MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 16, 2013

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

Revisions to the Medicaid Services Manual (MSM) Chapter 1200 were made to reflect approved actions by the Drug Use Review (DUR) Board at the July 26, 2012 meeting.

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.

New prior authorization criteria was approved by the DUR Board for Daliresp® (roflumilast); Byetta® (exenatide); Xarelto® (rivaroxaban), Kalydeco® (ivacaftor); Natroba® (spinosad); and Brilinta (ticagrelor) and was added to Chapter 1200. Prior authorization criteria was removed for Lyrica (pregabalin). ICD-9 codes of 299.0 or 299.01 (autistic disorder) can be written on prescriptions for Abilify to bypass the prior authorization requirement for children ages 17 and under. All quantity limitations were removed from MSM Chapter 1200, and will be added to the Nevada Medicaid, Nevada Check-Up Pharmacy Billing Manual. Medications with age and gender edits were moved to the end of Chapter 1200, Appendix A.

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

These changes are effective May 17, 2013.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 06/13 CHAPTER 1200 – PRESCRIBED DRUGS	MTL 21/03, 31/09, 05/10, 07/12 CHAPTER 1200 – PRESCRIBED DRUGS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1200	Introduction	Removed typo "0.5" in paragraph #1, line #2.
1203.1A.1	Coverage & Limitations - Covered	Added "dispensed per the manufacturers' guidelines" to clarify existing language.
1203.1A.4.a.	Coverage & Limitations - Refills	Reference to NAC 639.712 & 639.714 changed to NAC Chapter 639.
1203.1A.9.d.1.	Coverage & Limitations - Immunizations	Reference to NAC 639.297 changed to NAC Chapter 639.
1203.1B.2.a.5.	Provider Responsibility – Utilization Control	Added language indicating that all drugs may be subject to quantity limitations and referenced the Nevada Medicaid and Nevada Check Up Pharmacy Manual for established limits.
1203.1B.3	Provider Responsibility – Generic Substitutions	Reference to NRS 639.2583 changed to NRS Chapter 639.
1203.1C.1.a.	Service Delivery Model – Institutional Settings	Corrected typo ("thought" changed to "through").
1203.1C.7.a.	Service Delivery Model – NCPDP Standard Billing Units	Added "or by mls." to clarify existing language related to Tablets, Capsules, Suppositories, and Pre-filled Syringes.
1203.2.d.1	Intravenous (IV) Therapy Provider Type 37 – Long Term Care – Non-billable Items	Added language to state that only supplies associated with IV therapy, Enteral Nutrition and TPN administration are included in the LTC/NF rate and may not be billed as a separate charge.
Appendix A.		Appendix A is being reformatted to keep each drugs' clinical criteria on its own separate page. This allows providers to pull out the clinical information on the drugs they are interested in.
Appendix A.	Table of Contents	Updated the Table of Contents and Added a reference to finding Quantity Limitations in the Nevada Medicaid and Nevada Check Up Pharmacy Manual.
Appendix A.1.	Drugs Requiring a Prior Authorization	Added "and/or Quantity Limitation" to the section title.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A.1.A.	Proton Pump Inhibitors	Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and language confirming indicating that Proton Pump Inhibitors are subject to prior authorization.
Appendix A.1.B.	Cox 2 Inhibitors	Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and policy indicating that Cox 2 inhibitors are subject to quantity limitations as well as Prior Authorization. Deleted quantity limitation information as they will be moved to the Pharmacy Billing Manual.
Appendix A.1.C.	ADD/ADHD Agents	Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and language confirming that both stimulants and non-stimulants used for the treatment of ADD/ADHD require Prior Authorization.
Appendix A.1.D.	Growth Hormone	Added information on the Therapeutic Class and when the DUR Board last reviewed this item. Deleted redundant information.
Appendix A.1.E.	Over the Counter Medications	Added information on when this item was last reviewed by the DUR Board and policy indicating that over the counter medications are subject to quantity limitations. Deleted redundant information and quantity limit information as the quantity limits are be noted in the Pharmacy Billing Manual.
Appendix A.1.F.	Duragesic® (fentanyl transdermal) Patches	Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and policy which states Duragesic Patches are subject to quantity limitations. Removed dosage information as this information is noted in the Pharmacy Billing Manual. Rearranged the title for clarity.
Appendix A.1.G.	Fentora® and Actiq® (Fentanyl Citrate Buccal Tablet and Lozenge)	Added information on Therapeutic Class; when the DUR Board last reviewed these items; and added policy which states Fentanyl Citrate and Buccal Tablets and Lozenges are subject to quantity limitations. Deleted redundant information and quantity limits as this information is noted in the Pharmacy Billing Manual.
Appendix A.1.H.	Hematopoietic/ Hematinic Agents	Added information on the Therapeutic Class; when the DUR Board last reviewed these items; and added policy that Hematopoietics and Hematinics are subject to quantity limitations. Deleted redundant information and rearranged the first paragraph for clarity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A.1.I.	Anti-Fungal Oncychomyosis (Lamisil®, Spranox®, Penlac®)	Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added policy that Anti-Fungal Onchomycosis are subject to Prior Authorization. Deleted redundant information.
Appendix A.1.J.	Exenatide Injection (Byetta®)	Deleted this section as this information has been added to a new section numbered Appendix A.1. JJ.
Appendix A.1.J.	Pramlinitide Injection (Symlin®)	Previously numbered Appendix A.1.K. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added policy that this type of medication is subject to Prior Authorization and age restriction. Existing language reformatted for clarity.
Appendix A.1.K.	Regranex®	Previously numbered Appendix A.1.L. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added policy indicating that Regranex is subject to quantity limitations. Deleted redundant information and specific quantity limit information as this information is noted in the Pharmacy Billing Manual.
Appendix A.1.L.	Injectable Immunomodulator Drugs	Previously numbered Appendix A.1.M. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added language indicating that these medications are subject to Prior Authorization. Deleted redundant information.
Appendix A.1.L.d.	Injectable Immunomodulator Drugs	Added "Actemra® to the Juvenile Rheumatoid Arthritis/Juvenile Idopathic Arthritis category.
Appendix A.1.M.	Topical Immunomodulators	Previously numbered Appendix A.1.O. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added policy that indicates these are subject to quantity limitations. Deleted redundant information and specific quantity limit information as this is noted in the Pharmacy Billing Manual.
Appendix A.1.N.	Psychotropic Medications for Children and Adolescents	Previously numbered Appendix A.1.P. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added language indicating these medications are subject to Prior Authorization.
Appendix A.1.Q.	Lyrica	Deleted all criteria for Lyrica.
Appendix A.1.O.	Lidoderm 5% Patches®	Previously numbered Appendix A.1.R. Added information on the Therapeutic Class; when the DUR Board last

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		reviewed this item; and policy that this medication is subject to quantity limitations and Prior Authorization. Deleted redundant information and specific quantity limits as this information is noted in the Pharmacy Billing Manual.
Appendix A.1.P.	Omalizumab (Xolair®)	Previously numbered Appendix A.1.S. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added clarifying language that Omalizumab is subject to Prior Authorization. Deleted redundant information.
Appendix A.1.Q.	Long-Acting Narcotics	Previously numbered Appendix A.2.A. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and language indicating that these medications are subject to quantity limitations and Prior Authorization. Deleted redundant information and specific quantity limits as these are noted in the Pharmacy Billing Manual. Also rearranged existing language for clarity.
Appendix A.2.B.	Narcotic/ Acetaminophen Combinations	Deleted this section as quantity limitations are noted in the Pharmacy Billing Manual.
Appendix A.1.R.	Toradol® (ketorolac tromethamine) Tablets	Previously numbered Appendix A.2.C. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added language indicating that this medication is subject to quantity limitations and Prior Authorization. Deleted redundant information and specific quantity limits as this information is noted in the Pharmacy Billing Manual.
Appendix A.1.S.	Anti-Migraine Medications	Previously numbered Appendix A.2.D. Removed "triptans" from the section title. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added language that these medications are subject to Prior Authorization. Deleted redundant information and specific quantity limits as this information is noted in the Pharmacy Billing Manual.
Appendix A.1.T.	Tobacco Cessation Products	Previously numbered Appendix A.2.E. Changed the title from "Smoking Cessation Products". Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and language regarding the recipients' route of choice. Deleted redundant information and specific quantity limits as this information is noted in the Pharmacy Billing Manual.

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Appendix A.1.U.	Xopenex® (levalbuterol), Xopenex HFA (levalbuterol)	Previously numbered Appendix A.2.F. Added Xopenex HFA (levalbuterol) to the section title. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and language indicating these medications are subject to quantity limitations and Prior Authorization. Deleted redundant information and specific quantity limits as this information is noted in the Pharmacy Billing Manual.
Appendix A.2.G.	Sedative Hypnotics	Deleted this section as the quantity limits are noted in the Pharmacy Billing Manual.
Appendix A.2.H.	Inhaled Anticholinergic Agents	Deleted this section as the quantity limits are noted in the Pharmacy Billing Manual.
Appendix A.1.V.	Antiemetics-Serotonin Receptor Antagonists (also known as 5-HT3 Antiemetics)	Previously numbered Appendix A.2.I. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and language indicating that these medications are subject to quantity limitations and Prior Authorization. Deleted redundant information and specific quantity limits as this information is noted in the Pharmacy Billing Manual. Also deleted the reference to the Quantity Edits table and the Quantity Edits table approved at the DUR Board on December 16, 2004. This information is found in the Pharmacy Billing Manual.
Appendix A.3.A	Prenatal Vitamins	Relocated this information towards the end of Appendix A.
Appendix A.3.B	Oral/Topical Contraceptives	Relocated this information towards the end of Appendix A.
Appendix A.3.C	Hormones	Relocated this information towards the end of Appendix A.
Appendix A.3.D	Vitamins with Fluoride	Relocated this information towards the end of Appendix A.
Appendix A.3.E	Tretinoic Acid Cream/Ointment Gel	Relocated this information towards the end of Appendix A.
Appendix A.1.W.	Synagis [m13]® Palivisumaub	Previously numbered Appendix A.3.F. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and language indicating this medication type is subject to quantity limitations and Prior Authorization. Added clarifying language regarding doses for infants with congenital abnormalities of the airway or

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		neuromuscular disease. Rearranged existing language for clarity and deleted redundant information. Specific quantity information was removed as this information is noted in the Pharmacy Billing Manual.
Appendix A.1.X.	Cymbalta® (duloxetine)	Previously numbered Appendix A.3.G. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added policy indicating that this medication is subject to Prior Authorization.
Appendix A.1.Y.	Savella® (milnacipran)	Previously numbered Appendix A.3.H. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added policy indicating that this medication is subject to Prior Authorization.
Appendix A.1.Z.	Suboxone® (buprenorphine/ naloxone) and Subutex® (buprenorphine)	Previously numbered Appendix A.3.I. Added information on the Therapeutic Class; when the DUR Board last reviewed these items; and added policy indicating that Suboxone® is subject to quantity limitations and Prior Authorization. Deleted redundant information and specific quantity limit information as this is noted in the Pharmacy Billing Manual.
Appendix A.1.AA.	Ampyra™ (dalfampridine)	Previously numbered Appendix A.3.J. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added policy indicating that Ampyra™ is subject to quantity limitations and Prior Authorization. Deleted redundant information and specific quantity limits as this information can be found in the Pharmacy Billing Manual.
Appendix A.1 BB.	Androgen®, Androderm®, Testim® (Testosterone gel and transdermal system)	Previously numbered Appendix A.3.K. Added information on the Therapeutic Class; when the DUR Board last reviewed these items; and added policy indicating that Topical Androgens are subject to Prior Authorization. Deleted redundant information.
Appendix A.1.CC.	Colchicine (Colcrys®)	Previously numbered Appendix A.3.L. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added policy that this medication is subject to quantity limitations and Prior Authorization. Deleted specific quantity limitation information as this is noted in the Pharmacy Billing Manual.

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Appendix A.1.DD.	Pradaxa® (dabigatram etexilate)	Previously numbered Appendix A.3.M. Rearranged Title and added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added language to indicate that this medication is subject to quantity limitations and Prior Authorization. Deleted specific quantity limit information as this information is located in the Pharmacy Billing Manual.
Appendix A.1.EE.	Makena (Criteria for Physician Administered Drug)	Previously numbered Appendix A.3.N. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and language indicating that this medication is subject to quantity limitations and Prior Authorization. Deleted specific quantity limitations.
Appendix A.1.FF.	Victrelis® (boceprevir)	Previously numbered Appendix A.3.O. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and added language indicating that this medication is subject to quantity limitations and Prior Authorization. Deleted specific quantity limit information as this is noted in the Pharmacy Billing Manual.
Appendix A.1.GG.	Incivek® (telaprevir)	Previously numbered Appendix A.3.P. Added information on the Therapeutic Class; when the DUR Board last reviewed this item; and language indicating that this medication is subject to quantity limitations and Prior Authorization. Deleted specific quantity limit information as this information is noted in the Pharmacy Billing Manual.
Appendix A.1.HH.	Daliresp® (romflumilast)	Added this category and the associated prior authorization criteria which were approved by the DUR Board on July 26, 2012.
Appendix A.1.II.	Xarelto® (rivaroxaban)	Added this category and the associated prior authorization criteria which were approved by the DUR Board on July 26, 2012.
Appendix A.1JJ.	Byetta® (exenatide), Bydureon® (exenatide extended-release) and Victoza® (liraglutide)	Added this category and the associated prior authorization criteria approved by the DUR Board on July 26, 2012. Also moved Byetta® information from Appendix A, section 1.J. to this section.
Appendix A.1.KK.	Kalydeco® (ivacaftor)	Added this category and the associated prior authorization criteria which were approved by the DUR Board on July 26, 2012.

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Appendix A.1.LL.	Natroba® (spinosad)	Added this category and the associated prior authorization criteria which were approved by the DUR Board on July 26, 2012.
Appendix A.1.MM.	Brilinta® (ticagrelor)	Added this category and the associated prior authorization criteria which were approved by the DUR Board on July 26, 2012.
Appendix A.2.	MEDICATIONS WITH GENDER/AGE EDITS	Moved from Appendix A, Page 36. Previously numbered Appendix A.3.
Appendix A.2.A.	Prenatal Vitamins	Previously numbered Appendix A.3.A.
Appendix A.2.B.	Oral/Topical Contraceptives	Previously numbered Appendix A.3.B.
Appendix A.2.C.	Hormones	Previously numbered Appendix A.3.C.
Appendix A.2.D.	Vitamins with Fluoride	Previously numbered Appendix A.3.D.
Appendix A.2.E.	Medications for the Treatment of Acne	Previously numbered Appendix A.3.E. Changed title from Tretinoic Acid Cream/Ointment/Gel.
Appendix A.5.	Blood Glucose Testing	Added language indicating that blood glucose monitors and testing supplies for home use are subject to quantity limitations. Also clarified language regarding excess of quantity limitations and added language indicating that reimbursement is based upon the Wholesale Acquisition Cost plus 8% instead of 90% of the average wholesale price. Deleted specific quantity limitation information as it is noted in the Pharmacy Billing Manual.
Appendix B.	Therapeutic Classes	Revised the Ad Hoc Reporting System reference from SXC to CATAMARAN as Catamaran is the current vendor.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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PRESCRIBED DRUGS

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.

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 Medicaid Services Manual (MSM) 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.

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.

1202 RESERVED

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, dispensed per the manufacturer's guidelines, 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 Nevada Revised Statute (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.

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 specific classes based on clinical efficacy and safety, DHCFP or its Quality Improvement Organization (QIO)-like vendor may consider cost in determining which drugs are selected for inclusion on the PDL.

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

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

   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.

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 Food and Drug Administration (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 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. 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 FDA has issued a notice of an opportunity for a hearing as a result of the DESI program which has been found to be a less than effective or is Identical, Related or Similar to the DESI drug. The DESI drug is identified by the FDA or reported by the drug manufacturer for purposes of the Medicaid Drug Rebate Program. This listing is available on the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp.

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

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) Chapter 639.

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. 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;
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.

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.

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 nine 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 Chapter 639.

2. Pharmacies must receive childhood immunizations through the VFC Program. The DHCFP or Nevada Medicaid and 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.

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 Uniform Claim Form (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 authorizations 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.

5. All drugs may be subject to quantity limitations. Refer to the Nevada Medicaid and NCU Pharmacy Manual for established quantity limits.

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.

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 NRS Chapter 639, 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.

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 genetic 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.
      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).

3. Disposable Medical Supplies

Please refer to MSM 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, NFs 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.

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 Health Maintenance Organization (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 (MCO), 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.

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" or by "mls". For example, if 30 tablets of Metformin are dispensed, the quantity will be 30.

Liquids, Liquid Orals, Suspensions, Solutions, Opthalmic/Otic Solutions: must be billed by milliliters (mls). For example, if 560ml of guiafenesin 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, Catapress-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.

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 six hours for one 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 National Association of Boards of Pharmacy (NABP) provider number is to be used and entered when billing online using the POS system or when using the UCF.

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. The DHCFP Fiscal Agent will perform ongoing market analysis to monitor pricing patterns and product availability.

2. The 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 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 Center 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 MSM Chapter 3100 for the hearings process.

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.

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 only 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 MSM Chapter 500 (Nursing Facilities) for further information on items which may be billed separately to Nevada Medicaid.

1204 HEARINGS

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

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL

All drugs in Appendix A may be subject Quantity Limitations.
Check the Nevada Medicaid and Nevada Check Up Pharmacy Manual for a listing of the exact Quantity Limitation.

1. DRUGS REQUIRING A PRIOR AUTHORIZATION AND/OR QUANTITY LIMITATION

A. Proton Pump Inhibitors (PPIs)

Therapeutic Class: Proton Pump Inhibitor
Last Reviewed by the DUR Board: October 28, 2010

Proton Pump Inhibitors (PPIs) are subject to prior authorization

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

2. Completion of a prior authorization documenting a diagnosis of acute or recurrent erosive esophagitis.

f. Prevention of Gastrointestinal Events

1. Prevention of Non-Steroidal Anti-Inflammatory Drug (NSAID) induced Gastrointestinal (GI) 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 (≤ 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

Therapeutic Class: NSAIDs (nonsteriodal anti-inflammatory drugs)
Last Reviewed by the DUR Board: April 28, 2011

Cox–2 Inhibitors are subject to prior authorizations and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer for the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Indications:

A diagnosis of osteoarthritis, rheumatoid arthritis, alkylosing spondylitis, juvenile rheumatoid arthritis, primary dysmenorrheal, 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 six months.

g. The patient does not have a history of allergies to sulfonamides, aspirin or other NSAIDs.

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

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

Therapeutic Class: ADHD/ADD Agents
Last Reviewed by the DUR Board: January 24, 2008

Agents, both stimulants and non-stimulants used for the treatment of ADD/ADHD are subject to prior authorization for 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.

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 12 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).

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 one year time period.

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

D. Growth Hormone

Therapeutic Class: Growth Hormone
Last Reviewed by the DUR Board: January 24, 2008

Growth Hormone (GH) therapy is 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.

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 five and 75/ml/min/1.73m2).

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 (IGFPB#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. Height >2.25 SD below the mean for age or >2 SD below the mid-parenteral height percentile or growth velocity <25th percentile for bone age.

    b. At least one provocative stimuli test to show failure to raise the grow hormone level above 10 ng/ml.

    c. 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 (IGFPB#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 25th 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.

Prior authorization will be given for a six month time period for initiation of therapy, and six-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.

    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

Last Reviewed by the DUR Board: N/A

Over-the-Counter (OTC) medications are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

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

Therapeutic Class: Analgesics, Narcotic
Last Reviewed by the DUR Board: July 30, 2009

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

1. Coverage and Limitations

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, nonsteriodal analgesics, or PRN dosing with short-acting opioid.

b. Patient requires continuous opioid administration.

In addition the following guideline applies:

c. 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 six month time period.

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

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

Therapeutic Class: Analgesics, Narcotic
Last Reviewed by the DUR Board: July 30, 2009

1. Coverage and Limitations

Fentanyl Citrate and Buccal Tablets and Lozenges are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

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. Prior Authorization Guidelines

Initial prior authorization approval will be for six 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

H. Hematopoietic/Hematinic Agents

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

This policy applies in all settings with the exception of inpatient facilities. Hematopoietics and Hematinics are subject to prior authorizations and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Recipients must meet one of the following criteria for coverage:

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

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.

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 Oncychomycosis (Lamisil®, Sporanox®, Penlac®)

Therapeutic Class: Antifungal Agents
Last Reviewed by the DUR: June 3, 2010

Anti-Fungal Onchomycosis are subject to prior authorization.

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: six weeks – Toenail: 12 weeks.

2. Penlac® liquids Initial: three months.

2. Prior Authorization Guidelines

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

J. Pramlinitide Injection (Symlin®)

Therapeutic Class: Antihyperglycemic, Amylin Analog-Type
Last Reviewed by the DUR Board: September 21, 2006

Pramlinitide injection is subject to prior authorization and age restriction.

1. Coverage and Limitations (For recipients 15 years or older)

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 six months; and

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

K. Regranex®

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

Regranex® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

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

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

b. Recipient must be age 16 years or older.

2. Prior Authorization Guidelines

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

L. Injectable Immunomodulator Drugs

Therapeutic Class: Immunomodulators, Injectable
Last Reviewed by the DUR Board: June 3, 2010

Actemra® (tocilizumab)	Cimzia® (certolizumab pegol)
Amevive® (alefacept)	Kineret® (ankinra)
Enbrel® (etanercept)	Orencia® (abatacept)
Humira® (adalimumab)	Remicade® (infliximab)
Simponi™ (golimumab)	Stelara™ (ustekinumab)

Injectable immunomodulator drugs are subject to prior authorization.

1. Coverage and Limitations

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

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

1. Diagnosis of rheumatoid arthritis; and

2. Rheumatology consult with date of visit; and

3. Negative tuberculin test (Remicade®, Humira®, Orencia®, 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 ≤ six months (early RA) and has high disease activity;

Patient has had RA for ≥ six 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 ≥ six 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;

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, sulfasalzine, 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®, Actemra®):

1. Diagnosis of moderately or severely active juvenile rheumatoid arthritis; and

2. Patient is at least two 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

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. sulfasalzine, 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. Immunosuppresants; 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.

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-α 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 < five 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.

M. Topical Immunomodulators

Therapeutic Class: Immumomdulators, Topical
Last Reviewed by the DUR Board: April 26, 2007

Elidel®
Protopic®

Topical Immunomodulators drugs are a subject to prior authorization and quantity limitations and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

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

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

b. Patient has a documented diagnosis of Atopic Dermatitis:

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

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

3. Protopic® 0.1%; moderate to severe, for ages ≥ 18 years.

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.

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

N. Psychotropic Medications for Children and Adolescents

Therapeutic Class: Psychotropic Agents
Last Reviewed by the DUR Board: July 22, 2010

Psychotropic medications for children and adolescents are subject to prior authorization.

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.

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.

   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

O. Lidoderm 5% Patches®

Therapeutic Class: Topical, Local Anesthetics
Last Reviewed byt the DUR Board: April 30, 2009

1. Coverage and Limitations

Topical Lidoderm Patches® are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

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

a. If an ICD-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.

P. Omalizumab (Xolair®)

Therapeutic Class: Respiratory Monoclonal Antibody Agents
Last Reviewed by the DUR Board: Not Available

1. Coverage and Limitations

Omalizumab (XOLAIR®) is subject to prior authorization. Omalizumab has not been shown 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.

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 Radioallergosorbent (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

Q. Long-Acting Narcotics

Therapeutic Class: Analgesics, Narcotic
Last Reviewed by DUR Board: July 30, 2009

Long-Acting Narcotics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

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

a. Oxycontin (including generic)~~:~~; MS Contin (including generic); Avinza; Kadian; Oramorph.

1. No prior authorization is required for diagnosis of terminal cancer.

b. 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 Payment Authorization Request (PAR) must be available if requested.

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

R. Toradol® (ketorolac tromethamine) tablets

Therapeutic Class: Nonsteroidal Antinflammatory Drugs, NSAIDS
Last Reviewed by the DUR Board: Not Available

The pharmaceutical Toradal® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Ketorolac is indicated for the short-term (up to five 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 five days.

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

S. Anti-Migraine Medications

Therapeutic Class: Triptans
Last Reviewed by the DUR Board: September 21, 2006

Serotonin 5-HT1 receptor agonists commonly referred to as "triptans" or anti-migraine medications are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

An approved prior authorization is required for any prescription exceeding the 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 Monoamine Oxidase (MAO) Inhibitors present for approval of Imitrex® (sumitriptan), 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 tripitans 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

T. Tobacco Cessation Products

Therapeutic Class: Tobacco Cessation Agents
Last Reviewed by the DUR Board: Not Available

Smoking cessation products, including patches, gums, lozenges and inhalers (based on the recipients' route of choice), are subject to quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

U. Xopenex® (levalbuterol), Xopenex HFA (levalbuterol)

Therapeutic Class: Beta Adrenergic Agents
Last Reviewed by the DUR Board: July 26, 2012

Xopenex® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   a. 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.

2. Prior Authorization Guidelines

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

V. Sedative Hypnotics

Therapeutic Class:
Last Reviewed by the DUR Board:

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

1. Coverage and Limitations

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

W. Inhaled Anticholinergic Agents

Therapeutic Class:
Last Reviewed by the DUR Board:

Inhaled anticholinergic agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. General Criteria

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

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

Therapeutic Class: Atiemetics, Antivertigo Agents
Last Reviewed by the DUR Board: October 28, 2010

1. Coverage and Limitations

5-HT3 anti-emetics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

An approved prior authorization is required for any prescription exceeding the 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 six months.

Y. Synagis® Palivizumaub

Therapeutic Class: Antiviral Monoclonal Antibodies
Last Reviewed by the DUR Board: July 22, 2010

Synagis® (palivizumab) injection is subject to quantity limitations and prior authorization. Recipients must be under the age of two. 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 two years of age who have:

      1. diagnosis of chronic lung disease of prematurity; and

      2. have required medical therapy (e.g. bronchodilator, diuretics, oxygen, corticosteroids) within six months to the start of Respiratory Syncytial Virus (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, six days or less) who are up to six 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, six days) born less than three 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 five years live permanently in the child's household.

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

   e. Infants with congenital abnormalities of the airway or neuromuscular disease. These infants and children should receive five doses during the first year of life.

   f. Children who are two years of age or younger with hemodynamically significant cyanotic and acyanotic heart disease.

Prior authorization approval will be given on a per RSV season basis, as indicated by the Center for Disease Control.

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

Note: Providers must bill using the appropriate National Drug Code (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.

Z. Cymbalta® (duloxetine)

Therapeutic Class: Sertonin-Norepinephrine Reuptake Inhibitor (SNRI)
Last Reviewed by the DUR Board: Not Available

Cymbalta® (duloxetine) is subject to prior authorization.

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

AA. Savella® (milnacipran)

Therapeutic Class: Fibromyalgia Agents: Serotonin-Norephinephrine Reuptake Inhibitor
Last Reviewed by DUR Board: June 3, 2010

Savella® (milnacipran) is subject to prior authorization.

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

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

Therapeutic Class: Narcotic Withdrawal Therapy Agents
Last Reviewed by the DUR Board: June 3, 2010

Suboxone® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

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

CC. Ampyra™ (dalfampridine)

Therapeutic Class: Agents for the treatment of Neuromuscular Transmission Disorder
Last Reviewed by the DUR Board: July 22, 2010

Ampyra™ (dalfampridine) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval 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 eight 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. 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.

3. 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

c. The patient is not pregnant.

4. Renewal Prior Authorization Guidelines

The duration of renewal of the prior authorization is one year.

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

DD. Androgel®, Androderm®, Testim® (Testosterone gel and transdermal system)

Therapeutic Class: Androgenic Agents
Last Reviewed by the DUR Board: July 22, 2010

Topical Androgens are subject to prior authorization.

1. Coverage and Limitations

Recipients must 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 one year.

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

Length of authorization: one year.

EE. Colchicine (Colcrys®)

Therapeutic Class: Antigout Agents
Last Reviewed by the DUR Board: October 28, 2010.

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

1. Coverage and Limitations

a. 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. Prior Authorization Guidelines:

a. A prior authorization for additional medication beyond this limit will be approved for recipients with:

1. FMF.

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): one year

FF. Pradaxa® (dabigatran etexilate)

Therapeutic Class: Thrombin Inhibitors
Last Reviewed by the DUR Board: Not Available

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

1. Coverage and Limitations:

   a. 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

      2. Age ≥75 years; or

      3. Diabetes Mellitus; or

      4. History of left ventricular dysfunction or heart failure; or

      5. Age ≥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 three 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 creatitine 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. Length of approval: up to one year.

GG. Makena™ (Criteria for Physician Administered Drug)

Therapeutic Class: Progestational Agents
Last Reviewed by the DUR Board: April 28, 2011

Makena™ is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations:

   Authorization will be given if 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~~six 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. Length of approval:

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

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

HH. Victrelis® (boceprevir)

Therapeutic Class: Anti-Hepatitis Agents-Protease Inhibitors
Last Reviewed by the DUR Board: January, 26, 2012

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

1. Coverage and Limitations:

Authorization for treatment initiation will be for 24 weeks (treatment weeks four 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 four 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.

Continuation of treatment may be authorized for eight weeks or 20 weeks if the following criteria are met.

Authorization for treatment continuation for an additional eight 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 eight 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 eight 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-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-log_{10} decline in HCV-RNA at treatment week four following lead-in therapy with pegylated interferon alfa and ribavirin and HCV-RNA is undetectable at treatment week 24 (total boceprevir therapy: 44 weeks).

2. Prior Authorization 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 eight 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

II. Incivek® (telaprevir)

Therapeutic Class: Anti-Hepatitis Agents-Protease Inhibitors
Last Reviewed by the DUR Board: January 26, 2012

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

1. Coverage and Limitations

Authorization for treatment initiation will be for eight weeks (treatment weeks one through eight) 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 four weeks (treatment weeks nine 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 four.

2. Prior Authorization Guidelines

a. Initial prior authorization approval will be for eight weeks.

b. For recipients meeting criteria for continuation treatment for treatment weeks nine through 12, a prior authorization may be renewed once for an additional four weeks.

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

JJ. Daliresp® (roflumilast)

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

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

1. Coverage and Limitations:

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

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

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

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

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

e. The recipient has a history of COPD exacerbations.

2. Prior Authorization Guidelines:

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

KK. Xarelto® (rivaroxaban)

Therapeutic Class: Direct Factor XO Inhibitors
Last Reviewed by the DUR Board: July 26, 2012

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

1. Coverage and Limitations:

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

   a. The recipient has a diagnosis of nonvalvular atrial fibrillation;

   b. The recipient does not have an active pathological bleed; and

   c. The recipient has failed to consistently achieve and maintain an INR of 2.0 to 3.0 on warfarin therapy despite an adequate trial that included patient education and dose titration; or

   d. The recipient experienced an adverse event with warfarin therapy; or

   e. The recipient has an allergy or contraindication to warfarin therapy; or

   f. The recipient has a barrier of access to care.

2. Prior Authorization Guidelines:

   a. Prior authorization will be for one year.

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

   c. Xarelto® 10 mg tablets are available without prior authorization and are indicated for the prophylaxis of deep vein thrombosis in patients undergoing knee or hip replacement surgery.

LL. Byetta® (exenatide), Bydureon® (exenatide extended-release) and Victoza® (liraglutide)

Therapeutic Class: Incretin Mimetics
Last Reviewed by the DUR Board: July 26, 2012

Byetta® (exenatide), Bydureon® (exenatide extended-release) and Victoza® (liraglutide) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

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

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

b. The recipient has a diagnosis of type 2 diabetes mellitus; and

c. The recipient has failed to achieve glycemic control despite an appropriate trial with metformin and/or a sulfonylurea.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

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

MM. Kalydeco® (ivacaftor)

Therapeutic Class: Respiratory Agent
Last Reviewed by the DUR Board: July 26, 2012

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

1. Coverage and Limitations

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

a. The recipient has a diagnosis of cystic fibrosis, and

b. There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming presence of the G551D gene mutation.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

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

NN. Natroba® (spinosad)

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

Natroba® (spinosad) is subject to prior authorization.

1. Coverage and Limitations

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

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

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

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

2. Prior Authorization Guidelines

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

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

OO. Brilinta® (ticagrelor)

Therapeutic Class: Plate Aggregation Inhibitors
Last Reviewed by the DUR Board: July 26, 2012

Brilinta® (ticagrelor) is subject to prior authorizationand quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

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

a. The recipient has a diagnosis of Acute Coronary Syndrome (unstable angina, non-ST elevation myocardial infarction or ST elevation myocardial infarction;

b. The recipient does not have an active pathological bleed or history of intracranial hemorrhage;

c. The recipient will be receiving concomitant treatment with aspirin in a dose of <100 mg/daily; and

d. The recipient has been started and stabilized on the requested medication; or

e. The recipient has experienced an adverse event with or has an allergy or contraindication with clopidogrel; or

f. Another clinically appropriate rationale is provided for why clopidogrel cannot be used.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

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

2. 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 and 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. Medications for the Treatment of Acne

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

3. 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 Drug Efficacy Study and Implementation (DESI) drugs, are covered.

4. BLOOD GLUCOSE TESTING

Nevada Medicaid and 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 subject to quantity limitations. 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.

For all items in excess of the limitations, 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 prior authorization.

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 National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF) or on-line through the Point of Sale (POS) system with the correct NDC number, complete description, including brand name and package size. Reimbursement is Wholesale Acquisition Cost (WAC) plus 8% and handling and dispensing fee of $1.54 per prescription.

CATAMARAN 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 ANTIOBESITY 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

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

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