MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 25, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1200 – Prescribed Drugs are being proposed to align with provision of Senate Bill 378 which consist of changing the name of the Pharmacy and Therapeutics (P&T) Committee to Silver State Scripts Board. In addition, the Division of Health Care Financing and Policy (DHCFP) is proposing to replace the word immunization to vaccines to better align with the US Centers for Disease Control and Prevention (CDC) definition.

Revisions to MSM Chapter 1200 – Prescribed Drugs are being proposed to reflect recommendations approved on October 17, 2019 by the Drug Use Review (DUR) Board. The proposed changes include revisions to the existing criteria for Hematopoietic/Hematinic Agents, Topical Immunomodulators, Lidoderm 5% Patches and Daliresp® (roflumilast). These changes include the removal of criteria for Regranex®, Inhaled Anticholinergic Agents and Natroba® (spinosad). Lastly, the changes include the addition of new prior authorization criteria for Zolgensma® (onasemnogene abeparvovec-xioi).

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 policy changes are effective March 2, 2020.

These drug changes from Appendix A are effective March 2, 2020.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 02/20 Chapter 1200 – PRESCRIBED DRUGS	MTL 18/17 Chapter 1200 – PRESCRIBED DRUGS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1203.1(A)(4)	**COVERAGE AND LIMITATIONS**	Replaced "Pharmacy & Therapeutics Committee (P&T) Committee" to "Silver State Scripts Board" throughout entire section. Replaced "preferred drug list" language to "PDL" throughout section.
1203.1(A)(4)(e)	**COVERAGE AND LIMITATIONS**	Removed entire section.
1203.1(A)(4)(f)	**COVERAGE AND LIMITATIONS**	Removed entire section.
1203.1(I)	**IMMUNIZA-TIONS**	Replaced the Title "Immunizations" to "Vaccines."
1203.1(I)(2)		Updated hyperlink to reference Physician's Fee Schedule.
1203.1(I)(3)		Updated hyperlink to reference US FDA approved indications.
Appendix A Section H	**Hematopoietic/ Hematinic Agents**	Updated date to "October 17, 2019" for "Last Reviewed by the DUR Board."
Appendix A Section H(1)(a)		Addition of criteria language "The recipient has been evaluated for adequate iron stores."
Appendix A Section K	**Regranex**	Remove entire section. Addition of new prior authorization criteria for Zolgensma®.
Appendix A Section M	**Topical Immunomodu-lators**	Updated date to "October 17, 2019" for "Last reviewed by the DUR Board."
Appendix A Section M(1)(a)		Remove language "Patient must have a therapeutic failure with the use of a topical steroid."
Appendix A Section M(1)(b)4		Update age indication from 18 years of age to 16 years of age. The language will read, "Protopic® 0.1%; moderate to severe, for ages > 16 years."
Appendix A Section M(1)(d)		Remove language "The recipient must have had therapeutic failure with the trial of a topical steroid

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		of at least 14 days within the last six months of approval of Eucrisa®."
Appendix A Section O Appendix A Section O(2)	**Lidoderm 5% Patches**	Updated date to "October 17, 2019" for "Last Reviewed by the DUR Board." Addition of "Prior Authorization Guidelines."
Appendix A Section W	**Inhaled Anticholinergic Agents**	Removal entire section.
Appendix A Section II	**Daliresp® (roflumilast)**	Updated date to "October 17, 2019" for "Last Reviewed by the DUR Board."
Appendix A Section II(1)(d)		Remove word "severe" and wording "associated with chronic bronchitis."
Appendix A Section II(2)(a)		Addition of Contraindication criteria "Daliresp (roflumilast) may not be approved for a recipient with a diagnosis of moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment."
Appendix A Section II(3)(a)		Prior authorization approval duration added.
Appendix A Section MM	**Natroba® (spinosad)**	Removal entire section.

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 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 Silver State Scripts Board (formerly known as the Pharmacy and Therapeutics (P&T) Committee). Reference Medicaid Operations Manual (MOM) Chapter 200 for the Silver State Scripts Board ~~P&T~~ bylaws. Pharmaceuticals not on the ~~preferred drug list~~PDL, but within drug classes reviewed by the Silver State Scripts Board

~~P&T Committee~~, require prior authorization, unless exempt under NRS or federal law or excluded through recommendations of the Silver State Scripts Board ~~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 Silver State Scripts Board ~~P&T Committee~~ adds the drug class to the PDL and reviews the product or evidence.

b. New Food and Drug Administration (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~~PDL ~~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 Silver State Scripts Board ~~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 Silver State Scripts Board ~~P&T Committee~~ determines that there are no significant differences between drugs within specific classes based on clinical efficacy, ~~and~~ safety, and outcomes for patients, 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:~~

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 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 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.

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.

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. Antidiabetics;

d. Antihypertensives;

e. Cardiac Glycosides;

f. Diuretics;

g. Estrogens; and

h. Progesterone.

6. Contraceptive drugs are considered maintenance medication. Contraceptive drugs that are approved by the FDA 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.

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

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

9. 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 prior authorization (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 FFS recipients. There are NO exceptions.

I. ~~Immunizations~~Vaccines

Nevada Medicaid recognizes the importance of preventative health care through vaccines and immunizations. Unless otherwise stated in this chapter, ~~immunizations~~ vaccines are covered without prior authorization. Reference Appendix A of this chapter.

1. Childhood ~~Immunizations~~vaccines: All childhood ~~immunizations~~ vaccines are covered without prior authorization under the Healthy Kids Program. Refer to MSM Chapter 1500, Healthy Kids Program for more information on childhood ~~immunizations~~vaccines.

2. Adult ~~Immunizations~~vaccines: Adult ~~immunizations~~ vaccines such as tetanus, flu vaccine and pneumococcal vaccine are covered without prior authorization. For a list of covered adult ~~immunizations~~vaccines, please reference the Physician's Fee Schedule ~~under "Professional Rates"~~ at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/ ~~http://www.dhcfp.nv.gov/RatesUnit.htm~~

3. Human Papillomavirus (HPV) Vaccine: The 9-valent HPV vaccine (for both males and females) is covered for Medicaid eligible recipients ages nine years through 45

years, based on the US FDA approved indications. These may be accessed by following the link: https://www.fda.gov/vaccines-blood-biologics/vaccines/gardasil~~http://www.fda.gov/cber/products/gardasil.htm~~. The HPV vaccines are available through the State Division of Public and Behavioral Health (DPBH) as part of the Vaccines for Children (VFC) program for eligible females and males age nine through 18 years. Please refer to MSM Chapter 1500 for more information on the VFC program.

4. Pharmacies may administer childhood and adult vaccines/immunizations.

   a. Pharmacies must adhere to all Nevada State Board of Pharmacy (BOP) regulations regarding vaccine/immunization administration including certification to administer as documented in NAC Chapter 639.

   b. Pharmacies must receive childhood ~~immunizations~~ vaccinations through the VFC Program. The DHCFP or Nevada Medicaid and NCU do not reimburse for vaccines included in the VFC Program.

   c. Covered ~~immunizations~~ vaccinations not included in the VFC Program will be reimbursable per the Nevada Medicaid and NCU Pharmacy Manual.

   d. If the pharmacist administers the ~~immunization~~vaccination, the dispensing fee will not be reimbursed. An administration fee is paid instead.

J. Pharmacist Submitted Prior Authorizations

1. The DHCFP will allow pharmacists to submit a prior authorization if:

   a. The requesting pharmacist has access to the recipient's medical records.

K. Dispensing Practitioners:

1. Must have a current Certificate of Registration through the Nevada State Board of Pharmacy. Refer to NRS 639.070 and NAC 639.390; and

2. Must be enrolled with Nevada Medicaid provider enrollment as a Provider Type (PT) 28; and

3. Dispensing practitioners' offices must be located in the State of Nevada; and

4. All prior authorization criteria and quantity limitations apply to dispensing practitioner claims; and

5. Only PT 28 can be reimbursed for a dispensing fee; and

H. Hematopoietic/Hematinic Agents

Therapeutic Class: Erythropoiesis Stimulating Agents (ESAs)
Last Reviewed by the DUR Board: ~~January 24, 2008~~October 17, 2019

This policy applies in all settings with the exception of inpatient facilities. Hematopoietics and Hematinics are subject to prior authorizations 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

a. The recipient has been evaluated for adequate iron stores; and

b. Recipients must meet one of the following criteria for coverage:

a. Achieve and maintain hemoglobin levels within the range of 10 to 12 gm/dl in one of the following conditions:

a. Treatment of anemia secondary to myelosuppressive anticancer chemotherapy.

b. Treatment of anemia related to zidovudine therapy in HIV-infected patients.

c. Treatment of anemia secondary to ESRD.

c. Epoetin alfa (Epogen®) is indicated to reduce the need for allogenic transfusions in surgery patients when a significant blood loss is anticipated. It may be used to achieve and maintain hemoglobin levels within the range of 10 to 13 gm/dl. Darbepoetin Alfa (Aranesp®) does not have this indication.

2. Non-Covered Indications

a. Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding or bone marrow fibrosis.

b. Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) or erythroid cancers.

c. Anemia of cancer not related to cancer treatment.

d. Any anemia associated only with radiotherapy.

e. Prophylactic use to prevent chemotherapy-induced anemia.

f. Prophylactic use to reduce tumor hypoxia.

g. Patients with erythropoietin-type resistance due to neutralizing antibodies.

h. Anemia due to cancer treatment if patients have uncontrolled hypertension.

3. Prior Authorization Guidlines

Prior approval will be given for a one month period. Recent laboratory results are required for prior authorization, i.e. serum hemoglobin within seven days of prior authorization request.

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

K. ~~Regranex®~~

~~Therapeutic Class: Diabetic Ulcer Preparations, Topical~~
~~Last Reviewed by the DUR Board: July 17, 2008~~

~~Regranex® 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 all the following criteria are met and documented:~~

~~a. Diagnosis of lower extremity diabetic ulcer(s); and~~

~~b. Recipient must be age 16 years or older.~~

~~2. Prior Authorization Guidelines~~

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

Zolgensma (onasemnogene abeparvovec-xioi)

Therapeutic Class: Spinal Muscular Atrophy Agents
Last Reviewed by the DUR Board: October 17, 2019

Zolgensma® (onasemnogene abeparvovec-xioi) is subject to prior authorization and quantity limitatons based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid 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. The recipient must be two years of age or younger; and

1. The recipient must have the mutation or deletion of genes in chromosome 5q in one of the following: homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13); or

2. Compound hetereozygous mutation of Survival of Motor Neuron 1 (SMN1) gene (e.g., deletion of SMN1, exon 7 [allele 1] and mutation of SMN1 [allele 2]); and

a. The recipient has a diagnosis symptomatic Type I or Type II SMA confirmed by a neurologist with expertise in the diagnosis of SMA; or

b. The recipient has a diagnosis of SMA based on the results of SMA newborn screening with three copies or less of Survival of Motor Neuron 2 (SMN 2); and

3. The recipient is not dependent on either invasive ventilation or tracheostomy or use of non-invasive ventilation beyond use of naps and nighttime sleep; and

4. Submission of medical records (e.g., chart notes, laboratory values) documenting the recipient's anti-AAV9 antibody titers are less than or equal to 1:50; and

5. The recient is not to receive concomitant SMN modifying therapy (e.g. Spinraza®); and

6. The medication is prescribed by a neurologist with expertise in the diagnosis of SMA; and

7. The recipient has never received Zolgensma® treatment in their lifetime.

2. Prior Authorization Guidelines

a. Prior authorization approvals will be for a one time authorization in lifetime.

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

M. Topical Immunomodulators

Therapeutic Class: Topical Immunomodulators
~~Eucrisa® last reviewed by the DUR Board: July 26, 2018~~
Last Reviewed by the DUR Board: ~~April 26, 2007~~October 17, 2019

Topical Immunomodulators drugs are a subject to prior authorization and quantity limitations 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

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

~~a. Patient must have a therapeutic failure with the use of a topical steroid.~~

~~b.~~a. Patient has a documented diagnosis of Atopic Dermatitis:

1. Elidel® for mild to moderate, for ages ≥ two years.

2. Eucrisa® for mild to moderate, for ages ≥ two years.

3. Protopic® 0.03%; moderate to severe, for ages ≥ two years.

4. Protopic® 0.1%; moderate to severe, for ages ~~>~~≥ 1~~8~~6 years.

b. Not for chronic use.

c. Elidel® is not recommended for use on patients with Netherton's syndrome due to the potential for systemic absorption.

~~d. The recipient must have had therapeutic failure with the trial of a topical steroid of at least 14 days within the last six months for approval of Eucrisa®.~~

~~e.~~d. Not recommended for use in immunocompromised patients.

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

O. Lidoderm 5% Patches®

Therapeutic Class: Topical, Local Anesthetics
Last Reviewed by the DUR Board: ~~April 30, 2009~~October 17, 2019

1. Coverage and Limitations

Topical Lidoderm Patches® 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.

Authorization will be given if one of the following criteria are met and documented:

a. If an ICD code for herpes zoster is documented on the prescription; or

b. Completion of a prior authorization documenting a diagnosis of Post Herpetic Neuralgia/Neuropathy.

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.

W. ~~Inhaled Anticholinergic Agents~~RESERVED FOR FUTURE USE

~~Therapeutic Class: Respiratory Anticholinergic Agents~~
~~Last Reviewed by the DUR Board:~~

~~Inhaled anticholinergic agents 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. General Criteria~~

~~a. Only one inhaled anticholinergic agent may be used in a 30-day period~~.

II. Daliresp® (roflumilast)

Therapeutic Class: Phosphodiesterase-4 Inhibitors.
Last Reviewed by the DUR Board: ~~July 26, 2012~~October 17, 2019

Daliresp® (roflumilast) 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

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

a. The recipient has experienced an inadequate response, adverse event or has a contraindication to a long-acting anticholinergic agent;

b. The recipient has experienced an inadequate response, adverse event or has a contraindication to a long-acting beta (β) agonist;

c. The recipient has experienced an inadequate response, adverse event or has a contraindication to an inhaled corticosteroid;

d. The recipient has a diagnosis of ~~severe~~ Chronic Obstructive Pulmonary Disease (COPD)~~ associated with chronic bronchitis~~; and

e. The recipient has a history of COPD exacerbations.

2. Contraindication

a. Daliresp (roflumilast) may not be approved for a recipient with a diagnosis of moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment.

3~~2~~. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

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

MM. ~~Natroba® (spinosad)~~RESERVED FOR FUTURE USE

~~Therapeutic Class: Topical Antiparasitics~~
~~Last Reviewed by the DUR Board: July 26, 2012~~

~~Natroba® (spinosad) is subject to prior authorization.~~

~~1. Coverage and Limitations~~

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

~~a. The recipient has experienced an allergy or adverse event with a permethrin or pyrethrin-containing pediculicide product; or~~

~~b. The recipient has experienced a treatment failure with a permethrin or pyrethrin-containing pediculicide product despite a full course of treatment (two applications); or~~

~~c. The recipient has a contraindication to treatment with permethrin or pyrethrin-containing pediculicide product.~~

~~2. Prior Authorization Guidelines~~

~~a. Prior authorization approval will be for the date of service only.~~

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