstrate evidence of LDL reduction of at least 30 percent to 50 percent from pre-treatment baseline or a decrease to 130 mg/dL or less. Members also must continue to take the maximized statin regimen during treatment with Repatha.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

## *Clinical Criteria for Repatha for Members With HoFH*

ForwardHealth has revised the clinical criteria for Repatha for members with HoFH.

Repatha is FDA-approved as an adjunct to diet and other LDL-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) for the treatment of members with HoFH who require additional lowering of LDL cholesterol. Clinical criteria for approval of an initial PA request for Repatha for members with HoFH are **all** of the following:

- The member is 13 years of age or older.
- One of the following is true:
  - ✓ The member has genetic confirmation of **two** of the following mutant alleles at the LDL receptor:
    - Apolipoprotein-B
    - PCSK9
    - Autosomal recessive hypercholesterolemia adaptor protein gene locus
  - ✓ The member has an untreated low-density lipoprotein cholesterol (LDL-C) greater than 500 mg/dL **or** a total treated LDL-C greater than or equal to 300 mg/dL **and one** of the following:
    - Cutaneous tendinous xanthoma(s) before 10 years of age
    - Untreated LDL-C levels of greater than or equal to 190 mg/dL in both parents
- The member must have attempted to maximize treatment with LDL-lowering therapies prior to requesting Repatha. The member must have received maximized LDL-lowering therapies for **at least three** continuous months with failure to reach an LDL level of 130 mg/dL or less.
- The member must continue to take the maximized LDL-lowering therapies during treatment with Repatha.

If clinical criteria for Repatha for members with HoFH are met, initial PA requests may be approved for up to a maximum of 120 days. Renewal PA requests may be approved for up to 183 days.

Renewal PA requests for Repatha for members who have HoFH must meet the clinical criteria for initial PA requests

and demonstrate evidence of LDL reduction of at least 30 percent to 50 percent from pre-treatment baseline or a decrease to 160 mg/dL or less. Members also must continue to take the maximized LDL-lowering therapies during treatment with Repatha.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen. A copy of the current lipid panel report (within the past 30 days) must be included with the PA request.

## **Multiple Sclerosis Agents, Immunomodulators Form**

### ***Revised Prior Authorization/Preferred Drug List for Multiple Sclerosis Agents, Immunomodulators Form***

ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators form, F-00805 (07/2018). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Instructions archive page linked under the Archives section of the Pharmacy Resources page of the Portal. PA requests submitted on and after July 1, 2018, must be submitted on the revised form, or the PA request will be returned to the provider.

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

## **MS Agents, Immunomodulators**

Glatiramer will become a non-preferred drug in the MS agents, immunomodulators drug class.

The manufacturer of Zinbryta has withdrawn the drug from the market. As a result, ForwardHealth will no longer cover Zinbryta and will discontinue associated clinical criteria for the drug.

For more information about MS agents, immunomodulators, providers may refer to the Multiple Sclerosis Agents,

Immunomodulators topic (topic #10997) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

## **MS Agents, Other**

### ***Ampyra***

PA requests for Ampyra must be completed and signed by prescribers. PA requests for Ampyra should be submitted using the PA/DGA form and the PA/RF. PA requests for Ampyra may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

#### *Clinical Criteria for Ampyra*

ForwardHealth has revised the clinical criteria for Ampyra.

PA requests 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 initial PA requests for Ampyra are **all** of the following:

- The member has MS.
- The member has an MS-related walking impairment.
- The member has a creatinine clearance (CrCl) greater than or equal to 50 mL/min.
- The member is ambulatory.
- Results of a timed 25-foot walk test (within the past three months) include the following:
  - ✓ Date of the test
  - ✓ Walking time
  - ✓ Assistive devices the member uses (if any)

Current medical records documenting the member's walking ability and timed 25-foot walk test must be submitted with the PA request.

Initial PA requests for Ampyra may be approved for up to a maximum of 183 days.

Clinical criteria that must be documented for approval of initial renewal PA requests for Ampyra are **all** of the following:

- The member has a CrCl greater than or equal to 50 mL/min.
- The member is ambulatory.
- Results of a timed 25-foot walk test (within the past three months) include the following:
  - ✓ Date of the test
  - ✓ Walking time
  - ✓ Assistive devices the member uses (if any)
- The results of the timed 25-foot walk test have improved or the prescriber has documented how the member's ability to walk has improved since starting Ampyra.
- The member has been compliant with Ampyra therapy.

Current medical records documenting the member's walking ability and timed 25-foot walk test must be submitted with the PA request.

Initial renewal PA requests for Ampyra may be approved for up to a maximum of 365 days.

Clinical criteria that must be documented for approval of subsequent renewal PA requests for Ampyra are **all** of the following:

- The member has a CrCl greater than or equal to 50 mL/min.
- The member is ambulatory.
- Results of a timed 25-foot walk test (within the past six months) include the following:
  - ✓ Date of the test
  - ✓ Walking time
  - ✓ Assistive devices the member uses (if any)
- The member has been compliant with Ampyra therapy.

Current medical records documenting the member's walking ability and timed 25-foot walk test must be submitted with the PA request.

Subsequent renewal PA requests for Ampyra may be approved for up to a maximum of 365 days.

## Opioid Dependency Agents

The opioid dependency agents drug class contains the following subclasses:

- Opioid dependency agents — buprenorphine
- Opioid dependency agents — methadone
- Opioid dependency agents — rescue agent
- Opioid dependency and alcohol abuse/dependency agents

### **Opioid Dependency Agents — Buprenorphine Form**

#### *Revised Prior Authorization/Preferred Drug List for Opioid Dependency Agents — Buprenorphine Form*

ForwardHealth has revised the Prior Authorization/Preferred Drug List (PA/PDL) for Opioid Dependency Agents — Buprenorphine form, F-00081 (07/2018). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Instructions archive page linked under the Archives section of the Pharmacy Resources page of the Portal. PA requests submitted on and after July 1, 2018, must be submitted on the revised form, or the PA request will be returned to the provider.

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

### **Opioid Dependency Agents — Buprenorphine**

Sublocade will become a non-preferred drug in the opioid dependency agents — buprenorphine drug class.

Drugs in the opioid dependency agents — buprenorphine drug class **are** diagnosis restricted. Providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy Resources page of the Providers area of the Portal for the most current list of allowable diagnosis codes.

PA is not required for preferred drugs in the opioid dependency agents — buprenorphine drug class.

*Note:* The policy for obtaining provider-administered drugs applies to Sublocade. For information about obtaining provider-administered drugs, providers may refer to the Provider-Administered Drugs topic (topic #5697) in the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Online Handbook.

PA requests for non-preferred drugs in the opioid dependency agents — buprenorphine drug class must be submitted on the PA/PDL for Opioid Dependency Agents — Buprenorphine form.

#### *Submitting PA Requests for Opioid Dependency Agents — Buprenorphine*

PA requests for buprenorphine tablets for BadgerCare Plus, Medicaid, and SeniorCare members may be submitted using the STAT-PA system, on the Portal, by fax, or by mail.

PA requests for non-preferred buprenorphine-naloxone drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

PA requests for buprenorphine tablets and non-preferred buprenorphine-naloxone drugs may be approved for up to a maximum of 183 days.

Buprenorphine tablets (for pregnant women only) are available through an expedited emergency supply request, which may be granted for up to a 14-day supply. For more information about expedited emergency supply drugs, providers may refer to the Emergency Medication Dispensing topic (topic #1399).

#### *Clinical Criteria for Opioid Dependency Agents — Buprenorphine*

ForwardHealth has revised the clinical criteria for opioid dependency agents — buprenorphine.

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

Clinical criteria for opioid dependency agents — buprenorphine are **all** of the following:

- The member has a diagnosis of opioid type dependence.
- The member is 16 years of age or older.
- The prescriber has a valid Drug Addiction Treatment Act of 2000 waiver allowing them to prescribe buprenorphine-based agents for opioid dependency treatment.
- The member is not taking other opioids, tramadol, or carisoprodol.

### *Clinical Criteria for Buprenorphine Tablets Without Naloxone*

ForwardHealth has revised the clinical criteria for buprenorphine tablets without naloxone.

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

Buprenorphine tablets without naloxone are a non-preferred drug in the opioid dependency agents — buprenorphine drug class.

Clinical criteria for approval of a PA request for buprenorphine tablets without naloxone are **all** of the following:

- The member meets the clinical criteria for opioid dependency agents — buprenorphine.
- The member is pregnant and the prescriber has indicated the member's expected delivery date.

### *Clinical Criteria for Non-Preferred Buprenorphine-Naloxone Drugs*

ForwardHealth has revised the clinical criteria for non-preferred buprenorphine-naloxone drugs.

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

Clinical criteria for approval of a PA request for non-preferred buprenorphine-naloxone drugs are **all** of the following:

- The member meets the clinical criteria for opioid dependency agents — buprenorphine.
- The prescriber has submitted detailed clinical justification for prescribing a non-preferred buprenorphine-naloxone drug instead of both Suboxone film and Zubsolv, including clinical information explaining why the member cannot use both Suboxone film and Zubsolv and why it is medically necessary that the member receive a non-preferred buprenorphine-naloxone drug instead of Suboxone film and Zubsolv.

### *Clinical Criteria for Sublocade*

Sublocade is a non-preferred drug in the opioid dependency agents — buprenorphine drug class.

Clinical criteria for approval of a PA request for Sublocade are **all** of the following:

- The member meets the clinical criteria for opioid dependency agents — buprenorphine.
- The member has a moderate to severe opioid use disorder.
- The member has been initiated on treatment with a transmucosal buprenorphine-containing product delivering the equivalent of 8 mg to 24 mg of buprenorphine daily, and has been treated for a minimum of seven days.
- Sublocade will be used as part of a complete treatment program that includes counseling and psychosocial support.
- The prescriber has evaluated the member and determined that a monthly, provider-administered maintenance injection of Sublocade is a clinically appropriate treatment regimen.

## Stimulants – Related Agents Form

### **Revised Prior Authorization Drug Attachment for Modafinil and Nuvigil Form**

ForwardHealth has revised the Prior Authorization Drug Attachment for Modafinil and Nuvigil form, F-00079 (07/2018). The previous version will be removed from the Forms page of the Portal and placed on the Pharmacy-Related Forms and Instructions archive page linked under the Archives section of the Pharmacy Resources page of the Portal. PA requests submitted on and after July 1, 2018, must be submitted on the revised form, or the PA request will be returned to the provider.

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

### **Stimulants – Related Agents**

Drugs in this class **are not** diagnosis restricted.

PA requests for modafinil and Nuvigil must be completed and signed by the prescriber. PA requests for modafinil and Nuvigil should be submitted using the Prior Authorization Drug Attachment for Modafinil and Nuvigil form.

PA requests for modafinil and Nuvigil may be submitted using the STAT-PA system, on the Portal, by fax, or by mail.

### **Conditions for Which PA Requests for Use of Modafinil Will Be Considered for Review**

PA requests for modafinil will only be approved for use to treat the following identified clinical conditions:

- Obstructive sleep apnea hypopnea syndrome (OSAHS)
- Narcolepsy with cataplexy
- Narcolepsy without cataplexy
- Shift work sleep disorder
- Attention-deficit hyperactivity disorder (ADHD)

### *Clinical Criteria for Modafinil for Members With OSAHS*

ForwardHealth has revised the clinical criteria for modafinil for members with OSAHS.

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

Clinical criteria for approval of a PA request for modafinil for members with OSAHS are **all** of the following:

- The member had an overnight polysomnogram (PSG) sleep study with an apnea-hypopnea index (AHI) greater than or equal to five events per hour, confirming the member has OSAHS. (*Note:* The member's AHI must be documented.)
- The member is not taking any other stimulants or related agents.
- The member has tried continuous positive airway pressure (CPAP).

*Note:* If requested by ForwardHealth, the provider is required to submit the test results and provider interpretation for the PSG.

If clinical criteria for modafinil for members with OSAHS are met, PA requests may be approved for up to a maximum of 365 days.

### *Clinical Criteria for Modafinil for Members With Narcolepsy With or Without Cataplexy*

ForwardHealth has revised the clinical criteria for modafinil for members with narcolepsy with or without cataplexy.

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

Clinical criteria for approval of a PA request for modafinil for members with narcolepsy with or without cataplexy are **all** of the following:

- The member has had an overnight PSG sleep study followed by a multiple sleep latency test (MSLT) that confirm the member has narcolepsy.
- The overnight PSG test results include the following:
  - ✓ The member's total sleep time was at least 360 minutes.
  - ✓ The member did not experience significant sleep interruptions (e.g., respiratory events, periodic leg movements).
  - ✓ The provider interpretation indicates that an adequate night's sleep was achieved.
- The MSLT results include the following:
  - ✓ The MSLT was conducted the morning after the overnight PSG.
  - ✓ The average sleep latency for all naps was eight minutes or less.
  - ✓ The member achieved at least two sleep onset rapid eye movement periods (SOREMPs). (A SOREMP within 15 minutes of sleep onset on the preceding nocturnal PSG may replace one of the SOREMPs on the MSLT).
- The member is not taking any sedative hypnotics.
- For members currently taking central nervous system (CNS) depressants (e.g., anxiolytics, barbiturates, opioids), the prescriber has evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.

*Note:* If requested by ForwardHealth, the provider is required to submit the test results and provider interpretation for the PSG and MSLT, along with medical record documentation supporting a clinical correlation between the test results and a diagnosis of narcolepsy.

If clinical criteria for modafinil for members with narcolepsy with or without cataplexy are met, PA requests may be approved for up to a maximum of 365 days.

### *Clinical Criteria for Modafinil for Members With Shift Work Sleep Disorder*

ForwardHealth has revised the clinical criteria for modafinil for members with shift work sleep disorder.

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

Clinical criteria for approval of a PA request for modafinil for members with shift work sleep disorder are **all** of the following:

- The member has shift work sleep disorder.
- The member is a night shift worker. (*Note:* The member's current employer and weekly work schedule must be documented.)
- The member is not taking any sedative hypnotics.
- For members currently taking CNS depressants (e.g., anxiolytics, barbiturates, opioids), the prescriber has evaluated the CNS depressants and determined they are not significantly contributing to the member's daytime sleepiness.
- The member is not taking any other stimulants or related agents.

If clinical criteria for modafinil for members with shift work sleep disorder are met, initial PA requests may be approved for up to a maximum of 365 days.

### *Clinical Criteria for Modafinil for Members With ADHD*

ForwardHealth has revised the clinical criteria for modafinil for members with ADHD.

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

Clinical criteria for approval of a PA request for modafinil for members with ADHD are **all** the following:

- The member has a diagnosis of ADHD.
- The member is not taking any other stimulants or related agents.

- **At least one** of the following is true:
  - ✓ The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with **at least two** preferred stimulants.
  - ✓ The member has a medical history of substance use disorder.
  - ✓ The member has a serious risk of drug diversion.
- The member has experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with atomoxetine.

If clinical criteria for modafinil for members with ADHD are met, initial PA requests may be approved for up to a maximum of 365 days.

### *Dose Limit for Modafinil*

A dose limit applies to modafinil. The dose limit for modafinil is 200 mg per day.

ForwardHealth will only consider modafinil dose limit overrides up to 400 mg per day for members who meet the following criteria:

- The member has narcolepsy with or without cataplexy.
- The member has experienced a partial response to a modafinil dose of 200 mg per day.

Members must have an existing approved PA request for modafinil in order to request a dose limit override. To request a modafinil dose limit override, providers may call the Drug Authorization and Policy Override (DAPO) Center at 800-947-9627. Hours of operation are from 8:00 a.m. to 5:30 p.m., Monday through Friday. After business hours and on weekends, providers may leave a voicemail message for DAPO Center staff to return the next business day.

### ***Conditions for Which PA Requests for Use of Nuvigil Will Be Considered for Review***

PA requests for Nuvigil will only be approved for use to treat the following identified clinical conditions:

- OSAHS
- Narcolepsy with cataplexy
- Narcolepsy without cataplexy

- Shift work sleep disorder

### *Clinical Criteria for Nuvigil for Members With OSAHS*

ForwardHealth has revised the clinical criteria for Nuvigil for members with OSAHS.

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

Clinical criteria for approval of a PA request for Nuvigil for members with OSAHS are **all** of the following:

- The member had an overnight PSG sleep study with an AHI greater than or equal to five events per hour, confirming the member has OSAHS. (*Note:* The member's AHI must be documented.)
- The member is not taking any other stimulants or related agents.
- The member has tried CPAP.

*Note:* If requested by ForwardHealth, the provider is required to submit the test results and provider interpretation for the PSG.

If clinical criteria for Nuvigil for members with OSAHS are met, PA requests may be approved for up to a maximum of 365 days.

### *Clinical Criteria for Nuvigil for Members With Narcolepsy With or Without Cataplexy*

ForwardHealth has revised the clinical criteria for Nuvigil for members with narcolepsy with or without cataplexy.

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



Clinical criteria for approval of a PA request for Nuvigil for members with narcolepsy with or without cataplexy are **all** of the following:

- The member has had an overnight PSG sleep study followed by an MSLT that confirm the member has narcolepsy.
- The overnight PSG test results include the following:
  - ✓ The member's total sleep time was at least 360 minutes.
  - ✓ The member did not experience significant sleep interruptions (e.g., respiratory events, periodic leg movements).
  - ✓ The provider interpretation indicates that an adequate night's sleep was achieved.
- The MSLT results include the following:
  - ✓ The MSLT was conducted the morning after the overnight PSG.
  - ✓ The average sleep latency for all naps was eight minutes or less.
  - ✓ The member achieved at least two SOREMPs. (A SOREMP within 15 minutes of sleep onset on the preceding nocturnal PSG may replace one of the SOREMPs on the MSLT.)
- The member is not taking any sedative hypnotics.
- For members currently taking CNS depressants (e.g., anxiolytics, barbiturates, opioids), the prescriber has evaluated the CNS depressants and determined they are not contributing to the member's daytime sleepiness.

*Note:* If requested by ForwardHealth, the provider is required to submit the test results and provider interpretation for the PSG and MSLT, along with medical record documentation supporting a clinical correlation between the test results and a diagnosis of narcolepsy.

If clinical criteria for Nuvigil for members with narcolepsy with or without cataplexy are met, PA requests may be approved for up to a maximum of 365 days.

### *Clinical Criteria for Nuvigil for Members With Shift Work Sleep Disorder*

ForwardHealth has revised the clinical criteria for Nuvigil for members with shift work sleep disorder.

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

Clinical criteria for approval of a PA request for Nuvigil for members with shift work sleep disorder are **all** of the following:

- The member has shift work sleep disorder.
- The member is a night shift worker. (*Note:* The member's current employer and weekly work schedule must be documented.)
- The member is not taking any sedative hypnotics.
- For members currently taking CNS depressants (e.g., anxiolytics, barbiturates, opioids), the prescriber has evaluated the CNS depressants and determined they are not significantly contributing to the member's daytime sleepiness.
- The member is not taking any other stimulants or related agents.

If clinical criteria for Nuvigil for members with shift work sleep disorder are met, initial PA requests may be approved for up to a maximum of 365 days.

### *Dose Limit for Nuvigil*

A dose limit applies to Nuvigil. The dose limit for Nuvigil is 250 mg per day.

## **Pharmacy Policy Changes**

### ***Cystic Fibrosis Drugs Containing Ivacaftor***

ForwardHealth has revised the list of drugs containing ivacaftor used to treat cystic fibrosis that require clinical PA to include Symdeko.

Clinical PA is required for all cystic fibrosis drugs containing ivacaftor.

PA requests for cystic fibrosis drugs containing ivacaftor will only be approved for **one cystic fibrosis drug containing ivacaftor per member**. ForwardHealth does not cover treatment with more than one cystic fibrosis drug containing ivacaftor.

PA requests for cystic fibrosis drugs containing ivacaftor should be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form.

PA requests for cystic fibrosis drugs containing ivacaftor may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical criteria that must be documented for approval of a PA request for cystic fibrosis drugs containing ivacaftor are **all** of the following:

- The member has cystic fibrosis.
- The member's age is consistent with the FDA-approved indication for the use of the specific cystic fibrosis drug containing ivacaftor.
- The member has a gene mutation consistent with the FDA-approved indication for the use of the specific cystic fibrosis drug containing ivacaftor. (*Note:* A copy of the gene mutation test results must be included with an initial PA request.)

A copy of the member's medical records must be submitted with all PA requests for cystic fibrosis drugs containing ivacaftor. Medical records should document the following:

- Current progress notes related to the member's cystic fibrosis treatment plan
- A copy of the member's current pulmonary function test results

Initial PA requests for cystic fibrosis drugs containing ivacaftor may be approved for up to 183 days.

Renewal PA requests require that the member has been adherent with their entire cystic fibrosis medication regimen and that there is documentation demonstrating the member has experienced clinical improvement with the prescribed cystic fibrosis drug containing ivacaftor. Renewal PA requests may be approved for up to a maximum of 365 days.

### ***HealthCheck "Other Services"***

As a reminder, providers may refer to the Over-the-Counter Drugs Covered (BadgerCare Plus and Medicaid) data table

and the Over-the-Counter Drugs Covered by HealthCheck "Other Services" data table on the Pharmacy Resources page of the Providers area of the Portal for a list of over-the-counter (OTC) drugs that do not require PA. All other OTC drugs require PA. Prescribers are required to complete the appropriate sections of the PA/DGA form that pertain to HealthCheck "Other Services" PA requests. For more information about HealthCheck "Other Services" PA requests, providers may refer to the Prior Authorization/ Drug Attachment topic (topic #15937) in the Forms and Attachments chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

### ***Copayment for Brand Name Drugs Preferred Over Generic Drugs***

ForwardHealth generally applies a generic copayment to a brand name drug when a drug that previously required brand medically necessary PA becomes 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 to brand pricing.

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/Product Selection code on claims to ensure the generic copayment deduction.

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. This list is available on the Preferred Drug List Quick Reference on the Pharmacy Resources page of the Providers area of the Portal. Providers are encouraged to review the following list to identify future changes.

Drug Class	Drug Name	Effective Date
Acne Agents, Topical	Differin 0.1% cream	01/01/2012
	Differin 0.3% gel pump	02/01/2017
	Retin-A	07/01/2016
Anticonvulsants	Tegretol suspension	01/01/2016
	Tegretol tablet	01/01/2016
	Tegretol XR 100 mg	04/06/2016
	Tegretol XR 200 mg	01/01/2012
	Tegretol XR 400 mg	01/01/2012
Antihypertensives, Sympatholytics	Catapres-TTS	01/01/2014
Glucocorticoids, Inhaled	Pulmicort Respules	01/01/2016
Immunomodulators, Topical	Aldara	01/01/2014
Ophthalmics, Antibiotic-Steroid Combinations	TobraDex suspension	01/01/2012
Ophthalmics, Glaucoma — Other	Alphagan P 0.15%	01/01/2012
Stimulants	Adderall XR	01/01/2012
	Concerta	01/01/2018

## 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 Medicaid Services, the 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, DHS.

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

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## Expedited Emergency Supply

As a result of changes made during the July 2018 PDL review, the Expedited Emergency Supply Request Drugs data table on the Pharmacy Resources page of the Providers area of the Portal has been updated. The Emergency Medication Dispensing topic (topic #1399) includes more information about dispensing an emergency supply of medication.

## For More Information

Providers should refer to the Pharmacy service area of the Online Handbook for more information about PDL policies.

This *Update* was issued on 06/15/2018 and information contained in this *Update* was incorporated into the Online Handbook on 07/02/2018.

# ATTACHMENT 1

## Changes to Pharmacy Prior Authorization Forms and Instructions

The table below lists the pharmacy prior authorization forms and instructions that have been revised as a result of the July 2018 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/](http://www.forwardhealth.wi.gov/) for current copies of these forms and instructions. Unless otherwise noted, all form changes listed are effective July 1, 2018. The old versions of these forms and instructions will be moved to the Pharmacy-Related Forms and 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	Effective Date
Prior Authorization Drug Attachment for Modafinil and Nuvigil	F-00079	Revised	07/01/2018
Instructions	F-00079A	Revised	07/01/2018
Prior Authorization/Preferred Drug List (PA/PDL) for Glucagon-Like Peptide (GLP-1) Agents	F-00238	Revised	07/01/2018
Instructions	F-00238A	Revised	07/01/2018
Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs	F-11092	Revised	07/01/2018
Instructions	F-11092A	Revised	07/01/2018
Prior Authorization/Preferred Drug List (PA/PDL) for Multiple Sclerosis (MS) Agents, Immunomodulators	F-00805	Revised	07/01/2018
Instructions	F-00805A	Revised	07/01/2018
Prior Authorization/Preferred Drug List (PA/PDL) for Opioid Dependency Agents — Buprenorphine	F-00081	Revised	07/01/2018
Instructions	F-00081A	Revised	07/01/2018

# 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 2018 Preferred Drug List (PDL) review. The updated statuses are effective July 1, 2018. Drugs that have not been previously reviewed by the Wisconsin Medicaid Pharmacy Prior Authorization 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/](http://www.forwardhealth.wi.gov/).

<b>Drug Class</b>	<b>Drug Name</b>	<b>Status Effective July 1, 2018</b>
Acne Agents, Topical	adapalene/benzoyl peroxide (Epiduo)*	Non-Preferred
	dapsone gel*	Non-Preferred
	Retin-A Micro 0.06% Pump*	Non-Preferred
	tazarotene cream*	Non-Preferred
Analgesics, Opioids Long-Acting	Arymo ER*	Non-Preferred
	buprenorphine transdermal*	Non-Preferred
	Kadian	Non-Preferred
	MorphaBond ER*	Non-Preferred
Androgenic Agents	testosterone gel pump (Axiron)*	Non-Preferred
	testosterone gel (Vogelxo)*	Non-Preferred
Antibiotics, Beta-Lactam	cefaclor suspension	Non-Preferred
	cefadroxil tablet	Non-Preferred
	cephalexin tablet	Non-Preferred
	Daxbia*	Non-Preferred
Antibiotics, GI	Solosec*	Non-Preferred
Antiemetics/Antivertigo	scopolamine patch*	Non-Preferred
Antiemetics, Cannabinoids	Syndros*	Non-Preferred
Antivirals, Influenza	oseltamivir capsule	Non-Preferred
	oseltamivir suspension*	Non-Preferred
Beta Blockers	carvedilol ER*	Non-Preferred
Bone Resorption Suppression	Forteo*	Non-Preferred
	Tymlos*	Non-Preferred
Calcium Channel Blocking Agents	verapamil ER capsule	Non-Preferred
Fluoroquinolones	Baxdela*	Non-Preferred
GI Motility, Chronic — Constipation	Symproic*	Non-Preferred
Hypoglycemics, DPP-4 Inhibitors	Glyxambi	Preferred
Hypoglycemics, GLP-1	Bydureon BCise*	Non-Preferred
	Ozempic*	Non-Preferred
	Trulicity	Preferred

<b>Drug Class</b>	<b>Drug Name</b>	<b>Status Effective July 1, 2018</b>
Hypoglycemics, Insulin	Fiasp*	Non-Preferred
	Humalog Junior KwikPen*	Non-Preferred
Hypoglycemics, Other	Jardiance	Preferred
	Qtern*	Non-Preferred
	Segluromet*	Non-Preferred
	Steglatro*	Non-Preferred
	Steglujan*	Non-Preferred
	Synjardy XR*	Non-Preferred
Hypoglycemics, Sulfonylureas	chlorpropamide	Non-Preferred
Lipotropics, Other	ezetimibe/simvastatin*	Non-Preferred
Multiple Sclerosis Agents, Immunomodulators	glatiramer*	Non-Preferred
Opioid Dependency Agents — Buprenorphine	Sublocade*	Non-Preferred
Phosphate Binders	calcium acetate capsule	Preferred
	Eliphos	Non-Preferred
	lanthanum carbonate*	Non-Preferred
	sevelamer powder packet*	Non-Preferred
	sevelamer tablet*	Non-Preferred
Platelet Aggregation Inhibitors	prasugrel*	Non-Preferred
Prenatal Vitamins**	CompleteNate chewable tablet*	Preferred
	Elite-OB caplet*	Preferred
	Folivane-OB capsule*	Preferred
	PNV 29-1 tablet*	Preferred
	PNV Prenatal Plus Multivitamin tablet*	Preferred
	Prenatal Vitamin Plus Low Iron*	Preferred
	PreNata Chewable tablet*	Preferred
	Preplus CA-FE 27mg-FA 1 mg tab*	Preferred
	Pretab 29mg-1 mg tablet*	Preferred
	Se-Natal 19 chewable tablet*	Preferred
	Se-Natal 19 tablet*	Preferred
	Taron-C DHA capsule*	Preferred
	Thrivite 19 tablet*	Preferred
	Trinatal Rx 1 tablet*	Preferred
	Virt-PN DHA softgel*	Preferred
	Vol-Nate tablet*	Preferred
	Vol-Plus tablet*	Preferred
Vol-Tab Rx tablet*	Preferred	
Zatean-PN DHA capsule*	Preferred	
Pulmonary Arterial Hypertension	Tracleer suspension*	Non-Preferred

Drug Class	Drug Name	Status Effective July 1, 2018
Ulcerative Colitis Agents	mesalamine*	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 PDL section of this *ForwardHealth Update*.
- \*\* Drugs not listed for the prenatal vitamins drug class are either non-preferred or noncovered. Providers may use the Drug Search Tool on the Portal to determine the most current covered prenatal vitamins and their preferred or non-preferred status.