EqualityCare Pharmacy News

Dear Providers: **September 2, 2009**

Recent Wyoming DUR recommendations have been approved by the Department of Health, Office of Pharmacy Services and will be implemented in various therapeutic drug categories.

The following medications will have new dosing limits (Effective 09/30/09):

- **TORADOL (ketorolac)** Max 5 Day Duration/34 Days
- **ULTRACET (tramadol/apap)** Max 5 Day Duration/34 Days
- **DARVON (propoxyphene)** Max Dose ≤ 6 tablets/Day

New Drugs and PDL criteria (Effective 09/30/09):

- **APRISO** 14-Day trial and failure of Asacol will be required prior to approval.
- **ELIPHOS** 14-Day trial and failure of PhosLo will be required prior to approval.
- **NUCYNTA** Trial and failure of three (3) other short-acting CIIs at least 14-days each.
- **NUVIGIL** 14-Day trial and failure of Provigil will be required prior to approval.
- **RYZOLT** Trial and failure of Ultram ER. Max Dose 300mg/day.
- **FENOFIBRATE** Generic fenofibrate has been added as a preferred agent to the PDL.
- **LEXAPRO** Preferred agent for adolescents between the ages of 12-17; will remain non-preferred antidepressant (step therapy required) for all other age groups.
- **FIBROMYALGIA AGENTS** Cymbalta, Lyrica, and Savella, for diagnosis of fibromyalgia, will require a 6 week trial and failure of amitriptyline or cyclobenzaprine prior to any approval for these medications.
- **PROTON PUMP INHIBITORS** Omeprazole and Kapidex will become preferred agents, joining Protonix and Prilosec OTC. Kapidex will replace Prevacid which will no longer be preferred; however, if a client is ≤ 8 years of age, they may continue to receive Prevacid Solutabs.
- **MIGRAINE AGENTS** Brand Imitrex is no longer preferred; sumatriptan is now a preferred agent. However, to allow pharmacies time to adjust their inventory, clients may receive brand Imitrex until 12/31/09.

Miscellaneous Information (Effective 09/30/09):

- **SYNAGIS** Prior authorization will be required before mid-November and after late-March or as identified by EqualityCare. Notification will be provided as to the exact PA dates once determined by the Department of Health. Synagis will be limited to 5 doses per season; each dose must be at least 28 day supply or greater.

Products No Longer Covered (Effective Immediately):

- **DRISDOL (calciferol)** NDC's (00024-0391 Drisdol and 00091-4150 calciferol) do not meet the definition of a covered outpatient drug by CMS; therefore, they are no longer covered.

Stimulant update / Key points:

Preferred Stimulants: Adderall XR, Vyvanse, amphetamine salts combo, dextroamphetamine, Strattera, Concerta, Focalin XR, methylphenidate ER, dexmethylphenidate, methylphenidate

For a preferred stimulant, client must meet clinical criteria:

- Diagnosis of ADD or ADHD must be on a client's medical profile; otherwise, a prior authorization will be required.
- Prior authorization will be required for clients < 5 years of age.
- Prior authorization will be required if client has a history of glaucoma, cardiac arrhythmias, arteriosclerosis, untreated hypertension, substance abuse, or current MAO inhibitor use.

Dosing limits will apply (150% labeled max)	
Amphetamine salts	90mg/day
Adderall XR (Brand Adderall XR is preferred)	45mg/day
Concerta	135mg/day
d-amphetamine SA	45mg/day
d-amphetamine	90mg/day
Daytrana	45mg/9hours
Dexedrine/Dextro-stat	60mg/day
Focalin/Focalin XR	30mg/day
Methylphenidate, Methylin, Methylin ER	135mg/day
Ritalin, Ritalin SR	135mg/day
Ritalin LA	90mg/day
Strattera	150mg/day
Metadate CD	90mg/day
Vyvanse	105mg/day

For a non-preferred stimulant, a client must have a trial and failure of at least two preferred stimulants, each from a different class, greater than or equal to a 30 day supply within the last 12 months.

PRIOR AUTHORIZATION PROCESS: All prior authorizations are to be submitted via fax to GHS at 866-964-3472; prior authorizations will not be done over the phone. If prior authorizations are sent to another fax number other than the number listed above, this may delay the processing of a PA. Prior authorization forms may be obtained online at www.wyequalitycare.org or from the GHS Help Desk staff at 877-207-1126. Prior authorizations will be addressed within 24 hours.

Prior Authorization Forms (www.wyequalitycare.org):

Miscellaneous/PA Form: This form is used for most prior authorizations; please refer to the exception below when a Brand Name PA form is required.

Brand Name PA Form: *Please use only if brand is medically necessary when an A/B rated generic equivalent is available.* This form must be accompanied with a completed FDA MedWatch.

The following definitions correspond to the determination of prior authorization:

Approved: Client meets the prior authorization criteria; therefore, the PA has been approved.

Denied: Client does not meet the prior authorization criteria; therefore, the PA has been denied.

Deferred: There is not enough information available to determine if client meets PA criteria; therefore the PA has been "deferred" requesting additional information from the provider.

Not Required: A prior authorization is not required as client has met the criteria for the claim to process without a prior authorization. If the pharmacy is having difficulty processing the prescription, please have them contact the GHS Pharmacy Help Desk.

Please refer to www.wyequalitycare.org for the Preferred Drug List (PDL), clinical criteria, and PA forms.