MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

March 28, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1200 – Prescribed Drugs are being proposed to include Over-the-Counter (OTC) diabetic supplies to the list of exclusions on the current Maximum Allowable Cost (MAC) limits. Additionally, to change the current Atypical Antipsychotic Drugs section title to Long-Acting Injectable (LAI) Antipsychotics and add new clinical criteria for all LAIs to conform with FDA-approved label. Lastly, to update current gender edits for prenatal vitamins and oral/topical contraceptives.

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

These changes are effective April 3, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL N/A	MTL N/A
MSM Chapter 1200 - Prescribed Drugs	MSM Chapter 1200 - Prescribed Drugs

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section E	**Over-the-Counter (OTC) Drugs**	Adds diabetic supplies to prior authorization and OTC MAC limit exclusion.
Appendix A Section FFF	**Antipsychotic Drugs: Atypical**	Revised title to “Long-Acting Injectable (LAI) Antipsychotics. Added new clinical criteria for all LAIs.
Appendix B Section 2(A)-(B)	**Medications with Gender/Edits**	Revised gender edits for prenatal vitamins and oral/topical contraceptives.

E. Over-the-Counter (OTC Drugs) Drugs

Last Reviewed by the DUR Board: N/A

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

1. Coverage and Limitations

   a. OTC drugs must be FDA approved and manufactured by pharmaceutical companies participating in the Federal Medicaid Drug Rebate Program.

   b. OTC drugs are limited to two prescription requests for medications within the same therapeutic class.

   c. Nevada Medicaid will reimburse up to the OTC Maximum Allowable Cost (MAC) listed in the OTC MAC table. Refer to the Nevada Medicaid Nevada Check Up Pharmacy Manual for details.

   d. Insulin and diabetic supplies areis exempt from any prior authorization and OTC MAC limits.

2. Prior Authorization Guidelines:

   a. Prior Authorization is required for more than two prescriptions within the same therapeutic class. Determinations are based on medical necessity and may require additional information.

   b. Approval will be for a one-month time limit.

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FFF. ~~Antipsychotic Drugs: Atypical~~Long-Acting Injectable (LAI) Antipsychotics

Therapeutic Class: Second Generation (Atypical) Antipsychotic
Last Reviewed by the DUR Board: July 28, 2022

LAI antipsychotic drugs are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.
~~Atypical Antipsychotic Drugs~~

1. General for all LAIs:

   a. Treatment-naïve patients require documentation confirming tolerance to the oral formulation prior to transitioning to the LAI.

~~1.~~2. Invega Trinza® (paliperidone palmitate)

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

      1. The recipient has a diagnosis of schizophrenia; and

      2. The recipient has been stabilized on once-monthly paliperidone palmitate~~palmitrate~~ injection (Invega Sustenna®) for at least four months with the two most recent doses of the once-monthly injection being the same strength; and

      3. The recipient is 18 years of age or older; and

      4. The requested dose is one injection every three months.

   b. Prior Authorization Guidelines

      1. Prior authorization approvals will be for 12 months~~one year~~.

~~2.~~3. Invega Hafyera® (paliperidone palmitate)

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

      1. The recipient has a diagnosis of schizophrenia; and

      2. The recipient has been stabilized on once-monthly paliperidone ~~palperidone~~ palmitate~~palmitrate~~ extended-release (PP1M) injectable suspension (Invega Sustenna®) for at least four months, the two most recent doses of the once-monthly injection being the same strength or one dose of three-month IM paliperidone (Invega ~~Inevga~~ Trinza®); and

      3. Patient is 18 years of age or older; and

      4. The requested dose is one injection every six months.

   b. Recertification Requests:

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1. Documentation confirming ~~Recipient must have~~ a positive response from therapy.

c. Prior Authorization Guidelines:

1. Prior authorization approvals will be for 12 months~~one year~~.

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2. MEDICATIONS WITH GENDER/AGE EDITS

A. Prenatal Vitamins

1. Payable only for female recipients.

2. Exemption to the above gender edits:

A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriate ICD code is documented on the prescription and transmitted on the claim.

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B. Oral/Topical Contraceptives

1. Payable only for female recipients.

2. Exemption to the above gender edits:

A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriate ICD code is documented on the prescription and transmitted on the claim.

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