Medicaid Services Manual
Transmittal Letter

April 19, 2024

To: Custodians of Medicaid Services Manual

From: Casey Angres
Chief of Division Compliance

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 add Wegovy exception criteria due to new indication for use approved by the FDA to Appendix A, Section KK. – Incretin Mimetics and updated exclusion language in Section 1203.1.

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 May 29, 2024.

Material Transmitted	Material Superseded
MTL OL Chapter 1200 – Prescribed Drugs	MTL 11/23 Chapter 1200 – Prescribed Drugs

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section KK	**Incretin Mimetics**	Addition of Wegovy exception criteria due to new indication for use approved by the FDA in Appendix A, Section KK to Incretin Mimetics.
Section 1203.1	**Coverage and Limitations**	Exclusion language change.

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, including any prescription dietary supplement/vitamin/mineral (other than prescription pre-natal vitamins or fluoride) without an FDA-approved 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 (MDRP).

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 (SSSB) (formerly known as the Pharmacy and Therapeutics (P&T) Committee). Reference Medicaid Operations Manual (MOM) Chapter 200 for the Silver State Scripts Board bylaws. Pharmaceuticals not on the

PDL, but within drug classes reviewed by the SSSB, require prior authorization, unless exempt under NRS or federal law or excluded through recommendations of the SSSB or excluded by the DHCFP.

a. Per NRS 422.4025 the following drug classes are excluded from any PDL restrictions:

1. Prescribed drugs for the treatment of human immunodeficiency virus (HIV/AIDS);

2. Antirejection medications for organ transplants; and

3. Antihemophilic medications.

Additionally, the PDL must include the following drug classes as covered and preferred:

4. Any prescription essential for treating sickle cell disease and its variants; and

5. Prescribed drugs to prevent the acquisition of HIV/AIDS.

b. New pharmaceutical products not within reviewed PDL drug classes and not excluded under the state plan or by NRS are covered without a Standard PDL Exception prior authorization until, or if, the SSSB adds the drug class to the PDL and reviews the product or evidence.

c. 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 PDL and are not excluded under state plan or by NRS, are covered with an approved Standard PDL Exception prior authorization until SSSB can review the new evidence or drug.

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

e. If the SSSB determines that there are no significant differences between drugs within specific classes based on clinical efficacy, 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.

B. Standard PDL 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 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 through the Nevada Medicaid Pharmacy Portal at https://nevadamedicaid.magellanrx.com/home.

C. Excluded

The DHCFP will not reimburse for the following pharmaceuticals:

1. Agents used for weight management~~loss~~.

2. Agents used to promote fertility.

3. Agents used for cosmetic purposes or hair growth.

4. Yohimbine.

KK. Incretin Mimetics

Therapeutic Class: Incretin Mimetics
Last Reviewed by the DUR Board: January 18, 2024
Previously reviewed by the DUR Board: January 26, 2017

Incretin Mimetics 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. Approval will be given if all criteria are met and documented:

   a. Initial Requests:

      1. Medication being prescribed for one of the following:

         a. Adjunct to diet and exercise to improve glycemic control in patients with type 2 diabetes mellitus (T2DM); or

         b. Reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in patients with type 2 diabetes and established cardiovascular disease; and

      2. Documentation of A1C lab result within past 180 days; and

      3. Patient does not have history of pancreatitis; and

      4. Patient does not have type 1 diabetes mellitus; and

      5. Medication is not being prescribed for weight loss in absence of T2DM indication; and

      6. Medication prescribed at FDA-approved dose for T2DM indication; and

      7. Patient is appropriate age per FDA label.

   b. Renewal Requests:

      a. Patient continues to meet above criteria; and

      b. Documentation of positive response from therapy.

2. Prior Authorization Guidelines

   a. Prior authorization approval will be for one year.

   b. Prior Authorization forms are available at: https://nevadamedicaid.magellanrx.com/provider/forms.

3. Exception criteria:

a. Wegovy (semaglutide)

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

a. Medication is being prescribed for risk reduction of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight.

b. Patient must be 18 years of age or older; and

c. Documentation that patient has a body mass index (BMI) ≥27 kg/m^2; and

d. Have established cardiovascular (CV) disease as evidenced by at least one of the following:

1. prior myocardial infarction;

2. prior ischemic or hemorrhagic stroke;

3. symptomatic peripheral arterial disease (PAD), as evidenced by intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease.

e. Wegovy must be prescribed by, or in consultation with, a cardiologist or vascular specialist; and

f. Patient must not have type 1 or type 2 diabetes. Patients with type 1 or type 2 diabetes must have appropriate diabetic care with an alternative therapy as this indication is specific to non-diabetic patients; and

g. Patient must not have any contraindications for use of Wegovy; and

h. Patient must not be utilizing another GLP-1 therapy; and

i. Documentation that patient has received individualized healthy lifestyle counseling; and

j. Provider attestation that in addition to Wegovy the provider will maintain standard of care treatment for the patient's established cardiovascular disease; and

2. Prior Authorization Guidelines:

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

b. Recertification approval will be for six months and requires achievement of 2.4mg once weekly maintenance dose shown to reduce the risk of major cardiovascular events following titration according to package labeling or prescriber must provide reasoning why the 2.4mg once weekly maintenance dose is not appropriate.