

MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER

April 17, 2012

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL  
 FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE  
 SUBJECT: MEDICAID SERVICES MANUAL CHANGES  
 CHAPTER 1200 – PRESCRIBED DRUGS

**BACKGROUND AND EXPLANATION**

Medicaid Services Manual (MSM) Chapter 1200, Appendix A, Prescribed Drugs has revisions that are being made to reflect approved actions by the Drug Use Review (DUR) Board at the April 28, 2011 and January 26, 2012 meetings.

The DUR Board is a requirement of the Social Security Act to identify and reduce fraud, abuse, overuse, and medically unnecessary care. The DUR Board also works to minimize drug interactions, drug-induced illness, and undesirable drug reactions in recipients.

On April 28, 2011, the DUR Board approved prior authorization criteria for Makena and removed the prior authorization criteria for Ramipril. On January 26, 2012, the DUR Board approved criteria for Boceprevir (Victrelis®), and Telaprevir (Incivek®). Discussed at the January 26, 2012 DUR meeting was the proposed plan by DHCFP to reimburse pharmacists for the administration of immunizations/vaccines. Pharmacists must adhere to all Board of Pharmacy regulations related to the administration of vaccines/immunizations.

Throughout Chapter 1200, all references to Magellan Medicaid Administration (MMA) were removed. All general eligibility or provider requirements already found in MSM Chapter 100 were deleted. Grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections as necessary.

These changes are effective April 18, 2012.

**MATERIAL TRANSMITTED**

MTL 07/12  
CHAPTER 1200 – PRESCRIBED DRUGS

**MATERIAL SUPERSEDED**

MTL 21/03, 31/09, 50/10, 15/11  
CHAPTER 1200 – PRESCRIBED DRUGS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1201	Authority	Moved H to D and deleted the public law internet link as it is no longer active.

<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
1203.1A.1	<b>Pharmaceuticals – Coverage and Limitations - Covered</b>	Clarified existing language and added a reference to the Addendum for additional information regarding tamper-resistant prescription pads.
1203.1A.2	<b>Pharmaceuticals – Coverage and Limitations – Standard Preferred Drug List Exception Criteria</b>	Information was moved from Appendix A.
1203.1A.4	<b>Pharmaceuticals – Coverage and Limitations – Refills</b>	Previously numbered 1203.1A.3. Removed example related to refill intervals and added a reference to the Quantity of Medication section for additional information on maintenance medications.
1203.1A.5	<b>Pharmaceuticals – Coverage and Limitations – Early Refills</b>	Previously numbered 1203.1A.4. Removed the reference to the Point of Sale Manual for a list of acceptable overrides.
1203.1A.6	<b>Pharmaceuticals – Coverage and Limitations – Quantity of Medication</b>	Previously numbered 1203.A1.5. Removed the reference to another manual section within the chapter.
1203.1A.6	<b>Pharmaceuticals – Coverage and Limitations – Time Limits</b>	Deleted the section related to time limits for claims submission as information is duplicative of policies noted in Chapter 100 of the MSM.
1203.1A.9	<b>Pharmaceuticals – Coverage and Limitations – Immunizations</b>	Clarified the existing language and added policy indicating that pharmacies may administer childhood and adult /immunizations. Pharmacies must follow Board of Pharmacy regulations for administration of vaccines/immunizations.
1203.1B.1	<b>Provider Responsibility</b>	Clarified existing language and removed language related to provider enrollment with Nevada Medicaid as this information is located in MSM Chapter 100.

Deleted the references to specific sections and POS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
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system contractor.

Added reference to Nevada Medicaid and NCU Pharmacy Manual.

**1203.1B.2.a. Provider Responsibility-Utilization Control**

Clarified existing language and removed language regarding eligibility, verification of eligibility, and HMO/MCO reimbursement as this information is duplicative of information noted in MSM Chapter 100.

**1203.1C Recipient Responsibility**

Deleted this section as duplicate information can be found in MSM Chapter 100.

**1203.1C Service Delivery Model**

Previously numbered 1203.1D. Clarified existing language and removed language regarding Third Party Liability as this information is duplicative of policies noted in MSM Chapter 100. Also updated the internet link to obtain State Maximum Allowable Cost (SMAC) information and changed references to the appropriate Chapters, Sections and Billing Manual where appropriate.

**1203.1D Authorization Procedures**

Previously numbered 1203.1E. Clarified existing language and removed references to the prior fiscal agent MMA. Updated references.

**1203.2 Intravenous (IV) Therapy Provider Type 37**

Clarified existing language and removed language referring providers to the Pharmacy Manual but rather directed them to the Pharmacy vendor for billing questions.

**Appendix A**

MSM Chapter 1200, Appendix A, Prescribed Drugs has revisions that are being made to reflect actions that were approved by the Drug Use Review Board. The changes will require prior authorization and/or quantity limitations for drugs/drug classes.

**Appendix A Table of Contents**

Updated Table of Contents.

**Appendix A**

Throughout the entire Appendix, references to the Prior Authorization Form name have been removed and the Internet link to obtain the form has been revised. In addition, references to the previous fiscal agent MMA have been either removed or replaced with the new fiscal agent Hewlett Packard

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Enterprise Services (HPES).
Appendix A Section 1.B.1	<b>Drugs Requiring Prior Authorization-Cox 2 Inhibitors – Coverage and Limitations</b>	Deleted familial adenomatous polyposis (FAP) from the Indications.
Appendix A Section 1.J	<b>Drugs Requiring Prior Authorization- Altace® (Ramipril)</b>	Deleted this section.
Appendix A Section 1.T	<b>Drugs Requiring Prior Authroization- Standard Preferred Drug List Exception Criteria</b>	Deleted this section.
Appendix A Section 2.N	<b>Drugs with Quantity Limitations- Makena (Criteria for Physician Administered Drug)</b>	Added new policy and clinical criteria regarding Makena.
Appendix A Section 2.O	<b>Drugs with Quantity Limitations- Vitreliis® (boceprevir)</b>	Added new policy and clinical criteria regarding Vitreliis® (boceprevir).
Appendix A Section 2.P	<b>Drugs with Quantity Limitations- Incivek® (telaprevir)</b>	Added new policy and clinical criteria regarding Incivek® (telaprevir)
Appendix A Section 4	<b>Antiretrovirals</b>	Removed language regarding HMO coverage for antiretrovirals.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL  
TABLE OF CONTENTS

PRESCRIBED DRUGS

1200	INTRODUCTION .....	1
1201	AUTHORITY.....	1
1202	RESERVED.....	1
1203	POLICY.....	1
1203.1	PHARMACEUTICALS .....	1
1203.1A	COVERAGE AND LIMITATIONS .....	1
1203.1B	PROVIDER RESPONSIBILITY.....	8
1203.1C	SERVICE DELIVERY MODEL.....	10
1203.1D	AUTHORIZATION PROCEDURES.....	16
1203.2	INTRAVENOUS (IV) THERAPY PROVIDER TYPE 37.....	18
1204	HEARINGS.....	1

APPENDIX A

TABLE OF CONTENTS.....	1
DRUGS REQUIRING A PRIOR AUTHORIZATION .....	3
DRUGS WITH QUANTITY LIMITATIONS .....	27
MEDICATIONS WITH GENDER/AGE EDITS.....	36
ANTIRETROVIRALS .....	47
BLOOD GLUCOSE TESTING .....	47

APPENDIX B

<b>SXC HEALTH SOLUTIONS AD HOC</b> REPORTING SYSTEM STANDARD THERAPEUTIC CLASSES.....	1
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	MTL 50/10
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1200
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

## 1200 INTRODUCTION

The Nevada Medicaid Pharmacy Services program pays for medically necessary prescription services for eligible Medicaid recipients under the care of the prescribing practitioner. Such 0.5 services shall maintain a high standard of quality and shall be provided within the limitations and exclusions hereinafter specified.

All providers participating in the Medicaid program must furnish services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available from Provider Services.

This Chapter describes covered services, service limitations, and general reimbursement methodology.

This manual obsoletes all previous policy and procedure manuals, bulletins and policy news.

All Medicaid policies and requirements (such as prior authorizations, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1201
MEDICAID SERVICES MANUAL	Subject: AUTHORITY

1201 AUTHORITY

- A. The Code of Federal Regulations (CFR), Title 42, Public Health, Chapter IV Center for Medicare and Medicaid Services (CMS), Subchapter C Medical Assistance Programs, Parts 430 through 456, states prescription drug coverage is an optional service under Title XIX.
- B. The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandates additional preventive health care services for infants, children and young adults (newborn through age 20) eligible for Medicaid. These mandates provide that children and adolescents under age 21 receive follow-up services for a medically necessary condition discovered in a screening examination Early Preventative Screening and Diagnostic Testing (EPSDT) see Chapter 1500; this includes prescription services.
- C. CFR Title 42 and Section 1927 of the Social Security Act, require states to provide for a Drug Utilization Review (DUR) program for covered outpatient drugs in order to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results (Social Security Administration (SSA), Title 19, (g)(1)(A)).
- D. Section 1927 of the Social Security Act allows a state to require a prior authorization on any covered outpatient drug, providing the prior authorization program complies with the requirements outlined in the act.  
  

The Social Security Act requires the establishment of a DUR board to monitor therapeutic appropriateness, use of generic products, overutilization and underutilization of drugs and quality of care consistent with protecting the health of program beneficiaries.
- E. Chapter 422 of Nevada Revised Statute (NRS) amended by AB 384 to require the Department of Health and Human Services (DHHS) to:
  - 1. develop a list of preferred prescription drugs;
  - 2. manage prescription drug use through the use of prior authorization and step therapy; and
  - 3. create the Pharmacy and Therapeutics Committee.
- F. U.S. Troop Readiness, Veteran’s Health Care, Katrina Recovery and Iraq Accountability Appropriations Act 2007, Section 7002(b) of the act requires Medicaid outpatient drugs (defined in Section 1927(k)(2) of the Social Security Act) will be reimbursable only if non-electronic written prescriptions are executed on a tamper-resistant prescription pad.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1201
MEDICAID SERVICES MANUAL	Subject: AUTHORITY

- G. The Deficit Reduction Act of 2005 requires fee-for-service (FFS) State Medicaid programs to capture and report National Drug Codes (NDC) for outpatient drugs in order for the state to receive federal financial participation.



	MTL 15/11
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1202
MEDICAID SERVICES MANUAL	Subject: RESERVED

1202          RESERVED

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

1203 POLICY

Nevada Medicaid reimburses pharmacies for prescriptions dispensed to each Medicaid recipient, with a maximum of a 34 day supply. Maintenance medications have a maximum of 100 day supply.

1203.1 PHARMACEUTICALS

All legend and non-legend pharmaceuticals must be prescribed by a licensed physician, podiatrist, osteopath, dentist, advanced practitioner of nursing (APN), or physician's assistant within the scope of their practice.

1203.1A COVERAGE AND LIMITATIONS

1. Covered

The Nevada Medicaid Drug program will pay for the following prescribed pharmaceuticals with a written prescription and may be subject to restrictions (such as Prior Authorization, Quantity Limitations etc):

- a. 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 Medicaid Services Manual (MSM) Addendum for more information on tamper-resistant prescription pads.**
- b. Legend and non-legend pharmaceuticals manufactured by companies participating in the federal Medicaid Drug Rebate Program, not on the excluded list (see below).
- c. 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 Division of Health Care Financing and Policy (DHCFP).
  1. New pharmaceutical products not within reviewed PDL **drug classes** and **not** excluded under **the** state plan are available under prior authorization guidelines until the P&T Committee reviews the product or evidence.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

2. Existing pharmaceutical products for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs and are not excluded under state plan, are available under prior authorization guidelines until the P&T Committee can review the new evidence.
3. Pharmaceuticals may require prior authorization due to step therapy protocols regardless of inclusion in the PDL.
4. If the P&T Committee determines that there are no significant differences between drugs within a specific **classes** based on clinical efficacy and safety, DHCFP or **its QIO-like vendor** may consider cost in determining which drugs are selected for inclusion on the PDL.
5. The DUR Board shall not be required to develop, review or approve prior authorization policies necessary for the operations of the PDL.
6. Due to the 76<sup>th</sup> 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**.
7. Due to the 76<sup>th</sup> 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:
  - a. 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
  - b. maintains continuous eligibility for Medicaid.
- d. Pharmaceuticals prescribed for a medically accepted indication.
- e. Family planning items such as diaphragms, condoms, foams and jellies.

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

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

## 2. 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.

### a. Coverage and Limitations

1. Allergy to all preferred medications within the same class;
2. Contraindication to or drug-to-drug interaction with all preferred medications within the same class;
3. History of unacceptable/toxic side effects to all preferred medications within the same class;
4. Therapeutic failure of two preferred medications within the same class.
5. If there are not two preferred medications within the same class therapeutic failure only needs to occur on the one preferred medication;
6. An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or a FDA-approved indication;
7. Antidepressant Medication – Continuity of Care.

Recipients discharged from acute mental health facilities on a non-preferred antidepressant will be allowed to continue on that drug for up to 90 days following discharge. After 90 days, the recipient must meet one of the above five (5) PDL Exception Criteria; or

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

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

## 3. Excluded

The Nevada Medicaid Drug Rebate program will not reimburse for the following pharmaceuticals:

- a. Agents used for weight loss.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

- b. Agents used to promote fertility.
- c. Agents used for cosmetic purposes or hair growth.
- d. Yohimbine.
- e. 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 Food and Drug Administration (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](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.
- f. 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.
- g. Agents used for impotence/erectile dysfunction.

**4. Refills**

A refill is a prescription subject to the limitations below:

- a. Authorized refills are valid only from the pharmaceutical provider dispensing the original prescription, pursuant to Nevada Administrative Code (NAC) 639.712 and 639.714.
- b. 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.
- c. 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.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

Prior authorization may be granted in life-threatening situations and for maintenance medications only. **See Quantity of Medication in this chapter for more information on maintenance medications.**

**5. Early Refills**

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.

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.

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.

**6. Quantity of medication**

The maximum quantity of medication per prescription payable by the Medicaid program is a 34 day supply. Exceptions are allowed for maintenance medications.

- a. 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.)
- b. 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.
- c. The maximum quantity of medication per prescription for maintenance pharmaceuticals for chronic conditions for outpatients, payable by Medicaid, may be a 100-day supply.

The following drug categories are considered maintenance medications:

1. Antianginals;
2. Antiarrhythmics;

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

3. Anticonvulsants;
4. Antidiabetics;
5. Antihypertensives;
6. Cardiac Glycosides;
7. Diuretics;
8. Thyroid preparations;
9. Estrogens;
10. Progesterone; and
11. Oral/Topical Contraceptives.

7. Emergency supply of medication

- a. In an emergency situation, after QIO-like vendor working hours and weekends, dispensing of up to a 96 hour supply those covered outpatient drugs that require prior authorization will be allowed.
- b. Nevada Medicaid requires prior payment authorization for medications identified as requiring Prior Authorization (PA).
- c. The physician must indicate the diagnosis on the prescription (preferably with an ICD-9 code) to support the use of the emergency policy.
- d. 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.

8. 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.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

9. Immunizations

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

- a. Childhood Immunizations: All childhood immunizations are covered without prior authorization under the Healthy Kids Program. Refer to **MSM Chapter 1500, Healthy Kids Program**, for more information on childhood immunizations.
- b. Adult Immunizations: Adult immunizations such as tetanus, flu vaccine, and pneumococcal vaccine are covered without prior authorization. For a list of covered adult immunizations, please reference the Physician’s Fee Schedule under “Professional Rates” at: <http://www.dhcfp.nv.gov/RatesUnit.htm>.
- c. Human Papillomavirus (HPV) Vaccine: The quadrivalent HPV vaccine (for both males and females) is available to Medicaid eligibles age 19 years through 26 years, based on the US FDA approved indications. The bivalent HPV vaccine for ages 19-26 years is also available to Medicaid eligible females only. These may be accessed by following the link: <http://www.fda.gov/cber/products/gardasil.htm>. The HPV vaccines are available through the state Health Division as part of the Vaccines for Children (VFC) program for eligible females and males age 9 through 18 years. Please refer to MSM Chapter 1500, for more information on the VFC program.
- d. **Pharmacies may administer childhood and adult vaccines/immunizations.**
  1. **Pharmacies must adhere to all Nevada State Board of Pharmacy (BoP) regulations regarding vaccine/immunization administration including certification to administer as documented in NAC 639.297.**
  2. **Pharmacies must receive childhood immunizations through the Vaccines for Children (VFC) Program. DHCFP or Nevada Medicaid and Nevada Check Up (NCU) do not reimburse for vaccines included in the VFC Program.**
  3. **Covered immunizations not included in the VFC Program will be reimbursable per the Nevada Medicaid and NCU Pharmacy Manual.**
  4. **If the pharmacist administers the immunization, the dispensing fee will not be reimbursed. An administration fee is paid instead.**



	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

1203.1B PROVIDER RESPONSIBILITY

1. For information on **In-State and** Out-Of-State Provider Participation refer to MSM Chapter 100.
  - a. The pharmaceutical provider will maintain records for all prescriptions dispensed to eligible recipients as may be required.
    1. The provider will allow, upon request of proper representative, access to all records that pertain to Medicaid recipients for fiscal review, audit or utilization review.
    2. All fiscal records are to be maintained for a period of six years or as specified in federal regulation.
2. Utilization Control
  - a. Prospective (Concurrent) Drug Utilization Review (Pro-DUR)
 

Pro-DUR functions will be carried out via the Point of Sale (POS) Systems.

    1. Pro-DUR edits apply to POS claims and paper (UCF) claims.
    2. Long Term Care (LTC) claims are subject to all Pro-DUR edits that apply to retail.
    3. Providers may submit override codes using the National Council for Prescription Drug Programs (NCPDP) standard interactive DUR codes. Override codes may be submitted on the initial claim. A denied claim does not have to be on file.
    4. No long term Prior Authorization's are issued, codes must be entered each time errors occur. Reference the **Nevada Medicaid and NCU Pharmacy Manual (Pharmacy Manual)** for more information on the current Pro-DUR edits and override procedures.
  - b. Retro Drug Utilization Review (DUR)
 

Both recipient and provider profiles (i.e. claim payments) are reviewed to identify patterns of excess. Verification of receipt of services is ongoing on a sample basis. Providers may be audited on site.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

c. Drug Utilization Review (DUR)

Nevada Medicaid policy and federal law allows the state appointed DUR Board to conduct review of the information compiled about individual clients and providers and allows the DUR Board to educate Medicaid providers about the changes in drug therapeutics. Educational programs may include information such as drug interactions between medications that physicians have prescribed for the clients and medications they are prescribing that are unnecessarily expensive. In this case, educational efforts will be directed to help providers improve their efficiency in the allocation of the finite resources available for Medicaid clients.

d. Eligibility

Please refer to MSM Chapter 100 for information on Medicaid eligibility, eligibility verification and the Eligibility Verification System (EVS).

1. Lock-in Program: When a recipient has shown patterns of abuse/misuse of Nevada Medicaid benefits, the recipient may be “locked-in” to a pharmacy or provider. This means that Medicaid will only pay for controlled substance prescriptions/medical service at a single pharmacy/provider. The POS system that will not allow another pharmacy to bill for controlled substance prescriptions, and a message will be given at the time of service to notify the pharmacy that the recipient is locked-in.

3. Generic Substitution

Per Nevada Revised Statute (NRS) 639.2583, if the practitioner has not indicated that generic substitution is prohibited, the pharmacy provider must dispense, in substitution, another drug which is available to him if the other drug:

- a. is less expensive than the drug prescribed by brand name;
- b. is biologically equivalent to the drug prescribed by brand name;
- c. has the same active ingredient or ingredient of the same strength, quantity and form of dosage as the drug prescribed by brand name; and
- d. is of the same generic type as the drug prescribed by brand name the least expensive of the drugs that are available to him for substitution.

The pharmacy provider shall substitute the least expensive of the drugs available to him/her for substitution.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

#### 4. Prescriber Brand Certification

Upper Limit cost limitations specified in this Chapter will not apply when a prescriber certifies that a specific brand of medication is medically necessary for a particular patient. The physician should document in the patient's medical record the need for the brand name product in place of the generic form. The procedure for certification must comply with the following:

- a. The certification must be in the physician's own handwriting.
- b. Certification must be written directly on the prescription blank.
- c. The phrase "Dispense as written" is required on the face of the prescription. For electronically transmitted prescriptions "Dispense as written" must be noted. Not acceptable: A printed box on the prescription blank checked by the prescriber to indicate "brand necessary" or a handwritten statement transferred to a rubber stamp and then stamped on the prescription.
- d. A prior authorization is required to override generic substitution.
- e. Certification is not required if a generic is not manufactured.
- f. A fax copy/verbal order may be taken by the pharmacist from the physician but the pharmacy must obtain an original printed copy and keep on file.

#### 1203.1C SERVICE DELIVERY MODEL

For the rate and reimbursement methodology see MSM Chapter 700, Rates. For POS claims refer to the Pharmacy Manual, and for Medicaid Management Information System (MMIS) claims refer to the Nevada Medicaid and NCU Billing Manual (**Billing Manual**).

1. Institutional settings
  - a. Medical/Surgical, Specialty and Psychiatric Hospitals – All pharmacy services are included in the daily per diem rate for inpatient services, which are billed through MMIS.
  - b. Long Term Care (LTC)
    1. Nursing Facilities (NF) – Legend pharmaceutical services are excluded from the daily per diem facility rate. This includes compound prescriptions and Total Parental Nutrition (TPN) solution and additives. Legend pharmaceuticals are billed directly by a licensed pharmacy through POS.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

Non-legend pharmaceuticals are not separately reimbursable.

2. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) – Legend and non-legend pharmaceuticals are excluded from the facility rate. Pharmaceuticals are billed directly by a licensed pharmacy through POS.

2. Outpatient Pharmaceuticals

- a. Covered outpatient drugs that are billed separately from medical services, in accordance with Section 1927 of the Social Security Administration (SSA).

1. Retail pharmacies, (billed through POS).
2. Home Infusion Therapy (HIT)/Free Standing Infusion Clinics, (billed through POS). Refer to **the Intravenous (IV) Therapy Provider Type 37** Section of this chapter.
3. Physician administered drugs, all pharmacy charges are billed separately. The administered drug is to be billed utilizing the appropriate National Drug Code (NDC) and NDC quantity. The administration of the drug is billed using the appropriate Current Procedural Terminology (CPT) code (billed through MMIS).
4. Hospital based outpatient clinics, all pharmacy charges are billed separately. The administered drug is to be billed utilizing the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).
5. End Stage Renal Disease (ESRD) Facilities, the administered drug(s) is to be billed utilizing the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).

- b. Covered outpatient drugs that are not reimbursed separately in accordance with 1927(k)(2) of the SSA.

1. Ambulatory Surgical Centers (ASC)/Hospital-Based Ambulatory Infusion Centers, all pharmacy services are included in the facility rate. Pharmacy charges may not be billed separately, (billed through MMIS).
2. Emergency Rooms, all pharmacy services are included in the Emergency Room charges. “Take home” medications are also included in the facility rate and may not be billed separately, (billed through MMIS).

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

3. Disposable Medical Supplies

Please refer to Chapter 1300, Durable Medical Equipment (DME) for instructions on billing and any applicable limitations for these items.

4. Unit Dose (Repackage and Re-Stock) Repackage

Nevada Medicaid provides reimbursement incentives for LTC providers who repackage non-unit dose pharmaceuticals. An additional \$0.43 per claim is given on pharmaceuticals that are repackaged for unit dose dispensing. Pharmaceuticals that First Data Bank classifies as unit dose products are not covered for this policy.

This incentive is available only to pharmacies supplying long-term care inpatients. The pharmacy provider must apply to the QIO-like Vendor Pharmacy Department to enroll in this incentive program.

In accordance with the CMS, State Medicaid Director Letter (SMDL) 06-005, repackaging of pharmaceuticals must be in compliance with the Nevada State Board of Pharmacy. In addition, nursing facilities must properly credit the Medicaid program for the return of unused prescription medicines upon discontinuance of the prescription or transfer, discharge or death of a Medicaid beneficiary. This is to assure there is no double billing of the medication.

5. Coordination of Benefits (COB)

On-line COB (cost avoidance) is part of the Nevada Medicaid POS system.

- a. If Nevada Medicaid is the recipient's secondary carrier, claims for COB will be accepted.
- b. Nevada Medicaid is always the payer of last resort.
- c. Other coverage will be identified by the presence of other carrier information on the recipient eligibility file.
- d. If the recipient shows other coverage, the claim will be denied. The POS system will return a unique client-identified carrier code identifying the other carrier, the recipient's policy number and the carrier name in the additional message filed. It is possible that a recipient may have more than one active other carrier; in that case, the returned code will be from the first carrier, subsequent codes will be returned until fully exhausted. Providers will be required to submit this code OTHER PAYER ID (#340-7C) field as part of the override process.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

- e. Even if “no other insurance” is indicated on the eligibility file, the claim will be processed as a TPL claim if the pharmacy submits.
- f. If other insurance is indicated on the eligibility file, the claim will be processed as a TPL regardless of what TPL codes the pharmacy submits.
- g. In all cases, the Nevada Medicaid “allowed amount” will be used when calculating payment. In some cases, this may result in a “0” payment, when the insurance carrier pays more than the Medicaid “allowable amount”.
- h. In order to facilitate the TPL/COB process, Nevada Medicaid will allow providers to override “days supply limits” and/or “Drug Requires PA” conditions by entering a value of “5” (exemption from prescription limits) in the PA/MC CODE field (NCPCP #416DG) if there are no Prior Authorization requirements on these drugs from the primary insurer.

**6. Non-participating HMO Providers**

- a. Recipients, who have Medicaid and HMO coverage, including Medicare HMOs, must seek treatment and services through their preferred provider network or HMO. Nevada Medicaid is not liable to pay for HMO covered services if the recipient elects to seek treatment from a provider not authorized by the HMO. Unless the provider is an authorized provider of a recipient’s health plan, the recipient should be referred to the plan for covered treatment, or the provider should contact the HMO for treatment authorization. **Refer to MSM Chapter 3600, Managed Care Organizations, or MSM Chapter 100, Medicaid Program, for more information.**
- b. Exceptions to Medicaid liability policy are:
  - 1. The service(s) is/are a non-covered benefit of the HMO plan;
  - 2. The service is an emergency and a participating provider is more than 25 miles away;
  - 3. The service is for family planning;
  - 4. The recipient resides outside the service area of the HMO; or
  - 5. The recipient’s HMO coverage has been exhausted.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

**7. Pharmacy Billing Process**

**a. NCPDP Standard Billing Units**

Nevada Medicaid reimburses for outpatient pharmaceuticals according to NCPDP “Billing Unit Standard Format” guidelines. The standard provides for the billing of pharmaceuticals in one of three billing units for all drug products. These units are “each”, “milliliter (ml)”, and “gram (g)”. The following guidelines are to be used when billing Nevada Medicaid for pharmaceuticals:

Tablets, Capsules, Suppositories, Pre-filled Syringes: must be billed by “each”. For example, if 30 tablets of Metformin are dispensed, the quantity will be 30.

Liquids, Liquid Orals, Suspensions, Solutions, Ophthalmic/Otic Solutions: must be billed by milliliters (mls). For example, if 560ml of guaifenesin is dispensed, the quantity entered will be 560.

**PLEASE NOTE:**

Ounces must be converted to ml (1 ounce = 30ml).

Liters must be converted to ml (1L = 1000ml).

Ointments, Bulk Powders: must be billed by grams. For example, if a two ounce tube of oxiconazole nitrate is dispensed, the quantity entered will be 60.

**PLEASE NOTE:**

Ounces must be converted to grams (1 ounce = 30g, ½ ounce = 15g).

Oral Contraceptives/Therapy packs: must be billed per “each” tablet dispensed, not the number of packages. For example, Ortho Tri-Cyclen is a 28-day dial pack, the quantity entered will be 28.

Transdermal Patches/Powder Packets: must be billed per “each” patch/packet dispensed, regardless of whether they are pre-packaged in a box or come in individual pouches/packets. For example, Catapres-TTS comes in a box of four patches. If two of these boxes are dispensed, the quantity entered will be eight.

Inhalers and Aerosols: must be billed as either grams or ml, as specified by the manufacturer on the labeling. For example a 90mcg(microgram)/inh Albuterol Inhaler has a total of 17gm in the canister. If one of these is dispensed, 17 will be quantity entered.

	MTL 31/09
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

Topical Products: must be billed as either grams or ml, as specified by the manufacturer on the labeling.

PLEASE NOTE: Ounces must be converted to grams or ml.

1 ounce = 30ml

1 ounce = 30g

Reconstitutables (oral, otic, ophthalmic): must be billed per ml that are/will be in the bottle after reconstitution according to the manufacturer's instructions.

Liquid Injectables (vials, ampoules): must be billed by milliliters (ml). For example, if a 10ml vial of Novolin 70/30 is dispensed, the quantity entered will be 10.

Powdered Injectables (vials): must be billed by "each" vial given per dose. For example if the recipient receives Ampicillin 1g every 6 hours for 1 week, the quantity entered will be 1, as only one vial is used per dose (assuming a 1gm vial is used), and the # of doses entered will be 28 (4 per day x 7 days). PLEASE NOTE: If the product is supplied with a diluent, the quantity entered is only the number of powdered vials dispensed, the diluent is not factored in.

Intravenous Solutions: must be billed in ml administered per dose. For example, if a recipient receives 250ml of Normal Saline four times per day, the quantity entered will be 250, as that is the quantity per dose.

Blood Derived Products: products may vary in potency from batch to batch. Anithemophilic products must be billed as the number of antihemophilic units dispensed (each). Prolastin must similarly be billed as the number of milligrams dispensed (each).

Kits: defined as products with a least two different or discreet items (excluding diluents, applicators and activation devices) in the same package, intended for dispensing as a unit. Kits carry only a single NDC. Kits are intended to be dispensed as a unit and should be billed as a unit of each kit dispensed (each).

For further information, refer to the NCPDP Billing Unit Standard Format Official Release.

b. Provider Numbers

The state NABP provider number is to be used and entered when billing online using the POS system or when using the UCF.



	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

**8. State Maximum Allowable Cost (SMAC)**

- a. SMAC is the upper reimbursement limit for multi-source outpatient pharmaceuticals established by the DHCFP, or Fiscal Agent.
  1. DHCFP Fiscal Agent will perform ongoing market analysis to monitor pricing patterns and product availability.
  2. DHCFP Fiscal Agent will perform monthly updates of the drugs subject to the SMAC.
  3. All drugs subject to the SMAC and updates will be posted on the following website: <http://www.medicaid.nv.gov/providers/rx/MACinfo.aspx>.
- b. Providers may appeal the current SMAC for a pharmaceutical product if a provider determines that a particular multi-source drug is not available at the current SMAC reimbursement.
  1. The pharmacy must contact the Fiscal Agent technical call center to initiate the appeal.
  2. Information needed to make a decision will include NDC number, manufacturer, drug name, strength, and price paid. A faxed copy of the actual invoice for the drug may be requested.
  3. Inquiries not resolved by the technical call center are forwarded to the Fiscal Agent's SMAC Coordinator for investigation and resolution.
  4. If it is determined the SMAC is negatively impacting access to care for recipients, the SMAC Coordinator has the authority to:
    - a. adjust SMAC pricing for the particular claim being appealed; and
    - b. make changes to the SMAC pricing file.
  5. Appeals will be responded to within three working days of the referral to the SMAC Coordinator.

**1203.1D AUTHORIZATION PROCEDURES**

Prior Authorization Requests: Physician's may request payment for exceptions to program limitations **and medications requiring prior authorization** by forwarding a Prior Authorization

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

request to the QIO-like vendor. Prior Authorization requests may be done via phone, fax or internet. Refer to the Pharmacy Manual for more information.

1. When requesting a Prior Authorization, providers must:
  - a. Provide all relevant diagnoses.
  - b. List all routine essential drugs being prescribed.
  - c. The requesting physician will be advised of the decision within 24 hours of receipt. A facsimile signature stamp is acceptable on faxed Prior Authorization requests.
  - d. Unless otherwise indicated by the QIO-like vendor, the Prior Authorization is for no more than one 34-day supply of prescription for each authorized drug per month.
  
2. Prior Authorization Protocols
  - a. Alternate media (e.g. paper/UCF claims) are subject to all prior authorization types.

LTC claims, regardless of the media type, are subject to all prior authorization types. Note that the POS system does not require a “Prior Authorization Number” to be entered on a paper or electronic claim; the only requirement is that the Prior Authorization record is activated in the system prior to the claim submission. The approved Prior Authorization will be in the POS system and will be active for all pharmacies using the POS system, unless the recipient is “locked-in” to a particular pharmacy for abuse/misuse reasons.
  - b. A prior authorization will typically be required to be requested and entered prior to the dispensing of the medication, however there may be situations in which an authorization request is considered after the fact (e.g. retroactive eligibility).
  - c. For clinical prior authorizations in which a Clinical Call Centre Prior Authorization Unit pharmacist or pharmacy technician requests information from the prescribing physician, the Prior Authorization will deny if the doctor does not respond to a request for information within three working days.
  - d. The Nevada Medicaid QIO-like vendor will send all denial of service letters.
  - e. For any prior authorization requests that are denied due to criteria not being met, the recipient (only) may appeal the decision. Reference Nevada Medicaid Chapter 3100 for the hearings process.

	<b>MTL 07/12</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

- f. Standard protocols for “Emergency” or “72 Hour Fill” type of overrides will be used.

## 1203.2 INTRAVENOUS (IV) THERAPY PROVIDER TYPE 37

The purpose of IV therapy is to sustain life, reduce or eliminate infections, replace or provide necessary chemicals to maintain electrolyte balance or provide blood product or hemotherapeutics. IV therapy and treatment should only be used when the Medicaid recipient cannot use oral medications.

### a. Billing Guidelines

IV therapy is billed through the pharmacy POS system using the multi-ingredient functionality. A 37 provider number is required (Home Infusion Therapy Provider). The paper Multi-ingredient UCF may also be used if an exception is granted by the Division. Drug coverage edits and prior-authorization edits will be performed at the individual ingredient level.

The billing units used should be the NCPDP standards of “each”, milliliters (ml) or grams(g). Please refer to section 1203.1(D)(8) of this Chapter for complete explanation of these standards.

For specific instructions related to billing via the POS system, refer to the Nevada Medicaid QIO-like **pharmacy** vendor.

### b. Dispensing Fees

A daily dispensing fee of \$22.40 will be applied to IV therapy claims for outpatient antibiotic therapy. For recipients in LTC, a daily dispensing fee of \$16.80 will be applied to the claim. This will be multiplied by the number of days the therapy was provided.

### c. Supplies

Supplies for IV therapy, Enteral Nutrition and TPN are billed through the DME program (under Provider Type 33). Please refer to **MSM** Chapter 1300, DME, **Disposable Supplies and Supplements**, for instructions on billing and any applicable limitations on these items.

	MTL 50/10
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1203
MEDICAID SERVICES MANUAL	Subject: POLICY

d. Long Term Care (LTC)

1. Non-Billable Items

IV hydration therapy of standard fluids without additives (e.g., antibiotics, potassium, and heparin) as well as supplies associated with IV therapy, Enteral Nutrition, and TPN administration are included in Nevada Medicaid's LTC/NF rate and may not be billed as a separate charge.

2. Billable Items

IV Drugs/TPN for recipients in LTC facilities may be billed as a separate charge. Please refer to Chapter 500 (Nursing Facilities) of the MSMs for further information on items which may be billed separately to Nevada Medicaid.

	MTL 21/03
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1204
MEDICAID SERVICES MANUAL	Subject: HEARINGS

1204 HEARINGS

1204.1 Please reference Nevada Medicaid Services Manual, Chapter 3100 for the Medicaid Hearings process.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

DRUGS REQUIRING PRIOR AUTHORIZATION .....	3
PROTON PUMP INHIBITORS (PPI's).....	3
COX 2 INHIBITORS .....	5
AGENTS USED FOR THE TREATMENT OF ATTENTION DEFICIT DISORDER (ADD)/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD).....	6
GROWTH HORMONE.....	8
OVER-THE-COUNTER MEDICATIONS.....	12
DURAGESIC® (fentanyl transdermal) PATCHES .....	13
FENTANYL CITRATE BUCCAL TABLET AND LOZENGE (Fentora® and Actiq®) .....	13
HEMATOPOIETIC/HEMATINIC AGENTS.....	15
ANTI-FUNGAL ONCYCHOMYCOSIS (Lamisil®, Sporanox®, Penlac®).....	16
EXENATIDE INJECTION (Byetta®).....	17
PRAMLINITIDE INJECTION (Symlin®) .....	17
REGRANEX®.....	18
INJECTABLE IMMUNOMODULATOR DRUGS.....	18
TOPICAL IMMUNOMODULATORS.....	22
PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND ADOLESCENTS.....	23
LYRICA® (Pregabalin).....	25
LIDODERM 5% PATCHES® .....	26
OMALIZUMAB (Xolair®).....	26
DRUGS WITH QUANTITY LIMITATIONS .....	27
LONG ACTING NARCOTICS.....	27
NARCOTIC/ACETAMINOPHEN COMBINATIONS.....	29
TORADOL® (Ketorolac Tromethamine) TABLETS .....	29
ANTI-MIGRAINE MEDICATIONS (Triptans).....	30
SMOKING CESSATION PRODUCTS.....	31
XOPENEX® (Levalbuterol).....	32
SEDATIVE HYPNOTICS .....	32
INHALED ANTICHOLINERGIC AGENTS .....	32
ANTIEMETICS – SEROTONIN RECEPTOR ANTAGONIST.....	33
QUANTITY EDITS APPROVED AT DUR BOARD 12-16-2004 .....	33
MEDICATIONS WITH GENDER/AGE EDITS.....	36
PRENATAL VITAMINS .....	36
ORAL/TOPICAL CONTRACEPTIVES .....	36
HORMONES .....	36
VITAMINS WITH FLOURIDE.....	36
TRETINOIC ACID CREAM/OINTMENT/GEL.....	36
SYNAGIS® PALIVIZUMAB.....	36
CYMBALTA® (Duloxetine).....	38
SAVELLA® (Milnacipran).....	38
SUBOXONE® (Buprenorphine/Naloxone) and SUBUTEX® (Buprenorphine) .....	39
AMPYRA™ (Dalfampridine) .....	40
ANDROGEL®, ANDRODERM®, TESTIM® (testosterone gel and transdermal system) .....	41
COLCHICINE (Colcrys®) .....	42
DABIGATRAN ETEXILATE (Pradaxa®).....	42
<b>MAKENA.....</b>	<b>44</b>

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL

VICTRELIS® (Boceprevir)..... 45  
INCIVEK® (Telaprevir)..... 46  
ANTIRETROVIRALS ..... 47  
BLOOD GLUCOSE TESTING..... 47

## 1. DRUGS REQUIRING A PRIOR AUTHORIZATION

A. Proton Pump Inhibitors (PPIs)

## 1. Coverage and Limitations

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

## a. Gastric Esophageal Reflux Disease (GERD)

1. If an ICD-9 code of either 530.11 or 530.81 is documented on the prescription; or
2. Completion of a Prior Authorization documenting a diagnosis of GERD.

## b. Duodenal/Peptic/Gastric/Gastrojejunal Ulcer Disease

1. If an ICD-9 code(s) 531 Gastric Ulcer; an ICD-9 code(s) 532 Duodenal Ulcer; and ICD-9 code(s) 533 Peptic Ulcer; or an ICD-9 code(s) 534 Gastrojejunal Ulcer is documented on the prescription; or
2. Completion of a Prior Authorization documenting a diagnosis of Duodenal, Peptic, Gastric, or Gastrojejunal Ulcer Disease.

## c. Hypersecretory Conditions (Zollinger-Ellison etc)

1. If an ICD-9 code 251.5 Zollinger-Ellison is documented on the prescription; or
2. Completion of a Prior Authorization documenting a diagnosis of a hypersecretory condition.

## d. GI Hemorrhage

1. If an ICD-9 code of 578 GI Hemorrhage is documented on the prescription; or
2. Completion of a Prior Authorization documenting a diagnosis of GI Hemorrhage.

## e. Healing or Maintenance of Erosive Esophagitis (Barrett's Esophagus)

1. If an ICD-9 code of 530.85 Barrett's Esophagus is documented on the prescription; or



DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL

2. Completion of a Prior Authorization documenting a diagnosis of acute or recurrent erosive esophagitis.

f. Prevention of Gastrointestinal Events

1. Prevention of NSAID induced gastrointestinal ulcers in recipients who require NSAID therapy and are at risk due to one of the following defined risk factors:

- a. The recipient is over the age of 60; or
- b. The recipient has a documented history of gastrointestinal ulcer; and

Completion of a Prior Authorization documenting the requirement for NSAID therapy in recipients at risk for gastrointestinal events.

2. Prevention of gastrointestinal events in patients who require therapy with both a NSAID (either a traditional NSAID or a COX-2 inhibitor) and a cardioprotective dose of aspirin ( $\leq 325$  mg/day); and

Completion of a Prior Authorization documenting the requirement for concomitant therapy.

3. Prevention of gastrointestinal events in patients who require therapy with anticoagulants (heparin, low-molecular weight heparin, warfarin or dabigatran etexilate) and concurrent aspirin; and

Completion of a Prior Authorization documenting the requirement for concomitant therapy.

2. Prior Authorization Guidelines

Prior Authorization approval will be for up to one year.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

B. Cox 2 Inhibitors

Cox 2 Inhibitors are a covered benefit of Nevada Medicaid for adult recipients who meet the criteria for coverage.

## 1. Coverage and Limitations

## Indications:

A diagnosis of osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, primary dysmenorrhea, bone pain or acute pain in adults.

Upon documentation of a listed indication, authorization will be given if the patient meets one of the following criteria:

- a. Patient is at high risk of NSAID induced adverse GI events as evidenced by any of the following:
  1. Patient has a documented history or presence of peptic ulcer disease.
  2. Patient has a history or presence of NSAID-related ulcer.
  3. Patient has a history or presence of clinically significant GI bleeding.
- b. Patient is greater than 65 years of age.
- c. Patient is at risk for GI complications due to the presence of any of the following concomitant drug therapies:
  1. Anticoagulants (e.g. warfarin, heparin or Low Molecular Weight (LMW) heparin).
  2. Chronic use of oral corticosteroids.
- d. Patient has a documented history of inability to tolerate therapy with at least two non-selective (traditional) NSAIDs.
- e. The patient is not being treated daily with aspirin for cardioprophylaxis unless concurrent use of a proton pump inhibitor is documented.
- f. The patient does not have a documented history of a cardiac event (e.g. stroke, myocardial infarction or has undergone coronary artery bypass graft procedure) in the past 6 months.
- g. The patient does not have a history of allergies to sulfonamides, aspirin or other NSAIDs.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

## 2. Prior Authorization Guidelines

Prior authorization approval may be authorized for up to one year.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

Quantity limit: 400 mg/day

## C. Agents used for the treatment of Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)

Agents, both stimulants and non-stimulants used for the treatment of ADD/ADHD are a covered Nevada Medicaid benefit for the treatment of pediatric, adolescent, and adult clients that meet the criteria for coverage.

## 1. Coverage and Limitations

Approval for medications will be given at the therapeutics class level if the following criteria is met and documented:

## a. General Criteria (Children and Adults)

1. Only one long-acting agent at a time may be used for the treatment of ADD/ADHD (applies to the entire ADD/ADHD/Stimulant Class); a 30-day transitional overlap in therapy will be allowed.
2. The following two criteria's must be met and documented in the recipient's medical record for adult and pediatric recipients.
  - a. The decision to medicate for ADD or ADHD must be based on problems that are persistent and sufficiently severe to cause functional impairment in one or more of the following social environments: school, home, work or with peers; and
  - b. Before treatment with pharmacological methods is instituted, other treatable causes have been ruled out.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

## b. Children (up to age 18 years)

In addition to the general criteria above, the following conditions apply and must be documented in the recipient's medical record.

1. Prescriptions for ADD/ADHD medications do not require prior authorizations for children five years of age, up to eighteen years of age, if the following conditions apply:
  - a. The medication is prescribed by a psychiatrist; and
  - b. One of the following ICD-9 codes is documented on the prescription: 314.0-314.9.
2. In all other cases, prior authorization is required. The following is required for prior authorization.
  - a. An initial evaluation or examination has been done within the past twelve months by the treating physician, pediatrician, psychiatrist or neurologist documenting the developmental history, physical evaluation, medical history or a primary neurological diagnosis and all of the following:
    1. School information, Standardized Teachers Rating Scales testing reports such as Test of Variables of Attention (TOVA), achievement test, neuropsychological testing if indicated, Conner's scale, speech and language evaluation;
    2. Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) symptoms of ADD or ADHD, presence or absence-child behavior checklist, development and context of symptoms and resulting impairment, including school, family and peers, DSM-IV symptoms of possible alternate or comorbid psychiatric diagnosis, history of psychiatric, psychological pediatric or neurological treatment for ADD or ADHD; and
    3. Family history including diagnosis of ADD and ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder and other anxiety disorders, past or present family stressors, crises, any abuse or neglect, interview with parent(s) or guardian(s).

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

- c. Adults (18 years and above) In addition to the general criteria above, the following must be present and documented in the recipient's medical record:
1. An initial evaluation-complete psychiatric assessment, present and past DSM-IV, symptoms of ADD or ADHD, history of development and context of symptoms and resulting past and present impairment, including academic achievement, learning disorder evaluation, and
  2. One of the following:
    - a. Medical history, medical or primary neurological diagnosis, identify medication(s) that could be causing symptoms (e.g. Phenobarbital, steroids), or;
    - b. History of other psychiatric disorder(s) and treatment, or;
    - c. DSM-IV symptoms of ADD and ADHD presence or absence, possible alternate comorbid psychiatric diagnosis (especially: personality disorder, mood disorder, depression or mania, anxiety disorder, dissociative disorder, tic disorder including Tourette's disorder and substance abuse disorder); or
    - d. Family history including diagnosis of ADD or ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder, mood disorder and anxiety disorder, possible family stressors, any history of abuse or neglect.
  3. Prior Authorization will be given for a 1 year time period.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

D. Growth Hormone

Growth Hormone (GH) therapy is a covered Nevada Medicaid benefit subject to Prior Authorization. A Food and Drug Administration (FDA)-approved indication for the diagnosis being treated is required.

1. Coverage and Limitations
  - a. Children (up to age 21)

The following apply to all requests for children:

1. An evaluation by a pediatric endocrinologist or pediatric nephrologist with a recommendation for therapy.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

2. All other causes for short stature are ruled out.
3. Patient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids or gonatropic hormones.

Therapy will be approved for any one of the following:

4. Diagnosis of Turner's Syndrome.
5. Diagnosis of Prader-Willi Syndrome.
6. Patient has chronic renal insufficiency (defined as Creatinine Clearance between 5 and 75/ml/min/1.73m<sup>2</sup>).
7. If the patient has evidence of hypothalamic-pituitary disease or structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation and meeting any one of the following:
  - a. Has failed at least one GH stimulation test (peak GH level <10 nanograms (ng/ml)).
  - b. Had at least one documented low IGF-1 level (below normal range for patients age – refer to range on submitted lab document).
  - c. Has deficiencies in three or more pituitary axes (i.e. TSH, LH, FSH, ACTH, ADH).
8. If the patient is a newborn infant and has evidence of hypoglycemia and either a low GH level (<20ng/ml) or a low for age IGF-1 or IGF Binding Protein #3 level (IGFBP#3) (no stimulation test required for infants).
9. Children with a history of intrauterine growth restriction (small for gestational age (SGA)) who at age two years have a height at least two Standard Deviations (SD) below the mean for the patient's age and gender.
10. For Idiopathic Short Stature all the following criteria must be met:
  - a. Bone age >2 SD below the mean for age, Epiphysis open.
  - b. Height >2.25 SD below the mean for age or >2 SD below the mid-parental height percentile or growth velocity <25<sup>th</sup> percentile for bone age.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

- c. At least one provocative stimuli test to show failure to raise the grow hormone level above 10 ng/ml.
  - d. Exception to the requirement for stimuli testing: Patients meeting (10)(a) and (10)(b) above in addition to a documented low serum insulin-like growth factor 1 (IGF-1) and/or insulin-like growth factor binding protein #3 (IGFBP#3) will not be required to have stimuli testing.
- b. Criteria for the continuation of growth hormone therapy for children includes all of the following:
- Bone age >2 SD below the mean for age. Epiphysis open.
- 1. Growth rate with treatment is at least two centimeters greater than the untreated rate. Copy of the growth chart must accompany forms.
  - 2. Child has not reached the 25<sup>th</sup> percentile of normal height for gender.
  - 3. No diagnosis of an expanding lesion or tumor formation.
  - 4. Patient has not undergone renal transplant.
- c. Reasons for Non-Coverage/Denial include, but are not limited to, the following:
- 1. Indications other than those specified in this policy;
  - 2. Any condition(s) which is contraindicated and/or considered to be experimental;
  - 3. Patients with expanding lesions or tumor formation;
  - 4. Patients who have received renal transplantation; or
  - 5. Patients who do not meet criteria as set by this policy.
  - 6. Also, growth rate that is less than 2.0 cm/yr of untreated rate; growth that has reached the 25% of normal height for gender; bone age that is over recommended age for gender; or if epiphysis is closed.

An evaluation by a pediatric endocrinologist or a pediatric nephrologist is mandatory for initiation of growth hormone therapy and close monitoring either by a pediatric endocrinologist, pediatric nephrologist or the recipient's primary care physician is required throughout therapy.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

Prior Authorization will be given for a 6 month time period for initiation of therapy, and 6-12 months for continuation of therapy, dependent upon the response of growth by the recipient.

d. Adults (age 21 and older)

Indications for growth hormone therapy in adults are:

Adults who were growth hormone deficient as children or adolescents.

All of the following criteria must be met:

1. The patient is evaluated by an endocrinologist.
2. Patient has a growth hormone deficiency either alone or with multiple hormone deficiencies (hypopituitarism), as a result of either disease of the pituitary or hypothalamus, or injury to either the pituitary or hypothalamus from surgery radiation therapy or trauma.
3. Patient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids or gonadotropic hormone. Patient has failed to respond to standard growth stimulation tests. Exception: Complete hypopituitarism.
4. Patient has failed a growth hormone stimulation test. Failure generally defined as a maximum peak of <5ng/ml.

e. Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Wasting or Cachexia

Agents selected for treatment must have an FDA approved indication for the diagnosis being treated as stated in the package insert.

The following criteria must be met for the treatment of HIV/AIDS wasting or cachexia:

1. Patient must be stable on antiretroviral therapy and compliant with therapy.
2. Documented involuntary weight loss greater than 10% pre-illness baseline or a body mass index of <20KG/M2 (weight and diagnosis must be confirmed by faxed chart notes).
  - a. Patient has failed to adequately respond to dietary measures.
  - b. Patient has failed to respond or is intolerant to appetite-stimulating drugs, (e.g. Megace) and anabolic steroids.



## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

- c. Absence of a concurrent illness or medical condition other than HIV infection that would explain these findings.

- 3. No active malignancy other than Kaposi's Sarcoma.

Prior Authorization will be given for 12 weeks.

If patient maintains or gains weight, is experiencing no adverse events, and is being monitored on a regular basis by the prescriber, approve the Prior Authorization for 12 additional weeks. Subsequent Prior Authorization approvals based on this criteria may be granted in 12 week increments.

- f. Requests involving the following should be denied:
  - 1. Indications other than those specified above.
  - 2. Any condition that is considered contraindicated and/or considered to be experimental.
  - 3. Patients who do not meet the criteria.

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

#### E. Over-the-Counter Medications

Over-the-Counter medications are a covered Nevada Medicaid benefit subject to Prior Authorization.

##### 1. Coverage and Limitations

Two prescriptions per month within the same Standard Therapeutic Class (please see Appendix B for a list of Standard Therapeutic Classes) will be allowed without Prior Authorization. Any more than two prescription requests for medications within the same therapeutic class will require Prior Authorization.

A Prior Authorization form must be submitted to the Nevada QIO-like vendor. The QIO-like vendor will request further information needed on a case by case basis to determine the necessity of the medication for the recipient.

Note: Insulin will be exempt from any Prior Authorization requirements.

Approval will be for a one month time limit.

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

F. Duragesic® (fentanyl transdermal) Patches

Transdermal fentanyl, a narcotic agonist analgesic, is indicated in the management of chronic pain in patients requiring continuous opioid analgesia for pain that cannot be managed by lesser means such as acetaminophen-opioid combinations, non-steroidal analgesics or PRN dosing with short-acting opioids. Transdermal fentanyl is a covered Nevada Medicaid benefit subject to Prior Authorization.

## 1. Coverage and Limitations

Because serious or life-threatening hypoventilation could occur, fentanyl transdermal is contraindicated in management of acute or postoperative pain, mild or intermittent pain responsive to PRN or non-opioid therapy, or in doses exceeding 25 mcg/hr at the initiation of opioid therapy. Therefore, patients must meet the following two criteria in order to gain Prior Authorization approval:

- a. Patient cannot be managed by lesser means such as acetaminophen-opioid combinations, nonsteroidal analgesics, or PRN dosing with short-acting opioid.
- b. Patient requires continuous opioid administration.

In addition the following guidelines apply:

- c. Dosing interval 1 patch every 3 days; may be dosed every two days if failure to achieve pain relief is documented and clinical notes are provided to clinical call center.
- d. Do not authorize if on long-acting narcotics. If recipient is switching to fentanyl and has a prior authorization for a long-acting narcotic, discontinue the prior authorization for the long-acting narcotic and inform the prescriber.

2. **Prior Authorizations**

Prior approval will be given for a 6 month time period.

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

G. Fentanyl Citrate Buccal Tablet and Lozenge (Fentora® and Actiq®)

## 1. Coverage and Limitations

Fentanyl Citrate and Buccal Tablets and Lozenges are a covered Nevada Medicaid benefit subject to Prior Authorization.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

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

- a. Recipient must be age 18 years or older to receive fentanyl citrate buccal tablets;
- b. Recipient must be age 16 years or older to receive fentanyl citrate lozenges; and
- c. Recipient must have pain due to a malignancy; and
- d. Recipient is already receiving and is tolerant to opioid therapy; and
- e. Recipient is intolerant of two other immediate-release opioids including morphine, hydrocodone, oxycodone, or hydromorphone.

2. Non-Covered Indications

- a. Recipient with non-malignant pain including but not limited to fibromyalgia, migraines, headaches, peripheral neuropathy, chronic pain syndrome.
- b. Recipient is not opioid tolerant.
- c. Recipient diagnosis is for acute pain or chronic pain due to surgery or injury.
- d. Recipient diagnosis is for migraine/headache pain relief or prevention.
- e. Recipients not taking chronic opiates.

3. Quantity Limitations

120 Tablets per 30 rolling days for all strengths of fentanyl citrate buccal tablets.

120 Lozenges per 30 rolling days for all strengths of fentanyl citrate lozenges.

4. Prior Authorization Guidelines

Initial Prior Authorization approval will be for 6 months.

Continued coverage will require documentation of continued pain from the malignancy and the recipient is unable to use other oral dosage forms.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

H. Hematopoietic/Hematinic Agents

This policy applies in all settings with the exception of inpatient facilities. Hematopoietics and Hematinics also known as erythropoiesis stimulating agents (ESAs) are a covered Nevada Medicaid benefit for recipients who meet one of the following criteria for coverage.

## 1. Coverage and Limitations

- a. Achieve and maintain hemoglobin levels within the range of 10 to 12 gm/dl in one of the following conditions:
  1. Treatment of anemia secondary to myelosuppressive anticancer chemotherapy.
  2. Treatment of anemia related to zidovudine therapy in HIV-infected patients.
  3. Treatment of anemia secondary to End Stage Renal Disease (ESRD).
- b. 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.

Claims documenting doses exceeding the Center for Medicare and Medicaid Services (CMS) maximum threshold for ESAs will be denied.

### 3. Prior Authorizations

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>.

#### I. Anti-Fungal Onychomycosis (Lamisil®, Sporanox®, Penlac®)

Anti-Fungal Onychomycosis are a covered benefit for recipients who meet the criteria for coverage.

##### 1. Coverage and Limitations

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

- a. Do not authorize itraconazole if recipient has evidence of ventricular dysfunction.
- b. Do not authorize terbinafine if recipient has pre-existing liver disease.
- c. Positive KOH stain, positive PAS stain or positive fungal culture and any of the following:
  1. Recipient experiencing pain which limits normal activity;
  2. Recipient has an iatrogenically-induced or disease associated immunosuppression;
  3. Recipient has diabetes; or
  4. Recipient has significant peripheral vascular compromise.
- d. Length of Authorization:
  1. Lamisil® tablets & Sporanox® tablets Fingernail: 6 weeks Toenail: 12 weeks.
  2. Penlac® liquids Initial: 3 months.

##### 2. Prior Authorization Guidelines

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

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

**J. Exenatide Injection (Byetta®)**

Exenatide injection is a covered benefit of Nevada Medicaid for recipients (18 years or older) who meet the criteria for coverage.

## 1. Coverage and Limitations

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

- a. Diagnosis of Type 2 Diabetes Mellitus;
- b. Current use of metformin, a sulfonylurea, or both;
- c. Documented failure to achieve glycemic control despite an appropriate trial of metformin and/or a sulfonylurea;
- d. Not to be used for weight loss; and
- e. Approval will be for a six month period.

## 2. Prior Authorization Guidelines

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

**K. Pramlintide Injection (Symlin®)**

Pramlintide injection is a covered benefit of Nevada Medicaid for recipients (15 years or older) who meet the criteria for coverage).

## 1. Coverage and Limitations

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

- a. Diagnosis of Type 1 or Type 2 Diabetes Mellitus;
- b. Documentation that recipient has not achieved desired HbA1c despite optimal insulin therapy;
- c. Documented HbA1c < 9%;
- d. Patient is competent and has received diabetic education, able to self-administer drug, and willing to perform blood glucose monitoring;
- e. Approval period of 6 months; and

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

- f. Exclusion criteria:
1. HbA1c>9%;
  2. Confirmed diagnosis of gastroparesis;
  3. Use of drugs that alter GI motility;
  4. Presence of hypoglycemia unawareness; and
  5. Use of alpha-glucosidase inhibitors (e.g. acarbose, miglitol).

## 2. Prior Authorization Guidelines

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

L. Regranex®

## 1. Coverage and Limitations

Regranex® is a covered Nevada Medicaid benefit subject to Prior Authorization.

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. Quantity Limitations

- a. Original prescription (15 grams maximum per prescription) plus one refill (15 grams maximum per prescription OR a total life-time dose of 30 grams per recipient.

## 3. Prior Authorization Guidelines

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

M. Injectable Immunomodulator Drugs

Actemra® (tocilizumab)  
 Amevive® (alefacept)  
 Enbrel® (etanercept)  
 Humira® (adalimumab)

Cimzia® (certolizumab pegol)  
 Kineret® (ankinra)  
 Orencia® (abatacept)  
 Remicade® (infliximab)

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

Simponi™ (golimumab)

Stelara™ (ustekinumab)

Injectable immunomodulator drugs are a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage:

## 1. Coverage and Limitations

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

## a. Rheumatoid Arthritis (Enbrel®, Humira®, Remicade®, Oencia®, Kineret®, Cimzia®, Simponi™, Actemra®):

1. Diagnosis of rheumatoid arthritis; and
2. Rheumatology consult with date of visit; and
3. Negative tuberculin test (Remicade®, Humira®, Oencia®, Cimzia®, Enbrel®, Simponi™, Actemra®) or if positive, therapy with isoniazid was initiated at least one month prior to request;
4. Patient does not have an active infection or a history of recurring infections;
5. Patient has had RA for  $\leq 6$  months (early RA) and has high disease activity;

Patient has had RA for  $\geq 6$  months (intermediate or long-term disease duration) and has moderate disease activity and has an inadequate response to a disease modifying antirheumatic drug (DMARD) (methotrexate, hydroxychloroquine, leflunomide, minocycline or sulfasalazine); or

6. Patient has had RA for  $\geq 6$  months (intermediate or long-term disease duration) and has high disease activity.

## b. Psoriatic Arthritis (Enbrel®, Humira®, Remicade®, Simponi™):

1. Diagnosis of moderate or severe psoriatic arthritis; and
2. Rheumatology consult with date of visit or Dermatology consult with date of visit;
3. Inadequate response to any one NSAID or contraindication to treatment with an NSAID or to any one of the following DMARD (methotrexate, leflunomide, cyclosporine or sulfasalazine) as documented by a physician;



## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

4. Negative tuberculin test (Enbrel®, Humira®, Remicade®, Simponi™) or if positive, therapy with isoniazid was initiated at least one month prior to request; and
  5. Patient does not have active infection or a history of recurring infections.
- c. Ankylosing Spondylitis (Enbrel®, Remicade®, Humira®, Simponi™):
1. Diagnosis of ankylosing spondylitis; and
  2. Inadequate response to NSAIDs and to any one of the DMARDs (methotrexate, hydroxychloroquine, sulfasalazine, leflunomide, minocycline);
  3. Negative tuberculin test (Enbrel®, Humira®, Remicade®, Simponi™) or if positive, isoniazid was initiated at least one month prior to request; and
  4. Patient does not have an active infection or a history of recurring infections.
- d. Juvenile Rheumatoid Arthritis/Juvenile Idiopathic Arthritis (Enbrel®, Humira®, Orencia®):
1. Diagnosis of moderately or severely active juvenile rheumatoid arthritis; and
  2. Patient is at least 2 years of age; and
  3. At least five swollen joints; and
  4. Three or more joints with limitation of motion and pain, tenderness or both; and
  5. Inadequate response to one DMARD;
  6. Negative tuberculin test (Enbrel®, Humira®, Orencia®), or if positive, isoniazid was initiated at least one month prior to request; and
  7. Patient does not have an active infection or a history of recurring infections.
- e. Plaque Psoriasis (Amevive®, Enbrel®, Humira®, Remicade®, Stelara™):
1. Diagnosis of chronic, moderate to severe plaques psoriasis; and
  2. Prescribed by a dermatologist; and

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

3. Failed to adequately respond to a topical agent; and
  4. Failed to adequately respond to at least one oral treatment;
  5. Negative tuberculin test (Amevive®, Humira®, Enbrel®, Remicade®, Stelara™) or if positive, therapy with isoniazid was initiated at least one month prior to request; and
  6. Patient does not have an active infection or a history of recurring infections.
- f. Crohn's Disease (Remicade®):
1. Diagnosis of moderate to severe Crohn's Disease; and
  2. Failed to adequately respond to conventional therapy (e.g. sulfasalazine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine, parenteral methotrexate) or those with fistulizing Crohn's disease, and;
  3. Negative tuberculin test, or if positive, isoniazid therapy was initiated at least one month prior to request (Cimzia®, Humira®, Remicade®); and
  4. Patient does not have an active infection or a history of recurring infections.
- g. Ulcerative Colitis (Remicade®):
1. Diagnosis of moderate to severe ulcerative colitis; and
  2. Failed to adequately respond to one or more of the following standard therapies:
    - a. Corticosteroids;
    - b. 5-aminosalicylic acid agents;
    - c. Immunosuppressants; and/or
    - d. Thiopurines.
  3. Negative tuberculin test, or if positive, isoniazid therapy was initiated at least one month prior to request; and
  4. Patient does not have an active infection or history of recurring infections.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

Approval will not be given for the use of more than one biologic at a time (combination therapy).

Coverage is not provided for use of TNF- $\alpha$  blocking agents (Humira®, Cimzia®, Enbrel®, Simponi™ or Remicade®) in patients with any of the following conditions:

- h. Moderate or severe heart failure (NYHA Class III or IV);
- i. History of treated lymphoproliferative disease of < 5 years in the past;
- j. Acute or chronic liver disease graded as a Child-Pugh class B or C; or
- k. Multiple Sclerosis or other demyelinating disorder.

2. Prior Authorization Guidelines

The Prior Authorization must be initiated by the prescriber.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

Prior authorization will be given for a one year period.

O. Topical Immunomodulators

Elidel®

Protopic®

Topical Immunomodulators drugs are a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage.

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. Patient has a documented diagnosis of Atopic Dermatitis:
  - 1. Elidel®: for mild to moderate, for ages  $\geq$  two years.
  - 2. Protopic® 0.03%; moderate to severe, for ages  $\geq$  two years.
  - 3. Protopic® 0.1%; moderate to severe, for ages  $\geq$  18 years.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

- c. Not for chronic use.
- d. Elidel® is not recommended for use on patients with Netherton’s syndrome due to the potential for systemic absorption.
- e. Not recommended for use in immunocompromised patients.

## Quantity Limits:

- f. Elidel® 1% cream: 30g per 30 rolling days with a 25% tolerance for refills.
  - g. Protopic® 0.03% and 0.1% Ointment: 30 mg per 30 rolling days with a 25% tolerance for refills.
2. Prior Authorization forms are available at:  
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

P. Psychotropic Medications for Children and Adolescents

## 1. Coverage and Limitations

Nevada Medicaid has adopted the following practice standards to strengthen treatment outcomes for our children and adolescents.

These practices include:

- a. For psychotropic medications in this age group, when possible, be prescribed by or in consultation with a child psychiatrist.
- b. Psychotropic medication must be part of a comprehensive treatment plan that addresses the education, behavioral management, living home environment and psychotherapy.
- c. Physician monitoring is required while the recipient is utilizing the medication.
  - 1. For recipients who are in initial treatment or are unstable on the medication therapy, medical documentation must support a monthly or more frequent visit with the prescribing practitioner. If the recipient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician.
  - 2. For recipients who are considered stable in their medication therapy, medical documentation must support visits with the treating physician at least every three months.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

- d. Prescribing more than one medication from the same class or prescribing three or more psychotropic medications from different drug classes is to be avoided. Each pharmaceutical prescribed must be independently treating a specific condition (diagnosis). To be considered for multiple drug therapy for one diagnosis, treatment of unique symptoms, or treatments of medication side effects must be documented. Recipients must fail a trial of a single medication within the same class before treatment with multiple agents in the same class will be considered. This will be demonstrated by medical attestation by the treating physician.
2. Nevada Medicaid requires prior authorization for all psychotropic medications for recipients less than 18 years of age. Therapeutic classes subject to prior authorization for this age group include:
- a. Antianxiety Agents;
  - b. Anticonvulsants;
  - c. Antidepressants;
  - d. Lithium Preparations;
  - e. Sedatives; and
  - f. Antipsychotics.
- Exceptions to this policy are:
- g. Treatment for seizure disorders with the following diagnoses beginning with 345 (Epilepsy), beginning with 780.3 (Convulsions) and 779.0 (Convulsions in Newborn) will be approved. These diagnoses written on the prescription will bypass the prior authorization requirement in the pharmacy POS or the Prior Authorization requirement will be overridden for anticonvulsant medications when the prescriber has a provider specialty code of 126, neurology or 135, pediatric neurology, in the POS system.
  - h. The current policy for treatment of ADD/ADHD is to be followed. Refer to [this chapter's Appendix A](#).
3. Prior Authorization Criteria
- a. Each medication prescribed must be independently treating a specific condition (diagnosis).
  - b. To be considered for multiple drug therapy for one diagnosis, treatment of unique symptoms, or treatment of side effects must be documented.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

- c. Recipients must fail a trial of a single medication within the same class before treatment with multiple agents in the same class will be considered.
- d. Physician monitoring is required while the recipient is utilizing the medication(s).
  - 1. For recipients who are in initial treatment or are unstable on the medication therapy, medical documentation must support a monthly or more frequent visit with the prescribing practitioner. If the recipient was discharged from an institution on the medication, the follow up visit(s) can be with their treating physician.
  - 2. For recipients who are considered stable in their medication therapy, medical documentation must support visits with the treating physician at least every three months.
- e. Psychotropic medication must be part of a comprehensive treatment plan that addresses the education, behavioral management, living home environment and psychotherapy.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

Q. Lyrica® (pregabalin)

1. Coverage and Limitations

- a. Epilepsy and/or seizure disorder and/or convulsions:
  - 1. If an ICD-9 code of 345 Epilepsy; or 780.3 Seizures is documented on the prescription; or
  - 2. Completion of a Prior Authorization documenting a diagnosis of Epilepsy, Seizure Disorder or Convulsions.
- b. Diabetic Peripheral Neuropathy (DPN):
  - 1. If an ICD-9 code of 250.6 Diabetes with Neurological Manifestations is documented on the prescription; or
  - 2. Completion of a Prior Authorization documenting a diagnosis of Diabetes with Neurological Manifestations.
- c. Postherpetic Neuralgia/Neuropathy (PHN):
  - 1. If an ICD-9 code 053.1 Postherpetic Neuropathy/Neuralgia is documented on the prescription; or

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

2. Completion of a Prior Authorization documenting a diagnosis of Post Herpetic Neuralgia/Neuropathy.

d. Fibromyalgia:

1. If an ICD-9 code 729.1, Myalgia and Myositis, unspecified is documented on the prescription; or

2. Completion of a Prior Authorization documenting a diagnosis of Fibromyalgia, and/or Myalgia and Myositis, unspecified.

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

R. Lidoderm 5% Patches®

1. Coverage and Limitations

Topical Lidoderm Patches® are a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage.

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

a. If an ICD-9 code beginning with 053., herpes zoster, is documented on the prescription; or

b. Completion of a Prior Authorization documenting a diagnosis of Post Herpetic Neuralgia/Neuropathy.

2. Quantity Limits

a. Maximum of 90 patches per rolling 30 days.

S. Omalizumab (Xolair)®

1. Coverage and Limitations

Omalizumab (XOLAIR)® is a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage. Omalizumab has not been show to alleviate asthma exacerbations acutely and should not be used for treatment of acute bronchospasm or status asthmatics.

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

a. Recipient must have a diagnosis of moderate to severe persistent asthma.

b. Recipient must be age 12 years or older.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

- c. Recipient must have tried or have a contraindication to inhaled oral corticosteroids.
- d. Recipient must have tried or have a contraindication to an oral second generation antihistamine.
- e. Recipient must have tried or have a contraindication to a leukotriene receptor antagonist.
- f. Prescriber must be either a pulmonologist or allergist/immunologist.
- g. Recipient must have a history of a positive skin test or RAST test to a perennial aeroallergen.
- h. Recipient must have had a pretreatment serum total Immunoglobulin E (IgE) level.
- i. Recipient's current weight must be recorded.

## 2. Prior Authorization

Prior approval will be granted for a three month period.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

## 2. DRUGS WITH QUANTITY LIMITATIONS

### A. Long-Acting Narcotics

Long Acting Narcotics are a covered benefit of Nevada Medicaid, for recipients who meet the coverage criteria.

#### 1. Coverage and Limitations

Indications: Management of moderate-to-severe pain when continuous around-the-clock analgesic is needed for an extended period of time. Medications:

Brand Names	Generic Names	Dosage Strength	Dosage Form
Avinza®	Morphine Extended Release	30, 60, 90, 120mg	Capsules
Kadian®	Morphine Sustained Release	20, 30, 50, 80, 100mg	Capsules, sustained-Release pellets
MS Contin®	Morphine Controlled Release	15, 30, 60, 100, 200mg	Tablets
	Morphine Sulfate Extended Release	15, 30, 60, 100mg	Tablets



DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL

Oramorph®	Morphine Sulfated Controlled Release	15, 30, 60, 100mg	Tablets
Oxycontin®	Oxycodone Extended Release	10, 20, 40, 80mg	Extended Release Tablets

a. Oxycontin (including generic):

1. Any dosing greater than three tablets per day of any one strength will require a prior authorization.
2. No prior authorization is required for diagnosis of terminal cancer.

b. MS Contin (including generic):

1. Any dosing greater than three tablets per day of any one strength will require a prior authorization.
2. No prior authorization is required for a diagnosis of terminal cancer.

c. Avinza:

1. Any dosing greater than one capsule per day of any one strength will require a prior authorization.
2. No prior authorization is required for a diagnosis of terminal cancer.

d. Kadian:

- a. Any dosing greater than two capsules per day of any one strength will require a prior authorization.
- b. No prior authorization is required for a diagnosis of terminal cancer.

e. Please Note: The use of Long Acting Narcotics for acute/short term treatment of pain not within the quantity limits will not be approved.

Approval will be for a three month time limit.

2. Prior Authorization Guidelines:

The Prior Authorization must be initiated by the prescriber. The approved PAR must be available if requested.

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

B. Narcotic/Acetaminophen Combinations

Includes all strengths and dosage forms of:

1. Propoxyphene/Acetaminophen Combinations;
2. Oxycodone/Acetaminophen Combinations;
3. Meperidine/Acetaminophen Combinations;
4. Pentazocine/Acetaminophen Combinations;
5. Hydrocodone/Acetaminophen/Combinations;
6. Codeine/Acetaminophen Combinations;
7. Dihydrocodeine/Acetaminophen Combinations;
8. Tramadol/Acetaminophen Combinations; and
9. OTC Acetaminophen.

Coverage and Limitations:

Any dosing which amounts to greater than 4 grams of acetaminophen per day will NOT be covered.

C. Toradol® (ketorolac tromethamine) tablets

The pharmaceutical Toradol® is a covered benefit for recipients who meet the criteria for coverage.

## 1. Coverage and Limitations

Ketorolac is indicated for the short-term (up to 5 days) management of moderately severe acute pain that requires analgesia at the opioid level. It is not indicated for minor or chronic painful conditions. The following criteria must be met:

- a. Oral treatment is indicated only as continuation therapy to IV/IM therapy.
- b. Oral treatment is not to exceed 5 days.

A prescription for 20 or less tablets per month may be obtained without Prior Authorization. If the prescription is for a quantity of more than 20 tablets in the past 6 months, a Prior Authorization must be obtained through the Nevada Medicaid QIO-like vendor.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

## 2. Prior Authorization Guidelines

The Prior Authorization must be initiated by the prescriber. The approved Prior Authorization must be available if requested.

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

D. Anti-Migraine Medications (triptans)

Serotonin 5-HT<sub>1</sub> receptor agonists commonly referred to as “triptans” or anti-migraine medications are a covered benefit of Nevada Medicaid subject to quantity limitations.

## 1. Coverage and Limitations

The number of tablets/doses allowed per month is restricted on triptans. Only one prescription of triptans per month is allowable without Prior Authorization. Nevada Medicaid restricts the allowable number of tablets/doses per month per the following table:

Brand Name	Generic Name	Strength	Dosage Form	How Supplied	Limit Per Month
Amerge	Naratriptan	1mg	Tablet	9 tablets/package	9 tablets
		2.5mg	Tablet	9 tablets/package	9 tablets
Axert	Almotriptan	6.25mg	Tablet	6 tablets/package	6 tablets
		12.5mg	Tablet	6 tablets/package	6 tablets
Frova	Frovatriptan	2.5mg	Tablet	9 tablets/package	9 tablets
Imitrex	Sumatriptan	25mg	Tablet	9 tablets/package	18 tablets
		50mg	Tablet	9 tablets/package	9 tablets
		100mg	Tablet	9 tablets/package	9 tablets
		6mg	Injection	2 injections/package	4 injections
		5mg	Nasal Spray	6 units/package	12 units
		20mg	Nasal Spray	6 units/package	6 units
Maxalt	Rizatriptan	5mg	Tablet	6 tablets/package	12 tablets
		10mg	Tablet	6 tablets/package	12 tablets
Maxalt-MLT		5mg	Orally Disintegrating tablet	2 units of 3 tab/pack	12 tablets
		10mg	Orally Disintegrating tablet	2 units of 3 tab/pack	12 tablets
Zomig	Zolmitriptan	2.5mg	Tablet	6 tablets/package	12 tablets
		5mg	Tablet	3 tablets/package	6 tablets
Zomig ZMT		2.5mg	Orally Disintegrating tablet	6 tablets/package	12 tablets
		5 mg	Nasal Spray	6 units/package	12 tablets

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

An approved Prior Authorization is required for any prescription exceeding the above outlined quantity limits. Approval for additional medication beyond these limits will be considered only under the following circumstances:

- a. The recipient's current medication history documents the use of prophylactic medications for migraine headache or the medical provider agrees to initiate such therapy which includes beta-blockers, tricyclic antidepressants, anticonvulsants, Selective Serotonin Reuptake Inhibitors (SSRIs) and/or calcium channel blockers; or
- b. The medical provider is aware of and understands the implications of daily use and/or overuse of triptans and agrees to counsel the patient on this issue in an effort to taper the quantity of triptan medication required monthly.
  1. Recipient's current medication history must NOT have MAO (Monoamine Oxidase) Inhibitors present for approval of Imitrex® (sumatriptan), Maxalt® (rizatriptan) or Zomig® (zolmitriptan).
  2. Recipients whose current medication history indicates the use of propranolol will NOT be granted prior authorization of Maxalt® (rizatriptan) 10mg tablet or 10mg orally disintegrating tablet.
  3. Prior authorization will NOT be given to patients with ischemic heart disease.

Approval for exceeding the quantity limits on triptans will be given for a two month time period.

## 2. Prior Authorization Guidelines

The Prior Authorization must be initiated by the prescriber. The approved Prior Authorization must be available if requested.

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

## E. Smoking cessation products

Smoking cessation products, including patches, gums, lozenges and inhalers, are a covered Nevada Medicaid benefit subject to quantity limitations.

### 1. Coverage and Limitations

Smoking cessation products are limited to two 90 day therapy sessions, using the route of their choice, per year.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

F. Xopenex® (levalbuterol)

Xopenex® is a covered benefit for recipients that meet the coverage criteria.

## 1. Coverage and Limitations

- a. Authorization only for recipients experiencing side effects on one other beta-adrenergic agent of any formulation.
- b. Authorization for patients whose cardiovascular status is considered to be in severe deteriorating condition.
- c. Xopenex 0.31mg and 0.63mg cannot be dosed more than every 6 hours or as needed.
- d. Xopenex 1.25mg cannot be dosed more than every 8 hours or as needed.
- e. Maximum quantity per month = 4 boxes (288ml).

## 2. Prior Authorization Guidelines

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

G. Sedative Hypnotics

Sedatives Hypnotics are a covered Nevada Medicaid benefit subject to quantity limitations.

## 1. Coverage and Limitations

Quantity limit of 30 tablets per month of only one strength.

H. Inhaled Anticholinergic Agents

Inhaled anticholinergic agents are a covered benefit of Nevada Medicaid.

## 1. General Criteria

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

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

I. Antiemetics – Serotonin Receptor Antagonists (also known as 5-HT3 Antiemetics)

## 1. Coverage and Limitations

Nevada Medicaid restricts the allowable number of tablets/doses per fill of 5-HT3 antiemetics according to the following table:

<b>Drug</b>	<b>Dosage form</b>	<b>Strength</b>	<b>Quantity Per Fill</b>
Dolasetron (Anzemet®)	Tablets	50 mg	4 tabs
		100 mg	2 tabs
Granisetron (generic and Kytril®)	Tablets	1 mg	2 tabs
	Solution	1 mg/5 ml, 30 ml per bottle	1 bottle
Granisetron transdermal (Sancuso®)	Transdermal patch	3.1 mg/24 hr (7 day patch)	1 patch
Ondansetron (generic and Zofran®)	Tablets and ODT	4 mg	12 tabs
		8 mg	6 tabs
	Tablets	24 mg	1 tab
	Solution	4 mg/5 ml, 50 ml per bottle	1 bottle
Ondansetron (Zuplenz®)	Dissolving Film	4 mg	12 films
		8 mg	6 films

An approved Prior Authorization is required for any prescription exceeding the above outlined quantity limits. Approval for additional medication beyond these limits will be considered only under the following circumstances:

- a. The recipient has failed on chemotherapy-related antiemetic therapy at lower doses; or
- b. The recipient is receiving chemotherapy treatments more often than once a week; or
- c. The recipient has a diagnosis of AIDS associated nausea and vomiting; or
- d. The recipient has a diagnosis of hyperemesis gravidarum and has failed at least one other antiemetic therapy or all other available therapies are medically contraindicated.

## 2. Prior Authorization Guidelines

A Prior Authorization to override the quantity limits to allow for a 30 day fill for these drugs may be effective for up to 6 months.

## J. See table for Quantity Edits Approved at DUR Board 12-16-2004.

## APPENDIX A – Coverage and Limitations

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

## QUANTITY EDITS APPROVED AT DUR BOARD 12-16-2004

Quantity Edit					
December – 04					
Drug Name	HCL	GSN	NDC	Maximum Quantity Per RX	Reason
Anzemet 100mg		34750		2.0	Edit designed to ensure appropriate dose, duration of therapy and indication.
Anzemet 50mg		34749		4.0	Same
Emend 80mg		51911		2.0	Same
Emend 125mg		51912		1.0	Same
Kytril 1mg		21592		2.0	Same
Zofran ODT 4mg		41562		12.0	Same
Zofran ODT 8mg		41563		6.0	Same
Zofran 4mg		16392		12.0	Same
Zofran 8mg		16393		6.0	Same
Zofran 24mg		43230		1.0	Same
Zofran Solution		15869		1 bottle (50 ml)	Same
Copaxone 20mg Kit			00088115330	1.0	Provider should be billing each, not milligrams
Duoneb	009040			6 bottles per month	Maximum needed
Flovent Rotadisk 100mcg		19317		1 box per month	Maximum needed
Flovent Rotadisk 250mcg		19318		1 box per month	Same
Flovent Rotadisk 50mcg		19319		1 box per month	Same
Lovenox 30mg/0.3ml		19331		18.0	Maximum daily dose should be BID, therefore no more than 60 syringes should be dispensed per RX.
Lovenox 40mg/0.4ml		39482		24.0	Same
Lovenox 60mg/0.6ml		27993		36.0	Same
Lovenox 80mg/0.8ml		27994		48.0	Same
Lovenox 100mg/ml		27995		60.0	Same
Lovenox		44669		48.0	Same
February 10, 2009	PRESCRIBED DRUGS				Appendix A Page 34

APPENDIX A – Coverage and Limitations

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL

120mg/0.8ml					
Lovenox 150mg/ml		44668		60.0	Same
Neupogen	006070			15.0	Providers should be billing by mls and not micrograms
Rebif	023353			6.0	To prevent overbilling for number of syringes dispensed instead of ml's
Serevent Diskus		31417		1 box (60 inhalations per month)	Maximum needed
Synagis 100mg Vial		40293		4.0	This was the largest correct quantity submitted since 01/01/04
Xopenex (All Strengths)		49871, 41849, 41848		4 boxes (288ml) per month	Maximum needed



## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

## 3. MEDICATIONS WITH GENDER/AGE EDITS

A. Prenatal vitamins

1. Payable only for female recipients.

B. Oral/Topical Contraceptives

1. Payable only for female recipients.

C. Hormones

1. Estrogen – payable only for female recipients.
2. Progestins – payable only for female recipients.
3. Estrogen and Androgen Combinations – payable only for female recipients.
4. Estrogen/Progestin Combinations – payable only for female recipients.
5. Contraceptive Hormones – payable only for female recipients.
6. Transdermal Testosterone – payable only for male recipients.
7. Androgen Hormone Inhibitor – payable only for male recipients.

D. Vitamins with Fluoride

1. Payable only for recipients up to age 21 years.

E. Tretinoic Acid Cream/Ointment/Gel

1. Payable only for recipients up to age 21 years.

F. Synagis® Palivizumab

Synagis® (palivizumab) injection is a covered benefit of Nevada Medicaid for recipients under the age of 2 years who meet the criteria. A Prior Authorization is required for recipients within the indications and limitations of coverage. For consideration outside these guidelines, a Prior Authorization may also be submitted with supporting medical necessity documentation.

1. Coverage and Limitations. Recipients must meet one of the following criteria:
  - a. Infants and children younger than 2 years of age who have:
    1. diagnosis of chronic lung disease of prematurity; and

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

2. have required medical therapy (e.g. bronchodilator, diuretics, oxygen, corticosteroids) within 6 months to the start of RSV season.
- b. Infants born at 28 weeks of gestation or earlier during the first RSV season, whenever that occurs during the first 12 months of life.
  - c. Infants born at 29 to 32 weeks of gestation (31 weeks, 6 days or less) who are up to 6 months of age at the onset of the RSV season.
  - d. Infants born at 32 to less than 35 weeks of gestation (defined as 32 weeks, 0 days through 34 weeks, 6 days) born less than 3 months before the start of the RSV season or born at anytime throughout the RSV season with one of the following risk factors:
    1. Infant attends childcare; or
    2. One or more children younger than 5 years live permanently in the child's household.
  - e. Infants with congenital abnormalities of the airway or neuromuscular disease during the first year of life.
  - f. Children who are 2 years of age or younger with hemodynamically significant cyanotic and acyanotic heart disease.

For initiation and termination of prophylaxis, recipients are allowed no more than a maximum of 5 doses per RSV season.

Infants born between 32 and 35 weeks of gestation are allowed no more than a maximum of 3 doses. Prophylaxis is covered until 90 days of age.

The product must be administered within the RSV season duration as indicated by the Center for Disease Control. Only one dose (based on recipient weight) may be given in a 30 day period.

Prior authorization approval will be given on a per RSV season basis.

## 2. Prior Authorization Guidelines

For consideration outside these guidelines, a Prior Authorization may be submitted with supporting justifying medical documentation.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

Note: Providers must bill using the appropriate NDC. Providers may bill for one vial even if only part of the single-use vial was given to the recipient and the remainder of the drug was discarded. Safe handling guidelines per manufacturer must be observed (e.g. shelf life, cold chain requirements). The smallest size vial to cover the dose must be used. For example, if the appropriate dose is 120mg, one 100mg vial and one 50mg vial should be used, the provider may not bill for two 100mg vials in this case.

G. Cymbalta® (duloxetine)

## Coverage and Limitations

1. Diabetic Peripheral Neuropathy (DPN):
  - a. If an ICD-9 code of 250.6 Diabetes with Neurological Manifestations is documented on the prescription; or
  - b. Completion of a Prior Authorization documenting a diagnosis of Diabetes with Neurological Manifestations.
2. Fibromyalgia:
  - a. If an ICD-9 code 729.1 Myalgia and Myositis unspecified is documented on the prescription; or
  - b. Completion of a Prior Authorization documenting a diagnosis of Fibromyalgia and/or Myalgia and Myositis, unspecified.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

H. Savella® (milnacipran)

## Coverage and Limitations

1. Diagnosis of Fibromyalgia:
  - a. If an ICD-9 code 729.1 Myalgia and Myositis unspecified is documented on the prescription; or
  - b. Completion of a Prior Authorization documenting a diagnosis of Fibromyalgia and/or Myalgia and Myositis, unspecified.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

I. Suboxone® (buprenorphine/naloxone) and Subutex® (buprenorphine)

## 1. Coverage and Limitations

Suboxone® is a covered Nevada Medicaid benefit for recipients who meet the criteria for coverage.

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

- a. Diagnosis of Opioid Dependence;
- b. Patient is 16 years of age or older;
- c. Medication is prescribed by a physician with a Drug Addiction Treatment Act (DATA) of 2000 waiver:
  1. Authorizes a physician to treat narcotic-dependent patients using Schedule III-V substances without obtaining a separate Drug Enforcement Agency (DEA) registration as a narcotic treatment program.
  2. A Unique Identification Number (UIN), in addition to the DEA number, is required on the prescription, and is the same as the DEA number except an “X” replaces the first alpha character of the DEA number.
- d. Formal substance abuse counseling/treatment must be in place or, if the prescriber is a psychiatrist or certified addiction specialist, they may confirm that they personally render the counseling;
- e. Document the name of the specific substance abuse program or the name of the psychiatrist or certified addiction specialist that will provide the counseling services. The program license number and/or the treating psychiatrist’s or certified addiction specialist’s license number may be requested and documented; and
- f. Confirm that the patient has honored all of their office visits and counseling sessions in a compliant manner.

## 2. Quantity Limits

Suboxone® 8mg/2mg sublingual tablet: 60 tablets per 30 days  
 Suboxone® 2mg/0.5mg sublingual tablet: 90 tablets per 30 days  
 Subutex® 8mg sublingual tablet: 60 tablets per 30 days  
 Subutex® 2mg sublingual tablet: 90 tablets per 30 days

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

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

J. Ampyra™ (dalfampridine)

## 1. Coverage and Limitations

Ampyra™ (dalfampridine) is a covered benefit of Nevada Medicaid for recipients who meet the following criteria for coverage.

Approval for Ampyra™ (dalfampridine) will be given if all of the following criteria are met and documented:

- a. Prescriber is a neurologist;
- b. The patient has a diagnosis of Multiple Sclerosis (ICD-9 code of 340);
- c. The use is for the FDA Approved Indication: to improve walking;
- d. The patient is ambulatory and has an EDSS score between 2.5 and 6.5;
- e. The patient has undergone a timed 25 foot walk to establish baseline walking speed and baseline walking speed is documented to be between 8 and 45 seconds;
- f. The patient does not have moderate to severe renal dysfunction (CrCL > 50ml/min);
- g. The patient does not have a history of seizures; and
- h. The patient is not pregnant.

## 2. Quantity Limits

Sixty (60) 10 mg tablets per 30 days.

## 3. Prior Authorization Guidelines

The Prior Authorization initial Approval Duration is 12 weeks. At 12 weeks of treatment, the prescriber may request continuation of the Prior Authorization.

## 4. Criteria for renewal of the Prior Authorization

Approval for continuation of Ampyra™ (dalfampridine) will be given if all of the following criteria are met and documented:

- a. Patient still meets all initial criteria;
- b. Patient has demonstrated an improvement in timed walking speed of at least 20% on Ampyra™; and

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

- c. The patient is not pregnant.
5. Quantity Limits for Renewal  
Sixty (60) 10 mg tablets per 30 days.
6. Renewal Prior Authorization Guidelines  
The duration of renewal of the Prior Authorization is 1 year.  
Prior Authorization forms are available at:  
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.
- K. Androgel®, Androderm®, Testim® (Testosterone gel and transdermal system)
1. Coverage and Limitations  
Topical Androgens are a covered benefit of Nevada Medicaid for recipients who meet all of the criteria for coverage:
2. Criteria for approval
- a. Recipient is a male;
- b. Use is for the FDA Approved Indication:  
Primary (congenital or acquired) or secondary (congenital or acquired) hypogonadism with ICD-9 diagnosis code of 257.2;
- c. The patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used;
- d. The patient does not have breast or prostate cancer, a palpable prostate nodule or induration, prostate-specific antigen greater than 4 ng/ml or severe lower urinary symptoms with an International Prostate Symptom Score (IPSS) > 19;
- e. The patient does not have a hematocrit > 50%;
- f. The patient does not have untreated severe obstructive sleep apnea; and
- g. The patient does not have uncontrolled or poorly controlled heart failure.
3. Prior Authorization Guidelines  
Prior Authorization approval will be for up to 1 year.

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

Length of authorization: 1 year.

L. Colchicine (Colcrys®)

1. Coverage and Limitations

- a. Recipient has a diagnosis of Familial Mediterranean Fever (FMF); or
- b. Recipient has a diagnosis of acute gout and recipient has failed therapy with NSAIDs (indomethacin, naproxen, ibuprofen, sulindac or ketoprofen) or corticosteroids (oral or intra-articular) in the last 90 days; or
- c. Recipient has a diagnosis of chronic gout requiring prophylaxis and recipient has failed therapy with both xanthine oxidase inhibitors within the last 180 days or recipient has a contraindication to two xanthine oxidase inhibitors.

2. Quantity Limitations:

- a. Quantity limit: 6 tabs per fill.
- b. A Prior Authorization for additional medication beyond this limit will be approved for recipients with:
  1. FMF. The quantity limit for recipients with FMF is 120 tablets/30 days.
  2. Chronic gout requiring prophylaxis and recipient has failed therapy with two xanthine oxidase inhibitors or has a contraindication to both xanthine oxidase inhibitors. The quantity limit for prophylaxis of chronic gout is 60 tablets/30 days.

3. Length of Approval (up to): 1 year

M. Dabigatran etexilate (Pradaxa®)

1. Coverage and Limitations:

- a. Recipient has a diagnosis of non-valvular (no prosthetic valve) atrial fibrillation; and
- b. Recipient has at least one of the following documented risk factors for stroke:
  1. History of stroke, TIA, or systemic embolism; or

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

2. Age  $\geq 75$  years; or
  3. Diabetes Mellitus; or
  4. History of left ventricular dysfunction or heart failure; or
  5. Age  $\geq 65$  years with the presence of one of the following:
    - a. Diabetes mellitus; or
    - b. Coronary artery disease (CAD); or
    - c. Hypertension; and
  - c. Recipient has failed warfarin therapy or has a contraindication to warfarin therapy. Failure consists of an adequate trial of at least 3 months where the goal INR (2.0-3.0) has not been achieved (most recent two INR values outside of the therapeutic range). If recipient is being transitioned from warfarin to dabigatran etexilate, current INR is  $< 2.0$ ; and
  - d. Recipient is  $> 18$  years of age; and
  - e. Recipient does not have a history of any of the following:
    1. Gastrointestinal bleeding.
    2. Pathological bleeding.
    3. Rheumatic heart disease.
    4. Mechanical valve prosthesis.
    5. Mitral valve disease.
    6. Severe renal impairment (estimated creatinine clearance  $< 15$  mL/minute) or on dialysis.
    7. Inability to take capsules whole (capsules must not be broken, chewed or opened).
    8. Recipient is not receiving traditional (non-selective) nonsteroidal anti-inflammatory drugs (NSAIDs).
2. Quantity Limitations:
- a. Quantity limit: 60 tabs/30 days



## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

3. Length of approval: up to 1 year.

N. Makena (Criteria for Physician Administered Drug)

1. Coverage and Limitations:

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

- a. Treatment with Makena™ is ordered by or recommended by a physician specializing in Obstetrics/Gynecology, Perinatology or Maternal/Fetal Medicine; and
- b. The recipient is female, 16 years of age or older, and pregnant with a singleton pregnancy; and
- c. The recipient's pregnancy is between 16 weeks, 0 days and 20 weeks, 6 days of gestation when therapy begins; and
- d. The recipient has a history of singleton spontaneous preterm birth (prior to 37 weeks gestation); and
- e. The recipient does not have other risk factors for preterm birth; and
- f. There is no known major fetal anomaly or fetal demise; and
- g. The recipient has not been treated with heparin therapy during the current pregnancy; and
- h. The recipient has no history of thromboembolic disease; and
- i. The recipient has no maternal/obstetrical complication (e.g. current or planned cerclage, hypertension requiring medication or seizure disorder).

2. Quantity Limitation:

Quantity Limit: 1 vial per rolling 30 days (5 doses).

3. Length of approval:

Makena will be approved for use until the recipient's pregnancy is 36 weeks, 6 days of gestation or delivery, whichever occurs first.

4. Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

## O. Victrelis® (boceprevir)

## 1. Coverage and Limitations:

Authorization for treatment initiation will be for 24 weeks (treatment weeks 4 through 28) if all of the following criteria are met and documented:

- a. The recipient has a diagnosis of chronic hepatitis C genotype 1 infection; and
- b. The recipient will be treated with pegylated interferon alfa and ribavirin for 4 weeks prior to starting boceprevir and will continue pegylated interferon alfa and ribavirin for the entire duration of treatment with boceprevir; and
- c. The recipient has not received a previous course of therapy with telaprevir or boceprevir unless the drug is being switched due to an adverse event with the alternative drug.

Authorization for treatment continuation for an additional 8 weeks of therapy (treatment weeks 28 through 36) will be given if all of the following criteria are met and documented:

- d. The recipient is treatment-naïve and their HCV-RNA level was detectable at treatment week 8 and undetectable at treatment week 24 (total boceprevir therapy: 32 weeks); or
- e. The recipient is a previous partial responder or a relapser to interferon and ribavirin and their HCV-RNA was undetectable at treatment week 8 and treatment week 24 (total boceprevir therapy: 32 weeks).

Authorization for treatment continuation for an additional 20 weeks of therapy (treatment weeks 28 through 48) will be given if all of the following criteria are met and documented:

- f. The recipient has a diagnosis of chronic hepatitis C genotype 1 with compensated cirrhosis and their HCV-RNA was detectable at treatment week 24, (total boceprevir therapy: 44 weeks); or
- g. The recipient had a  $<2\text{-log}_{10}$  HCV-RNA drop by treatment week 12 on prior treatment with pegylated interferon alfa and ribavirin and HCV-RNA on triple therapy is undetectable at treatment week 24, (total boceprevir therapy; 44 weeks); or
- h. The recipient is treatment-naïve and poorly interferon responsive based on  $<1\text{-log}_{10}$  decline in HCV-RNA at treatment week 4 following lead-in therapy with pegylated interferon alfa and ribavirin and HCV-RNA is undetectable at treatment week 24 (total boceprevir therapy: 44 weeks).

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

## 2. PA Guidelines:

- a. Initial prior authorization will be for 24 weeks (through treatment week 28).
- b. For recipients meeting criteria for continuation treatment for treatment weeks 28 through 36, a Prior Authorization may be renewed once for an additional 8 weeks.
- c. For recipients meeting criteria for continuation treatment for treatment weeks 28 through 48, a Prior Authorization may be renewed once for an additional 20 weeks.
- d. Prior Authorization forms are available at:  
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>.

## 3. Quantity Limitations:

Quantity Limit: 336 tablets per rolling 25 days.

## P. Incivek® (telaprevir)

## 1. Coverage and Limitations

Authorization for treatment initiation will be for 8 weeks (treatment weeks 1 through 8) if all of the following criteria are met and documented:

- a. The recipient has a diagnosis of chronic hepatitis C genotype 1 infection; and
- b. The recipient is being treated with concomitant pegylated interferon alfa plus ribavirin; and
- c. The recipient has not received a previous course of therapy with telaprevir or boceprevir unless the drug is being switched due to an adverse event with the alternative drug.

Authorization for treatment continuation will be for 4 weeks (treatment weeks 9 through 12) if the following criteria are met and documented:

- d. The recipient is treatment naïve and their HCV RNA level was <1000 IU/mL at treatment week 4.

## 2. PA Guidelines

- a. Initial Prior Authorization approval will be for 8 weeks.
- b. For recipients meeting criteria for continuation treatment for treatment weeks 9 through 12, a Prior Authorization may be renewed once for an additional 4 weeks.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

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

3. Quantity Limitations:

Quantity Limit: 168 tablets per rolling 25 days.

4. ANTIRETROVIRALS

Antiretrovirals for the treatment of HIV/AIDS are a covered benefit for Nevada Medicaid recipients. FDA approved antiretrovirals whose manufacturers participate in the federal Drug Rebate Program and are not DESI drugs, are covered.

5. BLOOD GLUCOSE TESTING

Nevada Medicaid and Nevada Check Up (NCU) participate in a Diabetic Supply Procurement Program. This program allows for the State to receive additional rebates for diabetic monitors and test strips. Effective March 1, 2009, diabetic monitors and test strips are covered for Nevada Medicaid and NCU from preferred manufacturers. Preferred manufacturers are listed in the pharmacy billing manual. This policy does not negatively impact freedom of choice for recipients. The providers billing for the service will continue to be all willing enrolled pharmacies.

Blood glucose monitors and testing supplies for home use are a covered Medicaid benefit. A written prescription with a diagnosis is required and must be kept on the premise of the provider for 37 months. A recipient or their caregiver must specifically request refills of glucose supplies before they are dispensed. The provider must not automatically dispense a quantity of supplies on a predetermined regular basis, even if a recipient has “authorized” in advance.

No Prior Authorization is required for the items in the outlined quantities below:

Lancets	200/month
Alcohol Swabs	200/month
Battery for Monitor	1/year
Blood Glucose Monitor	1 every 2 years (not to exceed \$55/monitor)
Blood Glucose Strips	200/month
Insulin Syringes	100/month
Keto-Stix	100/month
Control Solution	1/month

For all other items/quantities in excess of those outlined above, a Prior Authorization must be obtained from the Nevada Medicaid QIO-like vendor.

Blood Glucose monitors with special features (e.g. voice synthesizers) require a Prior Authorization. For special blood glucose monitors, the recipient must be legally blind. A diagnosis, a statement from the physician of visual impairment, and manufacturers’ invoice in required with the PA.

DIVISION OF HEALTH CARE FINANCING AND POLICY
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MEDICAID SERVICES MANUAL
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ICD-9 codes 250.00 through 250.93 (Diabetes Mellitus) or 648.0 (Diabetes Mellitus complicating pregnancy) will be covered. No coverage will be provided for any other ICD-9 code.

Blood glucose monitors and related supplies are billed on the NCPDP Universal Claim Form (UCF) or on-line through the POS (Point of Sale) system with the correct NDC number, complete description, including brand name and package size. Reimbursement is 90% of average wholesale price plus and handling and dispensing fee of \$1.54 per prescription.

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

**SXC HEALTH SOLUTIONS AD HOC REPORTING SYSTEM**  
**STANDARD THERAPEUTIC CLASSES**

Standard Therapeutic	
Class	Description
00	MEDICAL SUPPLIES
01	ANTI-ULCER PREPS/GASTROINTESTI
02	EMETICS
03	ANTIDIARRHEALS
04	ANTISPASMODIC-ANTICHOLINERGICS
05	BILE THERAPY
06	LAXATIVES
07	ATARACTICS-TRANQUILIZERS
08	MUSCLE RELAXANTS
09	ANTIPARKINSON
10	CNS STIMULANTS
11	PSYCHOSTIMULANTS-ANTIDEPRESSAN
12	AMPHETAMINE PREPARATIONS
13	ALL OTHER ANTI OBESITY PREPS
14	ANTIHISTAMINES
15	BRONCHIAL DILATORS
16	COUGH PREPARATIONS/EXPECTORANT
17	COLD AND COUGH PREPARATIONS
18	ADRENERGICS
19	TOPICAL NASAL AND OTIC PREPARA
20	OPHTHALMIC PREPARATIONS
21	TETRACYCLINES
22	PENICILLINS
23	STREPTOMYCINS
24	SULFONAMIDES
25	ERYTHROMYCINS
26	CEPHALOSPORINS
27	OTHER ANTIBIOTICS
28	URINARY ANTIBACTERIALS
29	CHLORAMPHENICOL
30	ANTINEOPLASTICS
31	ANTIPARASITICS
32	ANTIMALARIALS
33	ANTIVIRALS
34	TB PREPARATIONS
35	TRIMETHOPRIM
36	CONTRACEPTIVES, NON-SYSTEMIC
37	VAGINAL CLEANSERS
38	GENERAL ANTIBACTERIALS AND ANT
39	DIAGNOSTICS
40	NARCOTIC ANALGESICS

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

41	NON-NARCOTIC ANALGESICS
42	ANTIARTHRITICS
43	ANESTHETICS GEN INHALANT
44	ANESTHETICS GEN INJECT
45	ANESTHETIC LOCAL TOPICAL
46	SEDATIVE BARBITURATE
47	SEDATIVE NON-BARBITURATE
48	ANTICONVULSANTS
49	ANTINAUSEANTS
50	CORTICOTROPINS
51	GLUCOCORTICOIDS
52	MINERALOCORTICOIDS
53	ALDOSTERONE ANTAGONISTS
54	ANTIDOTES
55	THYROID PREPS
56	ANTITHYROID PREPS
57	IODINE THERAPY
58	DIABETIC THERAPY
59	ANABOLICS
60	ANDROGENS
61	ESTROGENS
62	PROGESTERONE
63	SYSTEMIC CONTRACEPTIVES
64	OTHER HORMONES
65	LIPOTROPICS
66	CHOLESTEROL REDUCERS
67	DIGESTANTS
68	PROTEIN LYSATES
69	ENZYMES
70	RAUWOLFIAS
71	OTHER HYPOTENSIVES
72	VASODILATORS CORONARY
73	VASODILATORS PERIPHERAL
74	DIGITALIS PREPARATIONS
75	XANTHINE DERIVATIVES
76	OTHER CARDIOVASCULAR PREPS
77	ANTICOAGULANTS
78	HEMOSTATICS
79	DIURETICS
80	FAT SOLUBLE VITAMINS
81	WATER SOLUBLE VITAMINS
82	MULTIVITAMINS
83	FOLIC ACID PREPARATIONS
84	B COMPLEX WITH VITAMIN C
85	VITAMIN K

## DIVISION OF HEALTH CARE FINANCING AND POLICY

## MEDICAID SERVICES MANUAL

86	INFANT FORMULAS
87	ELECTROLYTES & MISCELLANEOUS N
88	HEMATINICS & BLOOD CELL STIMUL
89	ALLERGENS
90	BIOLOGICALS
91	ANTIPRURITICS
92	COAL TAR
93	EMOLLIENTS PROTECTIVES
94	FUNGICIDES
95	ALL OTHER DERMATOLOGICALS
96	HEMORRHOIDAL PREPARATIONS
97	OXYTOCICS
98	PARASYMPATHETIC AGENTS
99	MISCELLANEOUS