MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 11, 2014

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1200, Prescribed Drugs, are being proposed to reflect approved actions by the Drug Use Review (DUR) Board at the July 24, 2014 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.

Prior authorization criteria was revised by the DUR Board on July 24, 2014 for Xolair® (Omalizumab), Kalydeco® (Ivacaftor), and medications for the treatment of acne.

These changes are effective January 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 22/14 CHAPTER 1200 – PRESCRIBED DRUGS	MTL 16/14 CHAPTER 1200 – PRESCRIBED DRUGS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A	**1.P. Xolair® (Omalizumab)**	Updated last reviewed date to July 24, 2014. Added the standard disclaimer regarding prior authorizations and quantity limitations. Deleted language regarding treatment of acute exacerbations, bronchospasm and status asthmatics. Removed "Authorization" and replaced it with "Approval" for consistency. Added "Recipients must meet at least one condition (a. or b.)."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added "The recipient must meet all of the following criteria." Added new diagnosis for coverage: chronic idiopathic urticaria (CIL). Added guidelines pertaining to CIL and Xolair® usage.
Appendix A	**1.MM. Kalydeco® (Ivacaftor)**	Updated prior authorization approval from three to 12 months. Updated last reviewed date to July 24, 2014. Replaced "Authorization" with "Approval" for consistency. Added age restriction to six years or older.
Appendix A	**1.WW. Medications for the Treatment of Acne**	Added seven new gene mutations as qualifiers for coverage. Added therapeutic class and last reviewed date. Added standard disclaimer regarding prior authorizations and quantity limitations. Added Coverage and Limitations including no prior authorization for recipients up to age 21 years. Added criteria for recipients age 21 years or older to have a diagnosis of moderate to severe (Grade III or higher) acne.
Appendix A.	**2.E. Medications for the Treatment of Acne**	Added Prior Authorization Guidelines. Deleted this section as it has been replaced with new criteria in Appendix A. Section 1.WW.

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).

e. Lock-in Program: When a recipient has shown patterns of abuse/misuse of Nevada Medicaid benefits, or the DHCFP has determined that the recipient requires close medical management, the recipient may be "locked-in" to a specific pharmacy and/or provider. This means that Medicaid will only pay for controlled substance prescriptions/medical services at a single pharmacy/provider.

1. Criteria that is evaluated by the DHCFP when determining if a recipient should be locked in to a specific pharmacy begins with the number of controlled substance prescriptions filled in 60 days.

   If the recipient has filled ten or more controlled substance prescriptions in the past 60 day period (includes controlled substance pharmaceuticals given in the emergency room) then the clinical review continues with the following criteria:

   a. The recipient has utilized more than one pharmacy in the past 60 day period;

   b. The recipient has utilized more than three physicians in the past 60 day period;

c. The recipient has utilized the emergency room(s) for receiving controlled substances;

d. The recipient has been diagnosed with a drug dependency related condition;

e. The dispensed quantity per prescription of controlled substances appears excessive by the clinical review team; or

f. The recipient has other noted drug seeking behaviors(s).

2. The POS system 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. Any non-controlled substance prescriptions can be filled at any pharmacy.

3. Recipients who are locked-in to one pharmacy can change their locked-in pharmacy at any time by contacting their Medicaid District Office.

4. Pharmacies may call the Technical Call Center for an override to the locked-in pharmacy if:

a. The locked-in pharmacy is out of stock.

b. The locked-in pharmacy is closed.

c. The recipient is out of town and cannot access the locked-in pharmacy.

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, any administered drugs not included in the Prospective Payment System (PPS) Rate are to be billed using the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS). Drugs included in the PPS Rate as documented in the CMS Manual System, Publication # 100-04, Medicare Claims Processing, Transmittal 2134 will deny if billed separately.

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 "72-96 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.

a. 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.

b. 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.

c. 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.

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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: April 24, 2014

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

1. Coverage and Limitations

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

a. Prior Authorization is not required for once per day treatment if the following criteria is met:

1. The recipient is not on concomitant therapy of an H2 antagonist or sucralfate.

b. Requests for PPIs exceeding once per day must meet one of the following:

1. The recipient has failed an appropriate duration of once daily dosing; or

2. The recipient has a diagnosis of a hypersecretory condition (e.g., Zollinger-Ellison Syndrome), esophagitis, Barrett's esophagitis, reflux esophagitis, or treatment of an ulcer caused by H.Pylori.

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, 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. Diagnosis and symptoms of ADD or ADHD, presence or absence-child behavior checklist, development and context of symptoms and resulting impairment, including school, family and peers, diagnostic 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, diagnostic 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. Diagnostic 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: July 25, 2013

Growth Hormones 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:

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

a. Genotropin® (somatropin); Humatrope® (somatropin); Norditropin® (somatropin); Nutropin® (somatropin); Omnitrope® (somatropin); Saizen® (somatropin); Tev-Tropin® (somatropin):

1. Children, (up to age 21, with open epiphyses and with remaining growth potential) must meet all of the following:

a. The recipient has had an evaluation by a pediatric endocrinologist or pediatric nephrologist with a recommendation for growth hormone therapy; and

b. The recipient has had an evaluation ruling out all other causes for short stature; and

c. The recipient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids or gonadotropic hormones.

The recipient must then meet one of the following:

1. The recipient has a diagnosis of Noonan Syndrome, Prader-Willi Syndrome or Turner Syndrome and their height is as least two standard deviations below the mean or below the third percentile for the patient's age and gender; or

2. The recipient has a diagnosis of chronic renal insufficiency (<75 mL/minute), and their height is at least two standard deviations below the mean or below the third percentile for the recipient's age and gender; or

3. The recipient has a diagnosis of being small for gestational age, the recipient is two years of age or older, and their

height is at least two standard deviations below the mean or below the third percentile for the recipient's age and gender; or

4. The recipient is a newborn infant with evidence of hypoglycemia, and has low growth hormone level (<20 ng/mL), low for age insulin like growth factor (IGF)-1 or IGF binding protein (BP) 3 (no stimulation test required for infants); or

5. The recipient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease (e.g., hypopituitarism due to structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma or cranial irradiation), and their height is at least two standard deviations below the mean or below the third percentile for the patient's age and gender.

   And recipient must meet one of the following:

   a. The recipient has failed two growth hormone stimulation tests (<10 ng/mL); or

   b. The recipient has failed one growth hormone stimulation test (<10 ng/mL) and one IGF-1 or IGFBP-3 test; or

   c. The recipient has failed one growth hormone stimulation test (<10 ng/mL) or IGF-1 or IGFBP-3 test and they have deficiencies in three or more pituitary axes (e.g., thyroid stimulating hormone (TSH), luteinizing hormone (LH), follicle stimulating hormone (FSH), adrenocorticotropic hormone (ACTH) or antidiuretic hormone (ADH).

2. Adults, (age 21 years and older, with closed epiphyses, and no remaining growth potential) must meet all of the following:

   a. The recipient is being evaluated by an endocrinologist; and

   b. The recipient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids or gonadotropic hormones; and

   c. The recipient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease (e.g., hypopituitarism due to

structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation); and

The recipient must then meet one of the following:

1. The recipient has failed two growth hormone stimulation tests (<5 ng/mL); or

2. The recipient has failed one growth hormone stimulation test (<5 ng/mL) and one IGF-1 or IGFBP-3 test; or

3. The recipient has failed one growth hormone stimulation test (<5 ng/mL) or IGFBP-3 test and has deficiencies in three or more pituitary axes (i.e., TSH, LH, FSH, ACTH, ADH), and has severe clinical manifestations of growth hormone deficiency as evident by alterations in body composition (e.g., decreased lean body mass, increased body fat), cardiovascular function (e.g., reduced cardiac output, lipid abnormalities) or bone mineral density.

3. Continued authorization will be given for recipients (up to age 21, with remaining growth potential) who meet all of the following:

a. The recipient has a diagnosis of chronic renal insufficiency, growth hormone deficiency, hypothalamic pituitary disease, newborn infant with evidence of hypoglycemia, Noonan Syndrome, Prader-Willi Syndrome, small for gestational age or Turner Syndrome; and

b. The recipient's epiphyses are open; and

c. The recipient's growth rate on treatment is at least 2.5 cm/year; and

d. The recipient does not have evidence of an expanding lesion or tumor formation; and

e. The recipient has not undergone a renal transplant.

4. Continued authorization will be given for recipients (age 21 years and older, with closed epiphyses and no remaining growth potential) who meet all of the following:

a. The recipient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease; and

b. There is documentation of improvement in clinical manifestations associated with growth hormone deficiency.

b. Serostim® (somatropin)

Recipients must meet all of the following:

1. The recipient has a diagnosis of Human Immune Deficiency Virus (HIV) with wasting or cachexia; and

2. The medication is indicated to increase lean body mass, body weight and physical endurance; and

3. The recipient is receiving and is compliant with antiretroviral therapy; and

4. The recipient has experienced an involuntary weight loss of >10% pre-illness baseline or they have a body mass index of <20 kg/m^2; and

5. The recipient has experienced an adverse event, allergy or inadequate response to megestrol acetate, or the recipient has a contraindication to treatment with this agent; and

6. The recipient has experienced an adverse event, allergy or inadequate response to an anabolic steroid (e.g., testosterone, oxandrolone, nandrolone), or the recipient has a contraindication to treatment with these agents.

c. Zorbtive® (somatropin)

Recipients must meet all of the following:

1. The recipient has a diagnosis of short bowel syndrome; and

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

3. The medication is being prescribed by or following a consultation with a gastroenterologist; and

4. The recipient is receiving specialized nutritional support (e.g., high carbohydrate, low-fat diets via enteral or parenteral nutrition).

2. Prior Authorization Guidelines:

a. Prior Authorization approval will be 12 weeks for Serostim® (somatropin).

b. Prior Authorization approval will be six months for initial authorization (for all somatropin products except for Serostim®).

c. Prior Authorization approval will be one year for continuing treatment (for all somatropin products except Serostim®).

d. 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.

1. 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. Immediate-Release Fentanyl Products

Therapeutic Class: Analgesics, Narcotic
Last Reviewed by the DUR Board: July 25, 2013

Immediate-Release Fentanyl Products 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

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

a. Subsys® (fentanyl sublingual spray), Onsolis® (fentanyl citrate buccal film), Fentora® (fentanyl citrate buccal tablet), Lazanda® (fentanyl citrate nasal spray), Abstral® (fentanyl citrate sublingual tablet) and Actiq® (fentanyl citrate transmucosal lozenge):

The recipient must meet all of the following:

1. The recipient is≥ 18 years of age or ≥ 16 years of age if requesting fentanyl citrate transmucosal lozenge (Actiq®); and

2. The recipient has pain resulting from a malignancy; and

3. The recipient is already receiving and is tolerant to opioid therapy; and

4. The recipient is intolerant of at least two of the following immediate-release opioids: hydrocodone, hydromorphone, morphine or oxycodone.

2. Prior Authorization Guidelines

a. Prior Authorization approval will be for six months.

b. 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. Immunomodulator Drugs

Therapeutic Class: Immunomodulators
Last Reviewed by the DUR Board: January 23, 2014

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

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

1. Coverage and Limitations

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

a. Rheumatoid Arthritis (RA):

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

2. The recipient has had a rheumatology consultation, including the date of the visit; and

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

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

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

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

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

b. Psoriatic Arthritis:

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

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

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

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

5. The recipient does not have active infection or a history of recurring infections.

c. Ankylosing Spondylitis:

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

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

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

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

5. The recipient does not have an active infection or a history of recurring infections.

d. Juvenile Rheumatoid Arthritis/Juvenile Idiopathic Arthritis:

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

2. The recipient is at least two years of age; and

3. The recipient has at least five swollen joints; and

4. The recipient has three or more joints with limitation of motion and pain, tenderness or both; and

5. The recipient has had an inadequate response to one DMARD; and

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

7. The recipient does not have an active infection or a history of recurring infections.

e. Plaque Psoriasis:

1. The recipient has a diagnosis of chronic, moderate to severe plaque psoriasis; and

2. The agent is prescribed by a dermatologist; and

3. The recipient has failed to adequately respond to a topical agent; and

4. The recipient has failed to adequately respond to at least one oral treatment; and

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

6. The recipient does not have an active infection or a history of recurring infections.

f. Crohn's Disease:

1. The recipient has a diagnosis of moderate to severe Crohn's Disease; and

2. The recipient has failed to adequately respond to conventional therapy (e.g. sulfasalzine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine, leflunomide); or

3. The recipient has fistulizing Crohn's disease, and;

4. The recipient has a negative tuberculin test; and

5. The recipient does not have an active infection or a history of recurring infections.

g. Ulcerative Colitis:

1. The recipient has a diagnosis of moderate to severe ulcerative colitis; and

2. The recipient has 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; and

3. The recipient has a negative tuberculin test; and

4. The recipient does not have an active infection or history of recurring infections.

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

3. Prior Authorization Guidelines

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

Prior authorization approval will be for one year.

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 26, 2012

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 and on the claim 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.

   i. For treatment with Abilify, if ICD-9 codes of 299.00 or 299.01 (autistic disorder) are written on the prescription and on the claim it will bypass the prior authorization requirement in the pharmacy POS system.

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. Xolair® (Omalizumab

Therapeutic Class: Respiratory Monoclonal Antibody Agents
Last Reviewed by the DUR Board: July 24, 2014

Xolair® (Omalizumab) 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 the following criteria are met and documented: Recipients must meet at least one condition (a. or b.) listed below:

a. The recipient must have a diagnosis of moderate to severe persistent asthma; and

The recipient must meet all of the following criteria:

1. The recipient must be age 12 years or older; and

2. The recipient must have tried or have a contraindication to inhaled oral corticosteroids; and

3. The recipient must have tried or have a contraindication to an oral second generation antihistamine; and

4. The recipient must have tried or have a contraindication to a leukotriene receptor antagonist; and

5. The prescriber must be either a pulmonologist or allergist/immunologist; and

6. The recipient must have a history of a positive skin test or Radioallergosorbent (RAST) test to a perennial aeroallergen; and

7. The recipient must have had a pretreatment serum total Immunoglobulin E (IgE) level; and

8. The recipient's current weight must be recorded.

b. The recipient has a diagnosis of chronic idiopathic urticaria (CIL), and

The recipient must meet all of the following criteria:

1. The recipient is age 12 years or older; and

2. The recipient must have tried or have a contraindication to two oral second generation antihistamines; and

3. The recipient must have tried or have a contraindication to an oral second generation antihistamine in combination with a leukotriene receptor antagonist; and

4. The prescriber must be either a dermatologist or a rheumatologist.

2. Prior Authorization Guidelines

Prior Authorization approval will be for 12 months.

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.

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: Antiemetics, Antivertigo Agents
Last Reviewed by the DUR Board: October 28, 2010

1. Coverage and Limitations

5-HT3 Antiemetics 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: August 13, 2014

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

For consideration outside these guidelines, a prior authorization may also be submitted with supporting medical necessity documentation.

1. Coverage and Limitations

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

a. Recipients younger than 12 months of age at the start of Respiratory Syncytial Virus (RSV) season, must meet one of the following criteria:

1. The recipient was born at 28 weeks, six days of gestation or earlier; or

2. The recipient has a diagnosis of chronic lung disease (CLD) of prematurity; or

3. The recipient has hemodynamically significant congenital heart disease; or

4. The recipient has congenital abnormalities of the airways or neuromuscular disease; or

5. The recipient has a diagnosis of cystic fibrosis; and

a. The recipient has clinical evidence of CLD and/or nutritional compromise.

b. Recipients younger than two years of age at the start of RSV season must meet one of the following criteria:

1. The recipient has a diagnosis of CLD of prematurity; and

a. The recipient has required medical therapy (e.g., bronchodilator, diuretics, oxygen, coritcosteroids) within six months to the start of RSV season; or

2. The recipient has had a cardiac transplant; or

3. The recipient is severely immunocompromised (solid organ or hematopoietic stem cell transplant, chemotherapy, or other conditions) during the RSV season; or

4. The recipient has had a cardiopulmonary bypass and continues to require prophylaxis after surgery or at the conclusion of extracorporeal membrane oxygenation; or

5. The recipient has a diagnosis of cystic fibrosis; and

   a. The recipient has had manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persists when stable) or weight for length less than the tenth percentile.

2. Prior Authorization Guidelines

   a. Prior Authorization approval will be up to five doses per RSV season for recipients meeting criteria.

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

Z. Cymbalta® (duloxetine)

Therapeutic Class: Sertonin-Norepinephrine Reuptake Inhibitor (SNRI)
Last Reviewed by the DUR Board: July 25, 2013

Cymbalta® 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 the following criteria are met and documented. Recipients must meet at least one diagnosis listed below:

a. Diabetic Peripheral Neuropathy (DPN):

1. If an ICD-9 code of 250.6 Diabetes with Neurological Manifestations is documented on the prescription and transmitted on the claim; or

2. Completion of a prior authorization documenting a diagnosis of Diabetes with Neurological Manifestations.

b. Fibromyalgia:

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

2. Completion of a prior authorization documenting a diagnosis of Fibromyalgia and/or Myalgia and Myositis, unspecified.

c. Chronic Musculoskeletal Pain:

The recipient must meet one of the following:

1. The recipient has experienced an inadequate response or adverse event to at least two oral or topical non-steroidal anti-inflammatory drug (NSAIDS); or

2. The recipient has an allergy or contraindication to two NSAIDS.

d. Generalized Anxiety Disorder:

The recipient must meet the following:

1. The recipient has experienced an inadequate response or adverse event to at least two antidepressants from any of the following classes: selective

serotonin reuptake inhibitors, tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors or buspirone.

e. Major Depressive Disorder:

The recipient must meet the following:

1. The recipient has experienced an inadequate response, and/or adverse event and/or an allergy and/or contraindication to at least two antidepressants.

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

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. Buprenorphine/Naloxone (Suboxone®) and Buprenorphine (Subutex®)

Therapeutic Class: Narcotic Withdrawal Therapy Agents
Last Reviewed by the DUR Board: July 25, 2013

Buprenorphine/Naloxone (Brand Suboxone®) and Buprenorphine (Brand Subutex®) 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

Nevada Medicaid encourages recipients to participate in formal substance abuse counseling and treatment.

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

a. Buprenorphine/Naloxone (Suboxone®)

The recipient must meet all of the following:

1. The recipient has a diagnosis of opioid dependence; and

2. The recipient is 16 years of age or older; and

3. There is documentation that the recipient has honored all of their office visits; and

4. The medication is being prescribed by a physician with a Drug Addiction Treatment Act (DATA) of 2000 waiver who has a unique "X" DEA number.

b. Buprenorphine (Subutex®) (for female recipients):

The recipient must meet all of the following:

1. There is documentation that the recipient is pregnant or there is documentation the recipient is breastfeeding an infant who is dependent on methadone or morphine; and

2. The recipient has a diagnosis of opioid dependence; and

3. The recipient is 16 years of age or older; and

4. There is documentation that the recipient has honored all of their office visits; and

5. The medication is being prescribed by a physician with a Drug Addiction Treatment Act (DATA) of 2000 waiver who has a unique "X" DEA number.

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

CC. Ampyra® (dalfampridine)

Therapeutic Class: Agents for the treatment of Neuromuscular Transmission Disorder
Last Reviewed by the DUR Board: July 25, 2013

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. Ampyra® (dalfampridine)

The recipient must meet all of the following:

1. The recipient must have a diagnosis of Multiple Sclerosis (ICD-9 code of 340); and

2. The medication is being used to improve the recipient's walking speed; and

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

4. The recipient is ambulatory and has an EDSS score between 2.5 and 6.5; and

5. The recipient does not have moderate to severe renal dysfunction (CrCL >50 ml/min); and

6. The recipient does not have a history of seizures; and

7. The recipient is not currently pregnant or attempting to conceive.

2. Prior Authorization Guidelines

a. Initial Prior Authorization approval will be for three months.

b. Requests for continuation of therapy will be approved for one year.

c. 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); Eliquis® (apixaban); Xarelto® (rivaroxaban)

Therapeutic Class: Thrombin Inhibitors
Last Reviewed by the DUR Board: July 25, 2013

Pradaxa® (dabigatran etexilate), Eliquis® (apixaban) and Xarelto® (rivaroxaban) 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:

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

a. Pradaxa® (dabigatran etexilate)

1. An ICD-9 code of 427.31 (Atrial Fibrillation) documented on the prescription and transmitted on the claim; or

2. An approved Prior Authorization documenting the recipient having all of the following and:

a. The recipient has a diagnosis of nonvalvular Atrial Fibrillation; and

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

c. The recipient does not have a mechanical prosthetic heart valve.

b. Eliquis® (apixaban)

1. An ICD-9 code of 427.31 (Atrial Fibrillation) documented on the prescription and transmitted on the claim; or

2. An approved Prior Authorization documenting the recipient having all of the following:

a. The recipient has a diagnosis of nonvalvular Atrial Fibrillation; and

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

c. Xarelto® (rivaroxaban)

1. An ICD-9 code of 427.31 (Atrial Fibrillation) or an ICD-9 code beginning with 415.1 (Pulmonary Embolism and Infarction) or an ICD-9 code

beginning with 453.4 (Acute Venous Embolism and Thrombosis of Deep Vessels of Lower Extremity) documented on the prescription and transmitted on the claim; or

2. An approved Prior Authorization documenting the recipient meeting all of the following:

a. The recipient has a diagnosis of nonvalvular Atrial Fibrillation, or Deep Vein Thrombosis (DVT), or Pulmonary Embolism (PE), or treatment is needed for the reduction in the risk of recurrence of the DVT or PE; and

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

2. Prior Authorization Guidelines

a. Prior Authorization approval will be for up to one year.

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

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, 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. Anti-Hepatitis Agents – Protease Inhibitor Agents

Therapeutic Class: Anti-Hepatitis Agents-Protease Inhibitors
Last Reviewed by the DUR Board: April 24, 2014

Victrelis® (boceprevir), Incivek® (telaprevir), and Olysio® (simeprevir) 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:

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

a. Victrelis® (boceprevir)

1. For treatment initiation (treatment weeks 5 through 28), the recipient must have all of the following:

a. The recipient has a diagnosis of chronic hepatitis C genotype 1 infection; and

b. The recipient will be treated with peginterferon alfa and ribavirin for four weeks prior to starting Victrelis® (boceprevir) and will continue peginterferon alfa and ribavirin for the entire duration of treatment with Victrelis® (boceprevir); and

c. The recipient has not received a previous course of therapy with Incivek® (telaprevir), Olysio® (simeprevir) or Victrelis® (boceprevir) unless the drug is being switched due to an adverse event with the alternative drug.

2. For treatment continuation for treatment weeks 28 through 36, the recipient must have one of the following:

a. The recipient is treatment-naïve and their HCV-RNA level was detectable at treatment week eight and undetectable at treatment week 24; or

b. The recipient is a previous partial responder or a relapser to peginterferon alfa and ribavirin and their HCV-RNA was undetectable at treatment week eight and treatment week 24.

3. For treatment continuation for treatment weeks 28 through 48, the recipient must have one of the following:

a. The recipient has a diagnosis of chronic hepatitis C genotype 1 with compensated cirrhosis and their HCV-RNA was detectable at treatment week 24; or

b. The recipient had a <2-$\log_{10}$ HCV-RNA drop by treatment week 12 on prior treatment with peginterferon alfa and ribavirin and HCV-RNA on triple therapy is undetectable at treatment week 24; or

c. 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 peginterferon alfa.

b. Incivek® (telaprevir)

1. For treatment initiation (weeks one through eight) the recipient must have all of the following:

a. The recipient has a diagnosis of chronic hepatitis C genotype 1 infection; and

b. The recipient will be treated with concomitant peginterferon alfa plus ribavirin; and

c. The recipient has not received a previous course of therapy with Incivek® (teaprevir), Olysio® (simeprevir) or Victrelis® (boceprevir) unless the drug is being switched due to an adverse event with the alternative drug.

2. For treatment continuation for treatment weeks nine through 12:

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

c. Olysio® (simeprevir)

1. For treatment initiation (treatment weeks one through eight), the recipient must meet all of the following:

a. The recipient has a diagnosis of chronic hepatitis C genotype 1 infection; and

b. The recipient will be treated with concomitant peginterferon alfa plus ribavirin; and

c. The recipient has not received a previous course of therapy with Incivek® (telaprevir), Olysio® (simeprevir), or Victrelis® (boceprevir) unless the drug is being switched due to an adverse event with the alternative drug; and

d. The recipient has been pre-screened and does not test positive for the 1A NS3 Q80K polymorphism.

2. For treatment continuation for treatment weeks nine through 12, the recipient must have one of the following:

a. The recipient is treatment-naïve, and their HCV-RNA level was <25 IU/mL at treatment week four; or

b. The recipient is a previous prior relapser and their HCV-RNA level was <25 IU/mL at treatment week four; or

c. The recipient is a partial or a null-responder to previous therapy of interferon and ribavirin alone (no other HCV protease inhibitors) and their HCV-RNA was <25 IU/mL at treatment week four.

2. Prior Authorization Guidelines:

a. Victrelis® (boceprevir)

1. Initial prior authorization will be for 24 weeks (through treatment week 28).

2. 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.

3. For recipients meeting criteria for continuation treatment for treatment weeks 28 through 44, a prior authorization may be renewed once for an additional 24 weeks.

b. Incivek® (teleprevir) and Olysio® (simeprevir)

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

2. For recipients meeting criteria for continuation treatment for treatment weeks nine through 12, a prior authorization approval 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

II. Duexis® (famotidine/ibuprofen)

Therapeutic Class: Anti-arthritic
Last Reviewed by the DUR Board: January 23, 2014

Duexis® (famotidine/ibuprofen) 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 the following criteria are met and documented.

a. The recipient has an allergy to generic separate famotidine and/or ibuprofen dosage forms; and

b. The recipient has tried and failed a proton pump inhibitor and/or a prostaglandin agent and/or a proton pump inhibitor, in combination with a conventional nonsteroidal anti-inflammatory drug; and

c. The recipient is intolerant of cox-2 inhibitors.

2. Prior Authorization Guidelines

a. Initial Prior Authorization approval will be for six months.

b. Recertification approval will be for one year.

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. Hereditary Angioedema Agents

Therapeutic Class: Hereditary Angioedema Agents
Last Reviewed By DUR Board: July 25, 2013

Hereditary angioedema 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. Coverage and Limitations

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

a. Cinryze® (C1 esterase inhibitor)

The recipient must meet all of the following:

1. The recipient has a diagnosis of hereditary angioedema; and

2. The medication is being prescribed by or in consultation with an allergist or immunologist; and

3. The medication is being used as prophylaxis for hereditary angioedema attacks; and

4. The recipient has experienced an inadequate response or adverse event with an attenuated androgen (e.g. danazol, stanozolol) or antifibrinolytic (e.g. tranexamic acid, aminocaproic acid) agent or has a contraindication to all agents in these classes; and

5. The recipient routinely experiences more than one hereditary angioedema attack per month, or the recipient has a history of laryngeal attacks.

b. Berinert® (C1 esterase inhibitor), Kalbitor® (ecallantide) and Firazyr® (icatibant)

The recipient must meet all of the following:

1. The recipient has a diagnosis of hereditary angioedema; and

2. The medication is being prescribed by or in consultation with an allergist or immunologist; and

3. The medication is being used to treat acute hereditary angioedema attacks.

2. Prior Authorization Guidelines

   a. Initial Prior Authorization approval will be for six months.

   b. Prior Authorization requests for continuation therapy will be approved for one year.

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

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: Cystic Fibrosis Agent
Last Reviewed by the DUR Board: July 24, 2014

Kalydeco® (ivacaftor) 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 the following criteria are met and documented:

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

   b. The recipient has a diagnosis of cystic fibrosis; and

   c. There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming the presence of one of the following G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N or S549R gene mutations.

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. Platelet Inhibitors

Therapeutic Class: Platelet Inhibitors
Last Reviewed by the DUR Board: January 23, 2014

Brilinta® (ticagrelor) and Effient® (prasugrel) 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. Brilinta® (ticagrelor)

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

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

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

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

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

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

c. Effient® (prasugrel)

1. The recipient has a diagnosis of ACS (unstable angina, non-ST elevation myocardial infarction or ST elevation myocardial infarction); and

2. The recipient does not have an active pathological bleed or history of transient ischemic attack or cerebral vascular accident (CVA); and

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

4. The recipient has a history of percutaneous coronary intervention; and

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

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

7. 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

PP. Prolia® (Denosumab)

Therapeutic Class: Bone Resorption Inhibitors (Osteoporosis Agents)
Last Reviewed by DUR Board: October 25, 2012

Prolia® (Denosumab) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board.

1. Coverage and Limitations

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

a. Postmenopausal Osteoporosis

1. The recipient has a T score ≤ -2.5, and

2. The recipient has a history of osteoporotic fracture, or has multiple risk factors for fracture, and

3. The recipient is not receiving any second line or third line osteoporosis therapy concurrently, and

4. The recipient has experienced an inadequate response, adverse event or has a contraindication to one bisphosphonate; or the recipient has had esophagitis; or the recipient is unable to remain upright.

b. Male Osteoporosis

1. The recipient has a T score ≤ -2.5, and

2. The recipient has a history of osteoporotic fracture, or has multiple risk factors for fracture, and

3. The recipient is not receiving any second line or third line osteoporosis therapy concurrently, and

4. The recipient has experienced an inadequate response, adverse event or has a contraindication to one bisphosphonate; or the recipient has had esophagitis; or the recipient is unable to remain upright.

c. Non-metastatic Prostate Cancer

1. The recipient has a history of osteoporotic fracture, or has multiple risk factors for fracture;

2. The recipient is receiving treatment with androgen-deprivation therapy (e.g., anti-androgen or luteinizing hormone-releasing hormone agents;.

3. The recipient is not receiving any second line or third line osteoporosis therapy concurrently; and

4. The recipient has experienced an inadequate response, adverse event or has a contraindication to one bisphosphonate; or the recipient has had esophagitis; or the recipient is unable to remain upright.

d. Breast Cancer

1. The recipient has a history of osteoporotic fracture, or has multiple risk factors for fracture;

2. The recipient is receiving adjuvant aromatase inhibitor therapy (e.g., anastrozole, exemestane and letrozole);

3. The recipient is not receiving any second line or third line osteoporosis therapy concurrently; and

4. The recipient has experienced an inadequate response, adverse event or has a contraindication to one bisphosphonate; or the recipient has had esophagitis; or the recipient is unable to remain upright.

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

QQ. Forteo® (Teriparatide)

Therapeutic Class: Parathyroid/Bone Formation Stimulating Agent (Osteoporosis Agents)
Last Reviewed by DUR Board: October 25, 2012

Forteo® (Teriparatide) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board.

1. Coverage and Limitations

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

a. The recipient has been diagnosed with Postmenopausal Osteoporosis; or Glucocorticoid-Induced Osteoporosis, or the recipient is male and diagnosed with Primary or Hypogonadal Osteoporosis;

b. The recipient has a T score of ≤2.5;

c. The recipient has a history of osteoporotic fracture, or has multiple risk factors for fracture;

d. The recipient has experienced an inadequate response, adverse event or has a contraindication to one bisphosphonate;

e. The recipient is not receiving any second line or third line osteoporosis therapy concurrently; and

f. The total duration of treatment with this agent has not exceeded two years.

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

RR. Cesamet® (Nabilone) and Marinol® (Dronabinol)

Therapeutic Class: Antiemetic
Last Reviewed by DUR Board: October 25, 2012

Cesamet® (Nabilone) and Marinol® (Dronabinol) 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

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

a. Cesamet® (Nabilone)

1. The recipient has a diagnosis of chemotherapy-induced nausea and/or vomiting; and

2. The recipient has experienced an inadequate response, adverse event, or has a contraindication to at least one serotonin receptor antagonist; and

3. The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one other antiemetic agent; and

4. The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the recipient.

b. Marinol® (Dronabinol)

1. The recipient has a diagnosis of chemotherapy-induced nausea and/or vomiting; and

a. The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one serotonin receptor antagonist; and

b. The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one other antiemetic agent; and

c. The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the recipient; or

2. The recipient has been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) and has anorexia associated with weight loss; and

   a. The recipient has experienced an inadequate response, adverse event or has a contraindication to megestrol (Megace®); and

   b. The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the recipient.

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

SS. Omontys® (Peginesatide)

Therapeutic Class: Erythropoiesis Stimulating Agent (ESA)
Last Reviewed by DUR Board: October 25, 2012

Omontys® (Peginesatide) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board.

1. Coverage and Limitations

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

a. The recipient has a diagnosis of anemia secondary to chronic kidney disease, and

b. The recipient must be over 18 years of age;

c. The recipient is receiving dialysis;

d. Other causes for anemia have been evaluated and ruled out (e.g., iron, vitamin B12 or folate deficiencies);

e. The recipient's hemoglobin level is <10 g/dL, (laboratory values from the previous 14 days must accompany the request); and

f. The target hemoglobin level will not exceed 11 g/dL.

2. Prior Authorization Guidelines

a. Prior Authorization approval will be for one month.

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

TT. Colony Stimulating Factors (Point of Sale Claims Only)

Therapeutic Class: Colony Stimulating Factors
Last Reviewed by the DUR Board: July 25, 2013

Colony Stimulating Factors 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

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

a. Leukine® (sargramostim)

The recipient must meet one of the following:

1. The requested medication is being used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; or

2. The recipient has a diagnosis of acute myeloid leukemia, and has received induction chemotherapy; or

3. The recipient has a diagnosis of non-Hodgkin's lymphoma, acute lymphoblastic leukemia or Hodgkin's disease and is undergoing autologous bone marrow transplantation; or

4. The recipient is undergoing allogeneic bone marrow transplantation from human leukocyte antigen-matched related donors; or

5. The recipient has undergone allogeneic or autologous bone marrow transplantation and is experiencing engraftment failure or delay.

b. Neulasta® (pegfilgrastim)

The recipient must meet the following criteria:

1. The recipient has a diagnosis of nonmyeloid malignancy and

a. The recipient is receiving myelosuppressive anticancer drugs that are associated with a febrile neutropenia risk of ≥ 20%; or

b. The recipient is at high risk for complications from neutropenia (e.g., sepsis syndrome, current infection, age >65, absolute

neutrophil count (ANC) <100 cells/µL, or the expected duration of neutropenia is > 10 days); or

c. The recipient has experienced a prior episode of febrile neutropenia and the requested drug will be used as secondary prophylaxis.

c. Neupogen® (filgrastim)

The recipient must meet one of the following (1 to 5):

1. The recipient has a diagnosis of nonmyeloid malignancy; and

a. The recipient is receiving myelosuppressive anticancer drugs that are associated with a febrile neutropenia risk of ≥20%; or

b. The recipient is at high risk for complications from neutropenia (e.g., sepsis syndrome, current infection, age >65, ANC <100 cells/µL or the expected duration of neutropenia is >10 days); or

c. The recipient has experienced a prior episode of febrile neutropenia and the requested drug will be used as a secondary prophylaxis; or

2. The recipient has a diagnosis of acute myeloid leukemia and has received induction or consolidation chemotherapy; or

3. The recipient has a diagnosis of nonmyeloid malignancy and is undergoing myeloablative chemotherapy followed by marrow transplantation; or

4. The recipient has a diagnosis of symptomatic congenital neutropenia, cyclic neutropenia or idiopathic neutropenia; or

5. The requested medication is being used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.

2. Prior Authorization Guidelines

a. Prior Authorization approval will be for one month.

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

UU. Auvi-Q (epinephrine injection device)

Therapeutic Class: Anaphylaxis-Self Injectable Epinephrine
Last Reviewed by the DUR Board: January 23, 2014

Auvi-Q (Epinephrine Injection Device) 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 the following criteria are met and documented:

   a. The recipient or recipient's caregiver is unable to read or comprehend written directions.

2. Prior Authorization Guidelines

   a. Initial Prior Authorization approval will be for one year.

   b. Recertification approval will be for one year.

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

VV. Sovaldi® (sofosbuvir)

Therapeutic Class: Anti-Hepatitis Agents-Polymerase Inhibitor Agents
Last Review by the DUR Board: April 24, 2014

Sovaldi® (sofosbuvir) 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 Sovaldi® (sofosbuvir) for mono-infected or HCV/HIV-1 co-infected recipients will be given if the following criteria are met and documented:

   a. The recipient has a diagnosis of chronic hepatitis C Genotype 1 infection; and the recipient will be treated in combination with peginterferon alfa and ribavirin or, if the recipient is ineligible to receive peginterferon alfa, in combination with ribavirin; or

   b. The recipient has a diagnosis of Chronic Hepatitis C Genotype 2 or 3 Infection; and the recipient will be treated in combination with ribavirin; or

   c. The recipient has a diagnosis of Chronic Hepatitis C Genotype 4 Infection; and the recipient will be treated in combination with peginterferon alfa and ribavirin; or

   d. The recipient has a diagnosis of Chronic Hepatitis C Genotype 1, 2, 3, or 4 infection; and the recipient has a diagnosis of hepatocellular carcinoma and is awaiting a liver transplant; and the recipient will be treated in combination with ribavirin.

2. Prior Authorization Guidelines:

   a. Prior Authorization approval will be for 12 weeks for ALL of the following:

      1. Recipients with a diagnosis of Chronic Hepatitis C Genotype 1 infection and combination therapy with peginterferon alfa and ribavirin.

      2. Recipients with a diagnosis of Chronic Hepatitis C Genotype 2 infection and combination therapy with ribavirin.

   b. Prior Authorization approval will be for 24 weeks for all of the following:

      1. Recipients with a diagnosis of Chronic Hepatitis C Genotype 1 infection and combination therapy with ribavirin.

2. Recipient with a diagnosis of Chronic Hepatitis C Genotype 3 infection and combination therapy with ribavirin.

c. Prior Authorization approval will be for up to 48 weeks or until liver transplantation for recipients with a diagnosis of hepatocellular carcinoma and is awaiting a liver transplant combination therapy with ribavirin.

d. Prior Authorizations will be renewed in 12 week intervals based on genotype.

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

WW. Medications for the Treatment of Acne

Therapeutic Class: Acne Agents
Last Reviewed by the DUR Board: July 24, 2014

Acne 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. Coverage and Limitations

No prior authorization necessary for recipients up to 21 years of age.

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

a. The recipient is age 21 years of age or older; and

b. The recipient has a diagnosis of moderate to severe acne (Grade III or higher).

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.

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