

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

January 2019 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 (DOS) on and after January 1, 2019, unless otherwise noted.

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

Changes to Pharmacy-Related Forms and Instructions

Attachment 1 of this *Update* lists the prior authorization (PA) forms and instructions that are new or have been revised, renamed, or discontinued as a result of the January 2019 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 January 1, 2019. 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 previous 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 (SSRI) drug class
- Antiparkinson's agents drug class
- Antipsychotics drug class
- Pulmonary arterial hypertension drug class

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

- The member is new to ForwardHealth (i.e., the member has been granted eligibility for ForwardHealth within the past month) and has taken the requested non-preferred drug continuously for the last 30 days or longer and had a measurable therapeutic response.
- The member had an approved PA 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.
- 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 must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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 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 November 7, 2018, the Pharmacy PA Advisory Committee met to review 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 January 1, 2019, unless otherwise noted. 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 November 7, 2018, meeting are effective January 1, 2019, unless otherwise noted, 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*.

Alzheimer's Agents

Memantine ER will become a non-preferred drug in the Alzheimer's agents drug class for adult members who are 18 years of age or older.

As a reminder, ForwardHealth will not cover memantine products and Namenda products for members 17 years of age or younger.

Memantine Products and Namenda Products Policy Exceptions

ForwardHealth has revised the policy exceptions for memantine products and Namenda products.

Effective for DOS from July 1, 2014, through December 31, 2016, BadgerCare Plus, Medicaid, and SeniorCare members who were 44 years of age or younger and were taking Namenda (as identified from claims history) prior to February 15, 2013, were allowed to continue receiving memantine, Namenda, or Namenda XR products without PA. Those members who remained eligible in 2017 and 2018 to receive these products without PA will no longer be eligible to continue receiving memantine, memantine ER,

Namenda, or Namenda XR without PA for DOS on and after January 1, 2019, if **one** of the following is true:

- They do not have other primary insurance on file with ForwardHealth and have no claim activity for any memantine, memantine ER, Namenda, or Namenda XR products for DOS in the last six months of 2018.
- They have other primary insurance on file with ForwardHealth and have no claim activity for any memantine, memantine ER, Namenda, or Namenda XR products for any DOS in 2018.

The remaining previously identified BadgerCare Plus, Medicaid, and SeniorCare members with active claim activity will be allowed to continue receiving memantine, memantine ER, Namenda, or Namenda XR products without PA until further notice.

For more information about Alzheimer's agents, providers may refer to the Alzheimer's Agents topic (topic #15037) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Anticonvulsants

Primidone (AG) will become a preferred drug in the anticonvulsants drug class.

Effective for DOS on and after **January 1, 2019**, generic carbamazepine XR and generic diazepam rectal will become preferred drugs in the anticonvulsants drug class. Brand name Tegretol XR and brand name Diastat will remain preferred drugs for DOS through **January 31, 2019**, in order to allow for a one-month transition period. Effective for DOS on and after **February 1, 2019**, Tegretol XR and Diastat will be subject to brand medically necessary (BMN) policy but will not require PA.

Members should transition to generic carbamazepine XR or generic diazepam rectal unless it is medically necessary for a member to continue to use brand name Tegretol XR or brand name Diastat. Effective for DOS on and after **February 1, 2019**, if Tegretol XR or Diastat is medically necessary for a member, prescribers will be required to

handwrite “brand medically necessary” on the prescription for Tegretol XR or Diastat either directly on the prescription or on a separate order attached to the original prescription; pharmacy providers will be required to submit a Dispense as Written/Product Selection Code 1 (Substitution not allowed by prescriber) for Tegretol XR or Diastat. PA will not be required.

Effective for DOS on and after **February 1, 2019**, ForwardHealth will no longer apply a generic copayment to claims submitted for brand name Tegretol XR.

For more information about BMN policy for anticonvulsants, providers may refer to the Brand Medically Necessary Drugs: A Prescriber’s Responsibilities topic (topic #2016) and the Brand Medically Necessary Drugs: A Pharmacy Provider’s Responsibilities topic (topic #2017) in the Brand Medically Necessary Drugs and Brand Before Generic Drugs chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Emergency Medication Dispensing for Anticonvulsants

ForwardHealth strongly encourages pharmacy providers to utilize the expedited emergency supply process for anticonvulsant drugs when it is determined that the member should begin taking the medication immediately, but the PA request submission and adjudication process would delay dispensing the medication to the member. This may occur if the member receives a prescription for a covered anticonvulsant drug and the prescriber has not completed the necessary PA form or the PA request is still in process.

Expedited emergency supply requests for anticonvulsant drugs will be granted for up to a 14-day supply. Members will be limited to receiving two expedited emergency supply requests of the same drug in 30 days from one pharmacy provider within a six-month time period. A PA request is not required to be in process when the first expedited emergency supply request is submitted; however, before a second expedited emergency supply request for the same drug is submitted, a PA request must be submitted to ForwardHealth and be in the process of being adjudicated.

Requests for a second expedited emergency supply must be submitted either on day 15 or day 16 after the initial request was submitted.

Refer to the Emergency Medication Dispensing topic (topic #1399) of the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Pharmacy service area of the Online Handbook for detailed information regarding expedited emergency medication supply and emergency medication supply options.

Epidiolex

Epidiolex will be reviewed by the Pharmacy PA Advisory Committee as part of the November 2019 Pharmacy PA Advisory Committee meeting. Until the fall meeting has occurred, Epidiolex will become a non-preferred drug in the anticonvulsants drug class.

New PA/PDL for Epidiolex Form

ForwardHealth has created the Prior Authorization/Preferred Drug List (PA/PDL) for Epidiolex form, F-02433 (01/2019). PA requests submitted on and after January 1, 2019, must be submitted on the new form, or they will be returned to the provider.

PA requests for Epidiolex must be completed, signed, and dated by the prescriber. PA requests for Epidiolex should be submitted using the PA/PDL for Epidiolex form and the Prior Authorization Request Form (PA/RF), F-11018 (05/13).

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

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

Clinical Criterion for Epidiolex

ForwardHealth has established a clinical criterion for Epidiolex.

The clinical criterion for approval of a PA request for Epidiolex is **one** of the following:

- The member has Dravet syndrome.
- The member has Lennox-Gastaut syndrome.

If the clinical criterion for Epidiolex is met, PA requests may be approved for up to a maximum of 365 days.

Antiparkinson's Agents

Gocovri and Osmolex ER will become non-preferred drugs in the antiparkinson's agents drug class.

Pramipexole ER and ropinirole ER will no longer be diagnosis restricted.

Grandfathering for Antiparkinson's Agents

ForwardHealth has revised the grandfathering policy for antiparkinson's agents.

Generic ropinirole ER has replaced brand name Requip XL as a grandfathered antiparkinson's agent. If ropinirole ER becomes a preferred drug in the antiparkinson's agents drug class, then grandfathering for ropinirole ER will end for all members.

For more information about grandfathering for antiparkinson's agents, providers may refer to the Grandfathering for Antiparkinson's Agents topic (topic #10658) 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

Kevzara pen and Olumiant will become non-preferred drugs in the cytokine and cell adhesion molecule (CAM) antagonist drugs drug class.

Preferred cytokine and CAM antagonist drugs will no longer require PA.

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

Clinical PA is required for non-preferred cytokine and CAM antagonist drugs.

Initial PA requests for non-preferred cytokine and CAM antagonist drugs may be approved for up to a maximum of 183 days. Renewal PA requests for non-preferred cytokine and CAM antagonist drugs may be approved for up to a maximum of 365 days.

PA requests for non-preferred cytokine and CAM antagonist drugs will only be approved for use to treat the following identified clinical conditions:

- Ankylosing spondylitis
- Crohn's disease
- Giant cell arteritis
- Neonatal Onset Multisystem Inflammatory Disease (NOMID)
- Psoriasis
- Psoriatic arthritis
- Rheumatoid arthritis (RA) and juvenile idiopathic arthritis (JIA)
- Ulcerative colitis

Humira is a preferred cytokine and CAM antagonist drug and the only cytokine and CAM antagonist drug that is indicated for the clinical conditions of hidradenitis suppurativa and uveitis. Preferred cytokine and CAM antagonist drugs do not require PA.

PA requests for cytokine and CAM antagonist drugs will only be approved for **one cytokine and CAM antagonist drug per member**. ForwardHealth does not cover concurrent treatment with more than one cytokine and CAM antagonist drug.

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.

PA requests for cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

PA requests will not be considered for cytokine and CAM antagonist drugs that will be administered in a medical office or medical facility.

Non-Preferred Oral Agents

The following will **not** be considered as criteria to support the need for a non-preferred oral cytokine and CAM antagonist drug agent:

- Non-adherence to previous cytokine and CAM antagonist drug treatment
- The member's fear of needles
- Member or prescriber preference for the use of an oral agent

Revised and Renamed PA Forms for Cytokine and CAM Antagonist Drugs

ForwardHealth has revised and renamed the following PA forms for cytokine and CAM antagonist drugs:

- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, F-11304 (01/2018)
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis, F-01950 (01/2018)

- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis, F-11306 (01/2018)
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis, F-01951 (01/2018)
- Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Uveitis, Giant Cell Arteritis, and Neonatal Onset Multisystem Inflammatory Disease (NOMID), F-01952 (01/2018)

The respective cytokine and CAM PA forms have been renamed as the following:

- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis, F-11304 (01/2019)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis, F-01950 (01/2019)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis, F-11306 (01/2019)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis, F-01951 (01/2019)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Giant Cell Arteritis and Neonatal Onset Multisystem Inflammatory Disease (NOMID), F-01952 (01/2019)

The previous versions 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 January 1, 2019, 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.

Discontinued PA/PDL for Cytokine and CAM Antagonist Drugs for Hidradenitis Suppurativa Form

Effective on and after January 1, 2019, the Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Hidradenitis Suppurativa form, F-01674 (01/2017), is being discontinued and will no longer be accepted. It 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 on the Pharmacy Resources page of the Portal.

Clinical Criteria for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis

ForwardHealth has revised the clinical criteria for cytokine and CAM antagonist drugs used to treat ankylosing spondylitis.

Enbrel and Humira are preferred drugs used to treat ankylosing spondylitis. Preferred drugs do not require PA.

Cimzia, Cosentyx, and Simponi are non-preferred drugs used to treat ankylosing spondylitis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis are **all** of the following:

- The member has ankylosing spondylitis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The prescriber has indicated if the member has axial symptoms of ankylosing spondylitis.
- The prescriber has indicated if the member has attempted any of the following drugs for ankylosing spondylitis: leflunomide, methotrexate, non-steroidal anti-inflammatory drugs (NSAIDs), or sulfasalazine.

- The prescriber has indicated what other drugs the member has attempted for ankylosing spondylitis (e.g., glucocorticoids or IV immunomodulators such as infliximab).
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis must be submitted on the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for Crohn's Disease

ForwardHealth has revised the clinical criteria for cytokine and CAM antagonist drugs used to treat Crohn's disease.

Humira is a preferred drug used to treat Crohn's disease. Preferred drugs do not require PA.

Cimzia and Stelara are non-preferred drugs used to treat Crohn's disease.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease are **all** of the following:

- The member has Crohn's disease.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The prescriber has indicated if the member has attempted any of the following drugs for Crohn's disease: 6-mercaptopurine (6MP), azathioprine, oral aminosalicylates (balsalazide, mesalamine, olsalazine, or sulfasalazine), or methotrexate.
- The prescriber has indicated what other drugs the member has attempted for Crohn's disease (e.g., antibiotics, glucocorticoids, or IV immunomodulators such as infliximab).
- The member has taken **one** preferred cytokine and CAM antagonist drug for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease must be submitted on the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drug for Giant Cell Arteritis

ForwardHealth has revised the clinical criteria for Actemra used to treat giant cell arteritis.

Actemra is a non-preferred drug used to treat giant cell arteritis.

Clinical criteria for approval of a PA request for Actemra used to treat giant cell arteritis are **both** of the following:

- The member has giant cell arteritis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.

Clinical documentation and medical records must be submitted with the PA request to support the member's condition of giant cell arteritis and outline the member's current treatment plan for giant cell arteritis.

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM

antagonist drugs used to treat giant cell arteritis must be submitted on the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis and NOMID form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

PA requests for Actemra used to treat giant cell arteritis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Cytokine and CAM Antagonist Drug for Hidradenitis Suppurativa

Because preferred cytokine and CAM antagonist drugs will no longer require PA, ForwardHealth has discontinued the clinical criteria for Humira used to treat hidradenitis suppurativa.

Humira is a preferred drug used to treat hidradenitis suppurativa. Preferred drugs do not require PA.

Clinical Criteria for Cytokine and CAM Antagonist Drug for NOMID

ForwardHealth has revised the clinical criteria for Kineret used to treat NOMID.

Kineret is a non-preferred drug used to treat NOMID.

Clinical criteria for approval of a PA request for Kineret used to treat NOMID are **both** of the following:

- The member has NOMID.
- The prescription is written by a rheumatologist or through a rheumatology consultation.

Clinical documentation and medical records must be submitted with the PA request to support the member's

condition of NOMID and outline the member's current treatment plan for NOMID.

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat NOMID must be submitted on the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis and NOMID form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

PA requests for Kineret used to treat NOMID may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for Psoriasis

ForwardHealth has revised the clinical criteria for cytokine and CAM antagonist drugs used to treat psoriasis.

Enbrel, Humira, and Otezla are preferred drugs used to treat psoriasis. Preferred drugs do not require PA.

Cimzia, Cosentyx, Siliq, Stelara, Taltz, and Tremfya are non-preferred drugs used to treat psoriasis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis are **all** of the following:

- The member has psoriasis.
- The provider has indicated the areas affected and the approximate percent of body surface area involved.
- The prescription is written by a dermatologist or through a dermatology consultation.

- The prescriber has indicated if the member has attempted any of the following drugs or therapies for psoriasis: cyclosporine, methotrexate, phototherapy, or acitretin.
- The prescriber has indicated what other drugs the member has attempted for psoriasis (e.g., topicals, glucocorticoids, or IV immunomodulators such as infliximab).
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis must be submitted on the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for Psoriatic Arthritis

ForwardHealth has revised the clinical criteria for cytokine and CAM antagonist drugs used to treat psoriatic arthritis.

Enbrel, Humira, and Otezla are preferred drugs used to treat psoriatic arthritis. Preferred drugs do not require PA.

Cimzia, Cosentyx, Orencia subQ solution, Simponi, Stelara, Taltz, Xeljanz, and Xeljanz XR are non-preferred drugs used to treat psoriatic arthritis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis are **all** of the following:

- The member has psoriatic arthritis.
- The prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.
- The prescriber has indicated if the member has axial symptoms of psoriatic arthritis.
- The prescriber has indicated if the member has attempted any of the following drugs for psoriatic arthritis: azathioprine, hydroxychloroquine, leflunomide, or methotrexate.
- The prescriber has indicated what other drugs the member has attempted for psoriatic arthritis (e.g., NSAIDs, glucocorticoids, or IV immunomodulators such as infliximab).
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Note: The prescriber is required to submit detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. The clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR

instead of Xeljanz. Members currently taking Xeljanz XR who had previous claims for Xeljanz XR paid by ForwardHealth will be allowed to receive PA request approval as long as the PA request demonstrates that the member is currently stable on Xeljanz XR and has been adherent with treatment.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis must be submitted on the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for RA and JIA

ForwardHealth has revised the clinical criteria for cytokine and CAM antagonist drugs used to treat RA and JIA.

Clinical Criteria for RA

Enbrel and Humira are preferred drugs used to treat RA. Preferred drugs do not require PA.

Actemra subQ solution, Cimzia, Kevzara, Kineret, Olumiant, Orencia subQ solution, Simponi, Xeljanz, and Xeljanz XR are non-preferred drugs used to treat RA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat RA are **all** of the following:

- The member has RA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The prescriber has indicated if the member has attempted any of the following drugs for RA: azathioprine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine.
- The prescriber has indicated what other drug therapies the member has attempted for RA (e.g., NSAIDs, glucocorticoids, or IV immunomodulators such as infliximab).
- At least **one** of the following is true:
 - ✓ The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Additionally, the following apply for PA requests for Olumiant and Simponi:
 - For PA requests for Olumiant, members must have moderately to severely active RA and have had an inadequate response to one or more tumor necrosis factor antagonist therapies (e.g., Enbrel and Humira).
 - For PA requests for Simponi, members must also continue to take methotrexate in combination with Simponi.
 - ✓ The member has taken Enbrel or Humira along with one or more disease-modifying antirheumatic drugs for **at least three** consecutive months, and the member continues to have moderate to severe disease activity.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Note: The prescriber is required to submit detailed clinical justification for prescribing Xeljanz XR instead of Xeljanz. The clinical information must document why the member cannot use Xeljanz, including why it is medically necessary that the member receive Xeljanz XR instead of Xeljanz. Members currently taking Xeljanz XR who had previous claims for Xeljanz XR paid by ForwardHealth will be allowed to receive PA request approval as long as the PA request demonstrates that the member is currently stable on Xeljanz XR and has been adherent with treatment.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Clinical Criteria for JIA

Enbrel and Humira are preferred drugs used to treat JIA. Preferred drugs do not require PA.

Orencia subQ solution is a non-preferred drug used to treat JIA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat JIA are **all** of the following:

- The member has JIA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The prescriber has indicated if the member has attempted any of the following drugs for JIA: azathioprine, leflunomide, methotrexate, or sulfasalazine.
- The prescriber has indicated what other drug therapies the member has attempted for JIA (e.g., NSAIDs, glucocorticoids, or IV immunomodulators such as infliximab).
- At least **one** of the following is true:
 - ✓ The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three**

consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

- ✓ The member has taken Enbrel or Humira along with one or more disease-modifying antirheumatic drugs for **at least three** consecutive months, and the member continues to have moderate to severe disease activity.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat RA and JIA must be submitted on the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat RA and JIA may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Clinical Criteria for Cytokine and CAM Antagonist Drugs for Ulcerative Colitis

ForwardHealth has revised the clinical criteria for cytokine and CAM antagonist drugs used to treat ulcerative colitis.

Humira is a preferred drug used to treat ulcerative colitis. Preferred drugs do not require PA.

Simponi and Xeljanz are non-preferred drugs used to treat ulcerative colitis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The prescriber has indicated if the member has attempted any of the following drugs for ulcerative colitis: 6MP, azathioprine, or oral aminosalicylates (balsalazide, mesalamine, olsalazine, or sulfasalazine).
- The prescriber has indicated what other drugs the member has attempted for ulcerative colitis (e.g., antibiotics, glucocorticoids, or IV immunomodulators such as infliximab).
- The member has taken **one** preferred cytokine and CAM antagonist drug for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

A copy of the member's medical records must be submitted with all PA requests for non-preferred drugs. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the

prescriber. PA requests for cytokine and CAM antagonist drugs used to treat ulcerative colitis must be submitted on the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Cytokine and CAM Antagonist Drug for Uveitis

Because preferred cytokine and CAM antagonist drugs will no longer require PA, ForwardHealth has discontinued the clinical criteria for Humira used to treat uveitis.

Humira is a preferred drug used to treat uveitis. Preferred drugs do not require PA.

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.

Epinephrine, Self-Injected

On January 1, 2018, certain products in the epinephrine, self-injected drug class became non-preferred. In May 2018, ForwardHealth made EpiPen, EpiPen Jr, epinephrine 0.15 mg (Adrenaclick), and epinephrine 0.3 mg (Adrenaclick) preferred products due to a shortage of preferred products at that time.

EpiPen, EpiPen Jr, epinephrine 0.15 mg (Adrenaclick), and epinephrine 0.3 mg (Adrenaclick) were reviewed during the November 7, 2018, Pharmacy PA Advisory Committee meeting. Once the shortage is resolved, the status of these drugs will be non-preferred. In addition, EpiPen and EpiPen Jr will return to a BMN status once the shortage is resolved.

Immunomodulators, Atopic Dermatitis

The following will **not** be considered as criteria to support the need for a non-preferred immunomodulators, atopic dermatitis agent:

- Non-adherence to previous therapies
- Member or prescriber preference
- The use of samples to start a member on a medication

Dupixent and Eucrisa

PA requests for Dupixent and Eucrisa must be completed, signed, and dated by the prescriber. PA requests for Dupixent and Eucrisa 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 PA/RF. Clinical documentation supporting the use of Dupixent and Eucrisa must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

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

PA requests will not be considered for Dupixent that will be administered in a medical office or medical facility.

Conditions for Which PA Requests for Use of Dupixent Will Be Considered for Review

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

- Moderate to severe atopic dermatitis
- Moderate to severe asthma with an eosinophilic phenotype
- Oral corticosteroid dependent asthma

ForwardHealth has established clinical criteria for Dupixent for members with moderate to severe asthma with an eosinophilic phenotype and members with oral corticosteroid dependent asthma. Clinical criteria for Dupixent for members with moderate to severe atopic dermatitis have not changed.

Clinical Criteria for Dupixent for Members With Moderate to Severe Atopic Dermatitis

Clinical criteria for Dupixent for members with moderate to severe atopic dermatitis have not changed.

Clinical criteria that must be documented for approval of a PA request for Dupixent for members with moderate to severe atopic dermatitis are **all** of the following:

- The member is 18 years of age or older.
- The member has moderate to severe atopic dermatitis. Documentation must include the approximate body surface area involved and the area(s) affected.
- The prescription is written by or through consultation with a dermatologist, an allergist, or immunologist.
- Other causes of exacerbating factors that may contribute to the member's atopic dermatitis, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar dermatologic conditions, have been ruled out.
- At least **one** of the following is true:
 - ✓ The member has a recent history (within six months of the clinical visit when Dupixent treatment was first prescribed) of use of at least a medium potency topical corticosteroid for at least two months and experienced an unsatisfactory therapeutic response.

- ✓ The member has used at least a medium potency corticosteroid and experienced a clinically significant adverse drug reaction.
- At least **one** of the following is true:
 - ✓ The member has a recent history (within six months of the clinical visit when Dupixent treatment was first prescribed) of topical calcineurin inhibitor use for at least two months and experienced an unsatisfactory therapeutic response.
 - ✓ The member used a topical calcineurin inhibitor and experienced a clinically significant adverse drug reaction.
- The member will not use Dupixent in combination with other biologics (e.g., Enbrel, infliximab, Xolair).
- The member does not have a parasitic infection.

A copy of the member's medical records must be submitted with all PA requests for Dupixent. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Dupixent are met, initial PA requests for Dupixent may be approved for up to a maximum of 183 days. Renewal PA requests for Dupixent may be approved for up to a maximum of 365 days.

Renewal PA requests for members who have moderate to severe atopic dermatitis (eczema) must meet the clinical criteria for initial PA requests for Dupixent. Renewal requests must include copies of the current medical records demonstrating that the member has had a significant reduction in the area(s) affected and/or severity of atopic dermatitis and is not using Dupixent in combination with other biologics (e.g., Enbrel, infliximab, Xolair).

Note: All renewal PA requests require the member to be adherent to the prescribed treatment regimen.

Clinical Criteria for Dupixent for Members With Moderate to Severe Asthma With an Eosinophilic Phenotype

ForwardHealth has established clinical criteria for Dupixent for members with moderate to severe asthma with an eosinophilic phenotype.

Clinical criteria that must be documented for approval of a PA request for Dupixent for members with moderate to severe asthma with an eosinophilic phenotype are **all** of the following:

- The member is 12 years of age or older.
- The prescription is written by or through consultation with an asthma specialist (e.g., allergist, immunologist, pulmonologist).
- The member has moderate to severe asthma with an eosinophilic phenotype. A baseline blood eosinophil count of >150 cells/mcL within the previous three months must be documented.
- One of the following is true:
 - ✓ The member has a history of two or more asthma exacerbations that required treatment with systemic corticosteroids or emergency department visit or hospitalization for the treatment of asthma in the past year. Documentation should include the approximate dates and what interventions took place for each exacerbation.
 - ✓ The member's baseline forced expiratory volume in one second (FEV1) is less than 80 percent predicted. A baseline FEV1 percent predicted from the previous three months must be documented.
- The member has been adherent and maintained on a maximized asthma treatment regimen, including a high-dose inhaled corticosteroid (ICS) in combination with a long-acting beta-agonist (LABA) for at least three months prior to requesting Dupixent. Documentation should include the ICS and LABA names, doses, and start dates.
- Other causes of exacerbating factors that may contribute to the member's asthma, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar respiratory conditions, have been ruled out.

- The member will not use Dupixent in combination with other interleukin receptor antagonists (e.g., Cinqair, Fasentra, Nucala) or Xolair.

A copy of the member's medical records must be submitted with all PA requests for Dupixent. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Dupixent are met, initial PA requests for Dupixent may be approved for up to a maximum of 183 days. Renewal PA requests for Dupixent may be approved for up to a maximum of 365 days.

Renewal PA requests for members who have moderate to severe asthma with an eosinophilic phenotype must meet the clinical criteria for initial PA requests for Dupixent. Renewal requests must include copies of the current medical records demonstrating the member had a decrease in the number of asthma exacerbations or an increase in FEV1 percent predicted compared to their baseline prior to initiation of Dupixent. Documentation must support a decrease in the number of asthma exacerbations or an increase in FEV1 percent predicted. Members must also continue to take their maximized ICS/LABA asthma treatment regimen during treatment with Dupixent.

Note: All renewal PA requests require the member to be adherent to the prescribed treatment regimen.

Clinical Criteria for Dupixent for Members With Oral Corticosteroid Dependent Asthma

ForwardHealth has established clinical criteria for Dupixent for members with oral corticosteroid dependent asthma.

Clinical criteria that must be documented for approval of a PA request for Dupixent for members with oral corticosteroid dependent asthma are **all** of the following:

- The member is 12 years of age or older.

- The prescription is written by or through consultation with an asthma specialist (e.g., allergist, immunologist, pulmonologist).
- The member has oral corticosteroid dependent asthma.
- The member has been adherent and maintained on a maximized asthma treatment regimen, including a high-dose ICS in combination with a LABA for at least three months prior to requesting Dupixent. Documentation should include the ICS and LABA names, doses, and start dates.
- The member has required daily oral corticosteroid treatment for at least three months prior to requesting Dupixent. Documentation should include the oral corticosteroid name, daily dose, and start date.
- Other causes of exacerbating factors that may contribute to the member's asthma, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar respiratory conditions, have been ruled out.
- The member will not use Dupixent in combination with other interleukin receptor antagonists (e.g., Cinqair, Fasentra, Nucala) or Xolair.

A copy of the member's medical records must be submitted with all PA requests for Dupixent. Medical records should document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Dupixent are met, initial PA requests for Dupixent may be approved for up to a maximum of 183 days. Renewal PA requests for Dupixent may be approved for up to a maximum of 365 days.

Renewal PA requests for members who have oral corticosteroid dependent asthma must meet the clinical criteria for initial PA requests for Dupixent. Renewal requests must include copies of the current medical records demonstrating the member's daily oral corticosteroid dose has decreased, while maintaining asthma control compared to their baseline prior to initiation of Dupixent. Documentation must support a decrease in the daily oral

corticosteroid dose. Members must also continue to take their maximized ICS/LABA asthma treatment regimen during treatment with Dupixent.

Note: All renewal PA requests require the member to be adherent to the prescribed treatment regimen.

Clinical Criteria for Eucrisa

The clinical criteria for which PA requests are considered for Eucrisa have not changed.

For more information about the immunomodulators, atopic dermatitis agents drug class, providers may refer to the Immunomodulators, Atopic Dermatitis topic (topic #8857) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Stimulants

Adzenys ER will become a non-preferred drug in the stimulants drug class.

Certain brand name drugs will be preferred over their generic equivalents. Brand name Metadate CD will remain a preferred drug (in addition to other preferred drugs) in the stimulants drug class. ForwardHealth will automatically apply a generic copayment to claims submitted for Metadate CD.

Generic methylphenidate CD will remain a preferred drug for DOS through January 31, 2019, in order to allow for a one-month transition period. Effective for DOS on and after **February 1, 2019**, methylphenidate CD will become a non-preferred drug in the stimulants drug class and will be classified as a brand before generic (BBG) drug requiring PA.

Effective for DOS on and after **April 1, 2019**, amphetamine salt combo ER will remain a non-preferred drug in the stimulants drug class and will no longer be classified as a BBG drug requiring PA.

Brand name Adderall XR will remain a non-preferred drug in the stimulants drug class. Effective for DOS on and after **May 1, 2019**, Adderall XR will require BMN PA. Adderall

XR will remain a non-preferred drug for DOS through April 30, 2019, in order to allow for a one-month transition period. Pharmacy providers should begin to inform members and prescribers about Adderall XR moving to a BMN status for DOS on and after May 1, 2019. ForwardHealth will publish further information about Adderall XR in a future *Update*, including revised policy for grandfathering for stimulants.

For more information and clinical criteria for BBG PA requests, providers may refer to the following topics in the Brand Medically Necessary Drugs and Brand Before Generic Drugs chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook:

- An Introduction to Brand Medically Necessary Drugs and Brand Before Generic Drugs topic (topic #20078)
- Brand Before Generic Drugs topic (topic #20077)

For more information about BMN drugs, providers may refer to the Brand Medically Necessary Drugs and Brand Before Generic Drugs chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Stimulant Quantity Limits

As a reminder, quantity limits apply to all preferred and non-preferred stimulants, with the exception of liquids. Quantity limits do not apply to liquid dosage forms of stimulants. When a claim is submitted with a quantity that exceeds the limit, the claim will be denied.

All stimulants (with the exception of liquid dosage forms) have a cumulative quantity limit of 136 units per month across the stimulants drug class. Members are limited to a combined total of 136 stimulant units (tablets/capsules/patches) per month.

Providers may refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy Resources page of the Providers area of the Portal for the most current quantity limits.

Prior to requesting a quantity limit policy override, the pharmacy provider should contact the prescriber to

determine whether or not it is medically appropriate for a member to exceed the quantity limit. If it is medically appropriate for a member to exceed a quantity limit, pharmacy providers may request a quantity limit policy override by calling 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.

Note: Providers are reminded that they may dispense up to the allowed quantity limit without contacting the DAPO Center.

Pharmacy providers may request a quantity limit policy override for members enrolled in BadgerCare Plus, Medicaid, and SeniorCare.

A quantity limit override request for a stimulant drug is limited to a one-month override and will only be approved for the following situations:

- Lost or stolen medication
- Vacation supply
- Medication and/or dosage change by the prescriber

If the member does not meet the policy for a stimulant quantity limit override through the DAPO Center, and the claim submitted exceeds the allowed stimulant quantity limit, the claim will be denied and the service will be a noncovered service. Members do not have appeal rights for noncovered services.

For more information about stimulant quantity limits, providers may refer to the Stimulants topic (topic #16357) in the Preferred Drug List chapter of the Prior Authorization section and the Quantity Limits topic (topic #3444) in the Submission chapter of the Claims section of the Pharmacy service area of the Online Handbook.

Grandfathering for Stimulants

ForwardHealth has revised the grandfathering policy for stimulants.

BadgerCare Plus, Medicaid, and SeniorCare members who were grandfathered on certain amphetamine formulations for DOS on and after January 1, 2017, and remained eligible for grandfathering throughout 2018 will no longer be grandfathered for DOS on and after January 1, 2019, if **one** of the following is true:

- Members without other primary insurance on file with ForwardHealth have no claim activity for grandfathered amphetamine formulations for DOS in the last six months of 2018.
- Members with other primary insurance on file with ForwardHealth have no claim activity for grandfathered amphetamine formulations for DOS in all of 2018.

When a pharmacy claim is submitted in real-time for a member who is not eligible to be grandfathered on an amphetamine product, the pharmacy will receive an Explanation of Benefits code and a National Council for Prescription Drug Programs (NCPDP) reject code indicating a denial in the claim response, informing the pharmacy that the drug requires PA. For more information about grandfathering in this drug class, providers may refer to the Grandfathering for Stimulants topic (topic #10662) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Note: Grandfathering a member overrides the PDL PA policy only. Other policies, such as member enrollment eligibility, diagnosis restriction, quantity limit, and noncovered services policies, continue to apply.

Stimulants – Related Agents

Effective for DOS on and after **January 1, 2019**, generic armodafinil will remain a non-preferred drug in the stimulants – related agents drug class and will no longer be classified as a BBG drug requiring PA.

Brand name Nuvigil will remain a non-preferred drug in the stimulants – related agents drug class. Effective for DOS on and after **February 1, 2019**, Nuvigil will require BMN PA. Nuvigil will remain a non-preferred drug for DOS through

January 31, 2019, in order to allow for a one-month transition period.

For more information about BBG and BMN drugs, providers may refer to the Brand Medically Necessary Drugs and Brand Before Generic Drugs chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Revised and Renamed Prior Authorization Drug Attachment for Modafinil and Nuvigil Form

ForwardHealth has revised and renamed the Prior Authorization Drug Attachment for Modafinil and Nuvigil form, F-00079 (07/2018). The form has been renamed the Prior Authorization/Preferred Drug List (PA/PDL) for Armodafinil and Modafinil form, F-00079 (01/2019).

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 January 1, 2019, 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.

PA requests for armodafinil and modafinil must be completed, signed, and dated by the prescriber. PA requests for armodafinil and modafinil should be submitted using the PA/PDL for Armodafinil and Modafinil form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

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

PA requests for armodafinil and modafinil will only be approved for **one drug per member**. ForwardHealth does not cover concurrent treatment with armodafinil and modafinil for a member.

Clinical Criteria for Armodafinil

Due to the drug status changes previously described, the clinical criteria that currently apply to brand name Nuvigil will instead apply to armodafinil. The clinical criteria for which PA requests are considered have not changed.

For more information about the policy and clinical criteria for armodafinil for obstructive sleep apnea hypopnea syndrome, narcolepsy with or without cataplexy, and shift work sleep disorder, providers may refer to the Stimulants – Related Agents topic (topic #19878) in the Preferred Drug List chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Dose and Quantity Limits for Armodafinil and Modafinil

ForwardHealth has revised the dose limit policy for modafinil.

A dose limit will continue to apply to modafinil. The dose limit for modafinil will be 400 mg per day.

Armodafinil will continue to have a dose limit of 250 mg per day.

ForwardHealth will not consider dose limit overrides for armodafinil or modafinil.

Quantity limits continue to apply to armodafinil and modafinil but have been revised to accommodate the 400 mg per day dose limit for modafinil.

Providers should refer to the Quantity Limit Drugs and Diabetic Supplies data table on the Pharmacy page of the Portal for a list of the most current quantity limits.

For more information about the policy and clinical criteria for modafinil and armodafinil, providers should refer to the Stimulants – Related Agents topic (topic #19878). For more information about quantity limits, providers should refer to the Quantity Limits topic (topic #3444).

Pharmacy Policy Changes

Strensiq

Strensiq requires clinical PA. PA requests for Strensiq must 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.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA 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.

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

Clinical Criteria for Strensiq

ForwardHealth has revised the clinical criteria for Strensiq.

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

- Perinatal/infantile-onset hypophosphatasia (HPP)
- Juvenile-onset HPP

Clinical criteria that must be documented for approval of an initial PA request for Strensiq are **all** of the following:

- The member has perinatal/infantile-onset HPP or juvenile-onset HPP.
- The member was 18 years of age or younger at the onset of signs and/or symptoms of HPP.
- The member's current weight is provided.

- The member has clinical manifestations consistent with HPP (e.g., skeletal abnormalities, respiratory problems, hypercalcemia, seizures).
- Findings on radiographic imaging support the diagnosis of HPP (e.g., infantile rickets, alveolar bone loss, osteoporosis, low bone mineral content for age).
- The prescription is written by an endocrinologist or a provider who specializes in HPP.
- The member has a documented history of HPP-related skeletal abnormalities.
- The member has a serum alkaline phosphatase below the age-adjusted normal range.
- The member has a plasma pyridoxal-5'-phosphate level above the upper limit of normal.
- The member has a documented tissue-nonspecific alkaline phosphatase gene mutation.

Medical records must be provided to demonstrate that the member meets the clinical criteria previously listed.

Note: A copy of the gene mutation testing must be included with an initial PA request.

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

Clinical criteria that must be documented for approval of an **initial renewal** PA request for Strensiq are **all** of the following:

- The member meets the clinical criteria for an initial PA request approval for Strensiq.
- The member has responded to treatment with Strensiq as evidenced by improvement in respiratory status, growth, or radiographic findings compared to their baseline prior to initiation of treatment with Strensiq.

Medical records must be provided to demonstrate that the member meets the clinical criteria previously listed.

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

Clinical criteria that must be documented for approval of a **subsequent renewal** PA request for Strensiq are **all** of the following:

- The member meets the clinical criteria for an initial PA request approval for Strensiq.
- The member has responded to treatment with Strensiq as evidenced by a sustained improvement in respiratory status, growth, or radiographic findings compared to their baseline prior to initiation of treatment with Strensiq.

Medical records must be provided to demonstrate that the member meets the clinical criteria previously listed.

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

Xyrem

Due to the drug status changes described in the Stimulants – Related Agents section of this *Update*, armodafinil will replace Nuvigil in the clinical criteria for Xyrem. In addition, ForwardHealth has revised the clinical criteria for Xyrem to treat narcolepsy with cataplexy and narcolepsy without cataplexy to include members 7 years of age and older.

For more information about the policy and clinical criteria for Xyrem, providers may refer to the Xyrem topic (topic #16437) in the Services Requiring Prior Authorization chapter of the Prior Authorization section of the Pharmacy service area of the Online Handbook.

Revised Prior Authorization Drug Attachment for Xyrem Form

ForwardHealth has revised the Prior Authorization Drug Attachment for Xyrem form, F-01430 (01/2019). 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 January 1, 2019, 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.

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 BMN 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 an NCPDP 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

Drug Class	Drug Name	Effective Date
	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
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
	Metadate CD	01/01/2019

* Effective for DOS on and after February 1, 2019, Tegretol XR will be subject to BMN policy but will not require PA. It will be removed from the Brand Name Drugs with Generic Copay table on the Preferred Drug List Quick Reference.

Expedited Emergency Supply

As a result of changes made during the January 2019 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.

Information Regarding Managed Care Organizations

This *Update* contains 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) or the Family Care

Partnership program 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/.

P-1250

This *Update* was issued on 12/14/2018 and information contained in this *Update* was incorporated into the Online Handbook on 01/02/2019.

ATTACHMENT 1

Changes to Pharmacy Prior Authorization Forms and Instructions

The table below lists the pharmacy prior authorization forms and instructions that are new or have been revised, renamed, or discontinued as a result of the January 2019 Preferred Drug List review or as a result of other pharmacy policy changes. Providers should refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/ for current copies of these forms and instructions. Unless otherwise noted, all form changes listed are effective January 1, 2019. The previous 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	New, Revised, Renamed, or Discontinued	Effective Date
Prior Authorization Drug Attachment for Modafinil and Nuvigil	F-00079	Revised and Renamed: Prior Authorization/Preferred Drug List (PA/PDL) for Armodafinil and Modafinil	01/01/2019
Instructions	F-00079A	Revised and Renamed	01/01/2019
Prior Authorization Drug Attachment for Xyrem	F-01430	Revised	01/01/2019
Instructions	F-01430A	Revised	01/01/2019
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis	F-11304	Revised and Renamed: Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis	01/01/2019
Instructions	F-11304A	Revised and Renamed	01/01/2019
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis	F-01950	Revised and Renamed: Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis	01/01/2019
Instructions	F-01950A	Revised and Renamed	01/01/2019
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Hidradenitis Suppurativa	F-01674	Discontinued	01/01/2019
Instructions	F-01674A	Discontinued	01/01/2019

Form Name	Form Number	New, Revised, Renamed, or Discontinued	Effective Date
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis	F-11306	Revised and Renamed: Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis	01/01/2019
Instructions	F-11306A	Revised and Renamed	01/01/2019
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis	F-01951	Revised and Renamed: Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis	01/01/2019
Instructions	F-01951A	Revised and Renamed	01/01/2019
Prior Authorization/Preferred Drug List (PA/PDL) for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Uveitis, Giant Cell Arteritis, and Neonatal Onset Multisystem Inflammatory Disease (NOMID)	F-01952	Revised and Renamed: Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Giant Cell Arteritis and Neonatal Onset Multisystem Inflammatory Disease (NOMID)	01/01/2019
Instructions	F-01952A	Revised and Renamed	01/01/2019
Prior Authorization/Preferred Drug List (PA/PDL) for Epidiolex	F-02433	New	01/01/2019
Instructions	F-02433A	New	01/01/2019

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 January 2019 Preferred Drug List (PDL) review. Unless otherwise noted, the updated statuses are effective January 1, 2019. Drugs that have not been previously reviewed by the Wisconsin Medicaid Pharmacy Prior Authorization (PA) Advisory Committee are marked with the footnote No. 1. The complete Preferred Drug List Quick Reference can be referenced on the Pharmacy Resources page of the Providers area of the ForwardHealth Portal at www.forwardhealth.wi.gov/.

Drug Class	Drug Name	Status Effective January 1, 2019, Unless Otherwise Noted
Alzheimer's Agents	memantine ER ¹	Non-Preferred
Anticonvulsants	carbamazepine XR	Preferred
	Diastat	Non-Preferred ²
	diazepam rectal	Preferred
	primidone (AG) ¹	Preferred
	Tegretol XR	Non-Preferred ²
Antidepressants, SSRIs	paroxetine (Brisdelle) ¹	Non-Preferred
Antiparkinson's Agents	Gocovri ¹	Non-Preferred
	Osmolex ER ¹	Non-Preferred
Antipsychotics	Nuplazid capsule ¹	Non-Preferred
Antipsychotics, Injectable	Aristada Initio ¹	Preferred
	Perseris ¹	Non-Preferred
COPD Agents	Lonhala Magnair ¹	Non-Preferred
	Stiolto Respimat	Preferred
Cytokine and CAM Antagonists	Kevzara pen ¹	Non-Preferred
	Olumiant ¹	Non-Preferred
Epinephrine, Self-Injected	EpiPen	Non-Preferred ³
	EpiPen Jr	Non-Preferred ³
	epinephrine 0.15 mg (Adrenaclick)	Non-Preferred ³
	epinephrine 0.3 mg (Adrenaclick)	Non-Preferred ³
Erythropoiesis Stimulating Proteins	Mircera ¹	Non-Preferred
	Retacrit ¹	Preferred
Glucocorticoids, Inhaled	Advair HFA	Preferred
	Trelegy Ellipta ¹	Non-Preferred
	QVAR RediHaler ¹	Non-Preferred
Glucocorticoids, Oral	Taperdex ¹	Non-Preferred

Drug Class	Drug Name	Status Effective January 1, 2019, Unless Otherwise Noted
Intranasal Rhinitis Agents	olopatadine	Preferred
	Xhance ¹	Non-Preferred
Neuropathic Pain	Lyrica CR ¹	Non-Preferred
Ophthalmics, Anti-Inflammatory/ Immunomodulator	Restasis MultiDose	Non-Preferred
Ophthalmics, Glaucoma-Beta Blockers	timolol (Istalol) ¹	Non-Preferred
Ophthalmics, Glaucoma-Other	Rhopressa ¹	Non-Preferred
Ophthalmics, Glaucoma-Prostaglandins	Vyzulta ¹	Non-Preferred
Steroids, Topical High	desoximetasone spray ¹	Non-Preferred
Steroids, Topical Low	Derma-Smoothe/FS	Preferred
	fluocinolone oil	Non-Preferred
	hydrocortisone/mineral oil/petrolatum ointment	Non-Preferred
Steroids, Topical Medium	hydrocortisone butyrate lotion ¹	Non-Preferred
Steroids, Topical Very High	clobetasol propionate foam	Non-Preferred
Stimulants	Adzenys ER ¹	Non-Preferred
	methylphenidate CD	Non-Preferred ⁴

- ¹ Drug was not previously reviewed by the Wisconsin Medicaid Pharmacy PA Advisory Committee. For more information, refer to the Changes to the Preferred or Non-Preferred Status of Drugs on the PDL section of this *ForwardHealth Update*.
- ² Brand names Diastat and Tegretol XR will remain preferred drugs in the anticonvulsants drug class for the month of January 2019 to allow a one-month transition period. Effective for dates of service (DOS) on and after February 1, 2019, Diastat and Tegretol XR will become non-preferred drugs that will be subject to brand medically necessary policy but will not require PA.
- ³ Due to product shortages, this implementation may be delayed. Refer to the Epinephrine, Self-Injected section of this *Update* for further details.
- ⁴ Generic methylphenidate CD will remain a preferred drug in the stimulants drug class for the month of January 2019 to allow a one-month transition period. Effective for DOS on and after February 1, 2019, methylphenidate CD will become a non-preferred drug that will be classified as a brand before generic drug requiring PA.