MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 26, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

The Division of Health Care Financing and Policy (DHCFP) proposes revisions to Medicaid Services Manual (MSM) Chapter 1200, Section 1203, based on changes in the approved State Plan Amendment, Attachment 3.1-A, Page 5b (6) and Attachment 3.1-A, Page 5c (9) for Prescribed Drugs. The proposed revision will increase the required quantity of medication per prescription for maintenance medications to a 100-day (three-month) supply and will allow for up to a 12-month supply of a drug for contraception to be dispensed.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective July 2, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 31886 MSM 1200 – PRESCRIBED DRUGS	MTL 18/17 MSM 1200 – PRESCRIBED DRUGS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1203.1F	**Maintenance Medications**	Added "Maintenance medications are required to be filled in three-month (100-day) supplies." Added "A one-time initial fill of less than three months will be allowed for the first fill to assure tolerability and compliance." The paragraph explaining long-term care facilities was relocated for organizational clarity but the language remains the same.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed "The maximum quantity of medication per prescription for maintenance pharmaceuticals for chronic conditions for outpatients, payable by Medicaid, may be a 100-day (three-month) supply." Added, "and are required to be filled in three-month (100-day) supplies." Removed "Anticonvulsants", "Thyroid preparations" and "Oral/Topical Contraceptives" from the list of maintenance medications. Removed all (*). Removed, "Drug classes identified with (*) are required to be dispensed in a three-month (up to 100-day) supply, except for initial fills which can be dispensed in quantities of less than three months (100 days)." Removed, "This requirement does not include skilled nursing facility pharmacies." Added, "Contraceptive drugs are considered maintenance medication. Contraceptive drugs that are approved by the Food and Drug Administration are covered up to a 12-month supply. This includes a drug for contraception or its therapeutic equivalent; insertion of a device for contraception; removal of such a device that was inserted while the insured was covered by the same policy of health insurance; education and counseling relating to contraception; management of side effects relating to contraception; and voluntary sterilization for women. Up to three-months of contraception may be dispensed immediately, and up to nine months of contraception may be dispensed at the subsequent visit. For a refill following the initial dispensing of a contraceptive drug, the provider may dispense up to a 12-month supply or any amount that covers the remainder rolling year. If a prescription for a contraceptive drug is less than one-year period, the provider must dispense the contraceptive in accordance with the quantity specified in the prescription order." Added, "Anticonvulsants and thyroid preparations are considered maintenance medication, but are not required to be filled in a three-month (100-day) supply."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added "Medications administered in a skilled nursing facility or physician's office are exempt from the three-month (100-day) supply requirement" for consistency and clarity.

1203 POLICY

The Division of Health Care Financing and Policy (DHCFP), Nevada Medicaid, reimburses pharmacies and practitioners for legend (prescription) and non-legend (over the counter) pharmaceuticals dispensed or administered to Medicaid recipients. All prescribers must have a license as a healthcare practitioner, such as a physician, podiatrist, osteopath, dentist, Advanced Practice Registered Nurse (APRN), physician's assistant, etc., keeping within the scope of their practice. The DHCFP requires that pharmaceuticals are written, dispensed and prescribed in accordance with the Nevada State Board of Pharmacy regulations and enforcement.

1203.1 COVERAGE AND LIMITATIONS

A. Covered drugs are subject to prior authorization and/or quantity limits and the following:

1. Section 1927(d)(1)(B)(i) of the Social Security Act (SSA) allows Medicaid to restrict coverage for an outpatient drug if the prescribed drug is not for a medically accepted indication. Section 1927(k)(6) defines a medically accepted indication as any use for a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia:

   a. American Hospital Formulary Service Drug Information;

   b. United States Pharmacopeia;

   c. DRUGDEX Information System; or

   d. Peer-reviewed medical literature.

2. Pharmaceuticals must be manufactured by companies participating in the Federal Medicaid Drug Rebate Program.

3. Medicaid is mandated by Federal statute to require all written (non-electronic) prescriptions for all outpatient drugs for Medicaid recipients to be on tamper-resistant prescription pads. This requirement does not apply to e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber. Refer to MSM Addendum for more information on tamper-resistant prescription pads.

4. The Preferred Drug List (PDL) is a list of preferred outpatient drugs established by the Pharmacy and Therapeutics (P&T) Committee. Reference Medicaid Operations Manual (MOM) Chapter 200 for the P&T bylaws. Pharmaceuticals not on the preferred drug list, but within drug classes reviewed by the P&T Committee, require prior authorization, unless exempt under NRS or federal law or excluded through recommendations of the P&T Committee or excluded by the DHCFP.

a. New pharmaceutical products not within reviewed PDL drug classes and not excluded under the state plan or by NRS are covered without a Standard Preferred Drug List Exception prior authorization until or if the P&T Committee adds the drug class to the PDL and reviews the product or evidence.

b. New FDA approved drugs, or existing pharmaceutical products within reviewed PDL drug classes, for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs and are not excluded under state plan or by NRS, are covered with an approved Standard Preferred Drug List Exception prior authorization until the P&T Committee can review the new evidence or drug.

c. Pharmaceuticals may require prior authorization due to step therapy protocols regardless of inclusion in the PDL.

d. If the P&T Committee determines that there are no significant differences between drugs within specific classes based on clinical efficacy and safety, the DHCFP or its Quality Improvement Organization (QIO)-like vendor may consider cost in determining which drugs are selected for inclusion on the PDL.

e. Due to the 76th Special Session and in accordance with Senate Bill (SB) 4, every therapeutic prescription drug that is classified as an anticonvulsant medication or antidiabetic medication that was covered by the Medicaid program on June 30, 2010 must be included on the PDL as a preferred drug. If a therapeutic prescription drug that is included on the list of preferred prescription drugs is prescribed for a clinical indication other than the indication for which it was approved as of June 30, 2010, the Committee shall review the new clinical indication for that drug in accordance with Section 1203 of this chapter.

f. Due to the 76th Special Session and in accordance with SB 4, the P&T Committee must prefer atypical and typical antipsychotic medications that are prescribed for the treatment of a mental illness, anticonvulsant medications and antidiabetic medications for a patient who is receiving services pursuant to Medicaid if the patient:

1. was prescribed the prescription drug on or before June 30, 2010, and takes the prescription drug continuously, as prescribed, on and after that date; and

2. maintains continuous eligibility for Medicaid.

Reference Appendix A for coverage and limitations of medications with special criteria.

B. Standard Preferred Drug List Exception Criteria

Drugs that have a "non-preferred" status are a covered benefit for recipients if they meet the coverage criteria.

1. Coverage and Limitations

a. Allergy to all preferred medications within the same class;

b. Contraindication to or drug-to-drug interaction with all preferred medications within the same class;

c. History of unacceptable/toxic side effects to all preferred medications within the same class;

d. Therapeutic failure of two preferred medications within the same class;

e. If there are not two preferred medications within the same class, therapeutic failure only needs to occur on the one preferred medication;

f. An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or a Food and Drug Administration (FDA)-approved indication;

g. Psychotropic, Antidepressant Medication – Continuity of Care;

Recipients discharged from an institution on non-preferred psychotropic and/or non-preferred anti-depressant medication(s), their drugs will continue to be covered by Medicaid for up to six months to allow the recipient time to establish outpatient mental health services;

h. For atypical or typical antipsychotic, anticonvulsant and antidiabetic medications the recipient demonstrated therapeutic failure on one preferred agent.

2. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms/aspx

C. Excluded

The DHCFP will not reimburse for the following pharmaceuticals:

1. Agents used for weight loss.

2. Agents used to promote fertility.

3. Agents used for cosmetic purposes or hair growth.

4. Yohimbine.

5. Drug Efficacy Study and Implementation (DESI) list "Less than Effective Drugs": In accordance with current policy, federal financial participation is not allowed for any drug on the Federal Upper Limit (FUL) listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the DESI program which has been found to be a less than effective or is Identical, Related or Similar to the DESI drug. The DESI drug is identified by the FDA or reported by the drug manufacturer for purposes of the Medicaid Drug Rebate Program. This listing is available on the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp

   This includes pharmaceuticals designated "ineffective" or "less than effective" (including identical, related or similar drugs) by the FDA as to substance or diagnosis for which prescribed.

6. Pharmaceuticals considered "experimental" as to substance or diagnosis for which prescribed. Pharmaceuticals manufactured by companies not participating in the federal Medicaid Drug Rebate Program unless rated "1-A" by the FDA.

7. Agents used for impotence/erectile dysfunction.

D. Refills

A refill is a prescription subject to the limitations below:

1. Authorized refills are valid only from the pharmaceutical provider dispensing the original prescription, pursuant to Nevada Administrative Code (NAC) Chapter 639.

2. Refill intervals must be consistent with the dosage schedule indicated on the original prescription. If a prescription is for a 34-day supply, a consistent refill would be filled in 30 days; an inconsistent refill date would be filled in 20 days from the original fill. Lost Medications. Nevada Medicaid does not pay for replacement of lost, stolen or otherwise destroyed medications even if a physician writes a new prescription for the medication. It is the responsibility of the recipient to replace these medications. Prior authorization may be granted in life-threatening situations and for maintenance medications only. See Maintenance Medications in this section for more information on maintenance medications.

E. Early Refills

1. Nevada Medicaid only pays for up to a 34-day supply of medications (100-day supply for maintenance medications) for recipients each month. A prescription refill will be paid for by Nevada Medicaid only when 80% of the non-controlled substance prescription, and 90% of the controlled substance prescription, is used in accordance with the prescriber's orders on the prescription and on the label of the medication.

2. In the instance that a recipient will be out of town when a refill is due, the pharmacist may enter the appropriate override code to allow an early refill. This override will be monitored by Nevada Medicaid for misuse/abuse by the recipient and/or provider.

3. Medicaid will not pay for an early prescription refill when gross negligence or failure to follow prescriber's prescription instructions has been displayed by the recipient.

F. Maintenance ~~m~~Medications

1. Exceptions to the 34-day supply of medications are allowed for maintenance medications.

2. Maintenance medications are required to be filled in three-month (100-day) supplies.

3. A one-time initial fill of less than three months will be allowed for the first fill to assure tolerability and compliance.

~~1. In long-term care facilities, if the prescriber fails to indicate the duration of therapy for a maintenance drug, the pharmacy must estimate and provide at least a 30-day supply. Exceptions may be based on reasonable stop orders. (For oral liquid medications only, a 16-fluid ounce quantity will be considered sufficient to fulfill the 30-day supply requirement.)~~

~~2.~~4. Prescription quantities may be reviewed; in those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the dispensing fee may be disallowed.

~~1. The maximum quantity of medication per prescription for maintenance pharmaceuticals for chronic conditions for outpatients, payable by Medicaid, may be a 100-day (3-month) supply.~~

5. The following drug categories are considered maintenance medications and are required to be filled in three-month (100-day) supplies:

a. Antianginals~~*~~;

b. Antiarrhythmics~~*~~;

~~c. Anticonvulsants;~~

~~d.~~c. Antidiabetics~~*~~;

~~e.~~d. Antihypertensives~~*~~;

~~f.~~e. Cardiac Glycosides~~*~~;

~~g.~~f. Diuretics~~*~~;

~~h. Thyroid preparations;~~

~~i.~~g. Estrogens~~*~~; and

~~j.~~h. Progesterone~~*~~; ~~and~~

~~k.~~i. ~~Oral/Topical Contraceptives*.~~

~~1. Drug classes identified with (*) are required to be dispensed in a three-month (up to 100 day) supply, except for initial fills which can be dispensed in quantities of less than three months (100 days).~~

~~2.~~ ~~This requirement does not include skilled nursing facility pharmacies.~~

5. Contraceptive drugs are considered maintenance medication. Contraceptive drugs that are approved by the Food and Drug Administration are covered up to a 12-month supply.

a. This includes a drug for contraception or its therapeutic equivalent; insertion of a device for contraception; removal of such a device that was inserted while the insured was covered by the same policy of health insurance; education and counseling relating to contraception; management of side effects relating to contraception; and voluntary sterilization for women.

b. Up to three months of contraception may be dispensed immediately, and up to nine months of contraception may be dispensed at the subsequent visit.

c. For a refill following the initial dispensing of a contraceptive drug, the provider may dispense up to a 12-month supply or any amount that covers the remainder rolling year.

d. If a prescription for a contraceptive drug is less than a one-year period, the provider must dispense the contraceptive in accordance with the quantity specified in the prescription order.

6. Anticonvulsants and thyroid preparations are considered maintenance medications, but are not required to be filled in a three-month (100-day) supply.

7. Medications administered in a skilled nursing facility or physician's office are exempt from the three-month (100-day) supply requirement.

~~3.~~

8. In long-term care facilities, if the prescriber fails to indicate the duration of therapy for a maintenance drug, the pharmacy must estimate and provide at least a 30-day supply. Exceptions may be based on reasonable stop orders. (For oral liquid medications only, a 16 fluid ounce quantity will be considered sufficient to fulfill the 30-day supply requirement.)

G. Emergency supply of medication

1. In an emergency situation, dispensing of up to a 96-hour supply of covered outpatient drugs that require prior authorization will be allowed.

2. Nevada Medicaid requires prior payment authorization for medications identified as requiring prior authorization.

3. The physician must indicate the diagnosis on the prescription (preferably with an International Classification of Disease (ICD) code) to support the use of the emergency policy.

4. As a follow-up to the dispensing of the emergency supply of medication, the provider must contact the QIO-like vendor, to obtain a verbal verification number.

5. An approved PA (if required) will be necessary to get additional medication.

H. Nevada Check Up (NCU)

All coverage and limitation policies and rules, including any prior authorization requirements, outlined in this chapter apply to NCU recipients as well as Nevada Medicaid Fee-for-Service (FFS) recipients. There are NO exceptions.

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SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

The Division of Health Care Financing and Policy (DHCFP) proposes revisions to Medicaid Services Manual (MSM) Chapter 1200, Appendix A, to reflect recommendations approved by the Drug Use Review (DUR) Board at the January 25, 2018 meeting. The recommended changes include the revision of the criteria for Austedo® to include the diagnosis of Tardive Dyskinesia, new prior authorization requirements for Bevyxxa® and Benlysta®, the review of Opioid-Induced Constipation Agents and the addition of Kevzara® to the existing prior authorization list of Immunomodulator drugs. Clarifying language is also being proposed for the existing criteria on Immunomodulator drugs under Psoriatic Arthritis.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective July 2, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 31958 MSM Ch 1200 – PRESCRIBED DRUGS	MTL N/A MSM Ch 1200 – PRESCRIBED DRUGS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section B	**Bevyxxa® (betrixaban)**	Added new drug prior authorization criteria for Bevyxxa®**.**
Appendix A Section J	**Benlysta ® (belimumab)**	Added new prior authorization criteria for Benlysta®.
Appendix A Section L	**Immunomodulator Drugs**	Revised previously reviewed date to “January 25, 2018.”

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Addition of Kevzara® (sarilumab) to the drug list of Immunomodulators within the existing prior authorization criteria for Immunomodulator Drugs. The name "infliximab" following Siliq® was corrected to the name "brodalumab."
Appendix A Section L (1.c.4)	**Immunomodulator Drugs (Psoriatic Arthritis)**	Re-wording of the sentence for clarification so that the language reads, "The recipient had an inadequate response or a contraindication to treatment with any one nonsteroidal anti-inflammatory (NSAID) or to any one of the following DMARDs: methotrexate, leflunomide, cyclosporine or sulfasalazine."
Appendix A Section LLL	**Opioid-Induced Constipation Agents**	Revised previously reviewed date to "January 25, 2018."
Appendix A Section OOO	**Austedo® (deutetrabenazine)**	Revised previously reviewed date to "January 25, 2018." Revised Austedo® prior authorization criteria to include the diagnosis of Tardive Dyskinesia and added the new criteria for that diagnosis.

B. ~~RESERVED FOR FUTURE USE~~Bevyxxa® (betrixaban)

Therapeutic Class: Oral Anticoagulants
Last Reviewed by the DUR Board: January 25, 2018

Bevyxxa® (betrixaban) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. Initial request:

1. The recipient has a diagnosis of prophylaxis of venous thromboembolism (VTE); and

2. The recipient must be 18 years of age or older; and

3. The recipient has received Bevyxxa® during hospitalization and will be continuing Bevyxxa® therapy following discharge from the hospital; and

4. The recipient is at risk for thromboembolic complications due to moderate or severe restricted mobility and has other risk factors of VTE; and

5. The recipient has not received a cumulative 42 days of Bevyxxa® therapy.

2. Prior Authorization Guidelines:

a. Prior Authorization approvals will be for:

1. Prior Authorization Request: Up to a total treatment duration of 42 days.

b. Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

J. ~~RESERVED FOR FUTURE USE~~Benlysta® (belimumab)

Therapeutic Class: Benlysta® (belimumab)
Last Reviewed by the DUR Board: January 25, 2018

Benlysta® (belimumab) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. Initial request:

1. The recipient has a diagnosis of active Systemic Lupus Erythematosus (SLE); and

2. The recipient must be 18 years of age or older; and

3. Documentation confirms that the recipient is autoantibody positive (i.e., anti-nuclear antibody (ANA) and/or anti-double-stranded DNA (anti-dsDNA)); and

4. The recipient is currently receiving at least one standard of care treatment for active SLE that includes one or more of the following agents (unless all agents are contraindicated): antimalarials (e.g., Plaquenil (hydroxychloroquine)), corticosteroids (e.g., prednisone), glucocorticoids, or immunosuppressants (e.g., methotrexate, Imuran (azathioprine), mycophenolate); and

5. The medication is prescribed by or in consultation with a rheumatologist; and

6. The recipient must not have active CNS Lupus; and

7. The recipient must not currently be receiving treatment for a chronic infection; and

8. The recipient must not have evidence of severe renal disease.

b. Recertification Request (the recipient must meet all the following criteria):

1. Authorization for continued use shall be reviewed at least every six months when the following criteria are met:

a. Documentation of positive clinical response to Benlysta® therapy.

2. Prior Authorization Guidelines:

a. Prior Authorization approvals will be for:

1. Initial request: six months.

b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

L. Immunomodulator Drugs

Therapeutic Class: Immunomodulators
Last Reviewed by the DUR Board: ~~November 5, 2015~~January 25, 2018

Actemra® (tocilizumab)	Ilaris® (canakinumab)	Stelara® (ustekinumab)
Amevive® (alefacept)	Kevzara® (sarilumab)	Xeljanz® (tofacitinib)
Arcalyst® (rilonacept)	Kineret® (ankinra)	
Cimzia® (certolizumab pegol)	Orencia® (abatacept)	
Consentyx® (secukinumab)	Remicade® (infliximab)	
Enbrel® (etanercept)	Siliq® (~~infliximab~~brodalumab)	
Entyvio® (vedolizumab)	Simponi® (golimumab)	
Humira® (adalimumab)	Simponi® ARIA™ (golimumab)	

Immunomodulator Drugs are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. For all recipients:

1. The recipient has had a negative tuberculin test; and

2. The recipient does not have an active infection or a history of recurring infections; and

3. The approval will not be given for the use of more than one biologic at a time (combination therapy); and

4. Each request meets the appropriate diagnosis-specific criteria (b-j).

b. Rheumatoid Arthritis (RA):

1. The recipient has a diagnosis of moderately to severely active RA; and

2. The recipient is 18 years of age or older; and

3. The recipient has had a rheumatology consultation, including the date of the visit; and one of the following:

a. The recipient has had RA for ≤ six months (early RA) and has high disease activity; and an inadequate or adverse reaction to a disease modifying antirheumatic drug (DMARD) (methotrexate,

hydroxychloroquine, leflunomide, minocycline and sulfasalazine); or

b. The recipient has had RA for ≥ six months (intermediate or long-term disease duration) and has moderate disease activity and has an inadequate response to a DMARD (methotrexate, hydroxychloroquine, leflunomide, minocycline or sulfasalazine); or

c. The recipient has had RA for ≥ six months (intermediate or long-term disease duration) and has high disease activity.

c. Psoriatic Arthritis:

1. The recipient has a diagnosis of moderate or severe psoriatic arthritis; and

2. The recipient is 18 years of age or older; and

3. The recipient has had a rheumatology consultation including the date of the visit or a dermatology consultation including the date of the visit; and

4. The recipient had an inadequate response ~~to any one nonsteroidal anti-inflammatory drug (NSAID)~~ or a contraindication to treatment with any one nonsteroidal anti-inflammatory (NSAID) or to any one of the following DMARDs: ~~(~~methotrexate, leflunomide, cyclosporine or sulfasalazine~~)~~.

d. Ankylosing Spondylitis:

1. The recipient has a diagnosis of ankylosing spondylitis; and

2. The recipient is 18 years or older; and

3. The recipient has had an inadequate response to NSAIDs; and

4. The recipient has had an inadequate response to any one of the DMARDs (methotrexate, hydroxychloroquine, sulfasalzine, leflunomide, minocycline).

e. Juvenile Rheumatoid Arthritis/Juvenile Idiopathic Arthritis:

1. The recipient has a diagnosis of moderately or severely active juvenile RA or juvenile idiopathic arthritis; and

2. The recipient is at an appropriate age, based on the requested agent, and:

a. Abatacept: Six years of age or older.

LLL. Opioid-Induced Constipation Agents

Therapeutic Class: Opioid-Induced Constipation Agents
Last Reviewed by the DUR Board: ~~April 28, 2016~~January 25, 2018

Opioid-induced constipation agents are subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations:

   Approval will be given if all the following criteria are met and documented:

   a. The recipient is 18 years of age or older; and

   b. The requested medication is being used for an FDA approved indication; and

   c. The recipient must meet the following criteria:

      1. There is documentation in the recipient's medical record of an inadequate response, adverse reaction or contraindication to one agent from three of the four traditional laxative drug classes:

         a. Bulk forming laxatives;

         b. Osmotic laxatives;

         c. Saline laxatives;

         d. Stimulant laxatives

   d. And, requests for methylnaltrexone bromide that exceed the quantity limit must meet all of the following criteria:

      1. The recipient has opioid-induced constipation in advanced illness, is receiving palliative care, and is not enrolled in the DHCFP's hospice program; and

      2. The requested dose is 0.15 mg/kg; and

      3. The recipient's current weight is >114 kg.

2. Prior Authorization Guidelines

   a. Prior Authorization approval will be for one year.

   b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

OOO. Austedo® (deutetrabenazine)

Therapeutic Class: Austedo® (deutetrabenazine)
Last Reviewed by the DUR Board: ~~October 19, 2017~~January 25, 2018

Austedo® (deutetrabenazine) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits. Austedo® is indicated for the diagnosis of chorea associated with Huntington's disease or Tardive Dyskinesia.

1. Coverage and Limitations for Diagnosis of Chorea Associated with Huntington's Disease

Approval will be given if all the following criteria are met and documented:

a. Initial request:

1. The recipient must have a diagnosis of chorea associated with Huntington's disease; and

2. The recipient must be 18 years of age or older; and

3. The medication is prescribed by or in consultation with a neurologist; and

4. Prior authorization will not be approved for recipients who are suicidal or have untreated/inadequately treated depression, or hepatic impairment, or are currently utilizing monoamine oxidase inhibitors (MAOIs), reserpine or tetrabenazine.

b. Recertification request (the recipient must meet all of the following criteria):

1. Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

a. Documentation of positive clinical response to Austedo® therapy.

2. Recertification will not be approved for recipients who are suicidal or have untreated/inadequately treated depression, or hepatic impairment, or are currently utilizing monoamine oxidase inhibitors (MAOIs), reserpine or tetrabenazine.

c. Prior Authorization Guidelines

1. Initial prior authorization approval will be for 12 months.

2. Prior authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

2. Coverage and Limitations for Diagnosis of Tardive Dyskinesia

Approval will be given if all of the following criteria are met and documented:

a. Initial Request:

1. The recipient must have a confirmed diagnosis of Tardive Dyskinesia; and

2. The recipient must be 18 years of age or older; and

3. At least 60 days of stable (drug, dose) neuroleptic medication exposure (either typical or first-generation antipsychotic agents, atypical or second-generation antipsychotic agents or certain dopamine receptor-blocking drugs used in treatment of nausea and gastroparesis); and

4. Presence of involuntary athetoid or choreiform movements lasting at least 30 days; and

5. Must be prescribed by, or in consultation with, a neurologist or psychiatrist; and

6. The recipient must have one of the following:

a. Persistent symptoms of tardive dyskinesia despite a trial dose reduction, tapering or discontinuation of the offending medication; or

b. The recipient is not a candidate for trial dose reduction, tapering or discontinuation of the offending medication.

b. Recertification request (the recipient must meet all the following criteria):

1. Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

a. Documentation of positive clinical response to Austedo® therapy.

2. Prior Authorization Guidelines

a. Initial prior authorization approval will be for three months.

b. Prior authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx