Wyoming
Department
of Health

Division of Healthcare Financing

Medicaid Pharmacy News

Dear Providers: December 17, 2015

ADAP AND TB CLAIMS

Effective January 1, 2016 claims for the Aids Drug Assistance Program (ADAP) and the Tuberculosis (TB) program ***WILL NO LONGER BE PROCESSED*** through Goold Health Systems' Point-of-Sale system. Starting on January 1st, claims for those two programs will need to be submitted to ScriptGuide RX. For information regarding processing claims with ScriptGuide RX, please contact the ScriptGuide RX help desk at 855-367-7479.

CLIENT PHONE CALLS TO PHARMACY HELP DESK

Recently, the GHS pharmacy help desk has begun to see an increase in the number of phone calls from Medicaid clients stating that they have been directed to contact the pharmacy help desk to assist in the resolution of pharmacy claim issues. ***GHS, as the pharmacy help desk, does not have the ability to resolve any questions or concerns with Medicaid clients themselves. When issues arise with Medicaid client's pharmacy claims, the pharmacy and/or the prescriber should be contacting GHS to resolve those issues. Directing a Medicaid client to contact the pharmacy help desk, will only delay any resolution that our help desk technicians and pharmacists can provide.***

2016 PHARMACY PROVIDER MANUAL

The 2016 Pharmacy Provider Manual is now available for online viewing at www.wymedicaid.org. Please call the GHS Pharmacy Help Desk with any questions regarding the Pharmacy Provider Manual. If a provider would like a paper copy, the GHS Pharmacy Help Desk will mail a copy upon request.

NEW THERAPEUTIC CATEGORIES/PREFERRED DRUG LIST (PDL) CHANGES (Effective 01/01/2016)

Please refer to http://wymedicaid.org/ for the complete PDL.

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
ADDICTION AGENTS	***Bunavail will be non-preferred**
ALLERGY/ASTHMA Corticosteroid/Bronchodilator Combinations	Advair HFA will be preferred
ALLERGY/ASTHMA Nasal Antihistamines	***Azenase will be non-preferred (use separate agents)**
ALLERGY/ASTHMA Nasal Steroids	*** Azenase will be non-preferred (use separate agents)**
ALLERGY/ASTHMA Steroid Inhalants	Pulmicort Susp 0.25mg/2mL and 0.5mg/2mL will be preferred ***Budesonide susp 0.25mg/2mL and 0.5/2mL will be non-preferred (brand is preferred)**
ANTIBIOTICS Inhaled Tobramycin	Kitabis will be preferred TOBI Podhaler will be preferred with clinical criteria (requires PA) ***Bethkis and inhaled tobramycin will be non-preferred**
ANTICONVULSANTS Oral Anticonvulsants	Fycompa will be preferred with clinical criteria (requires PA)
ANTIHYPERTENSIVES ARBs	Valsartan will be preferred with clinical criteria (requires PA)
ATYPICAL ANTIPSYCHOTICS	Aripiprazole will be preferred ***Aristada will be non-preferred (use preferred)**
CHOLESTEROL Intestinal Cholesterol Inhibitor	Zetia will be preferred
DIABETES Incretin Mimetics (GLP-1 Receptor Agonists)	Bydureon will be preferred with clinical criteria (requires PA) ***Tanzeum will be non-preferred**

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
DIABETES SGLT2 Inhibitors	***Invokana will be non-preferred**
DIABETES SGLT2 Inhibitor Combo Agents	***Invokamet will be non-preferred**
EAR Antibiotic/Steroid Combination	***Ofloxacin will be non-preferred**
GASTROINTESTINAL Bowel Prep	Prepopik will be preferred
GASTROINTESTINAL Digestive Enzymes	Pancrelipase will be preferred
GASTROINTESTINAL Mesalamine	Delzicol will be preferred ***Apriso will be non-preferred**
GROWTH HORMONE	Nutropin AQ will be preferred with clinical criteria (requires PA) ***Humatrope will be non-preferred**
HEART FAILURE	Entresto will be preferred
IMMUNOMODULATORS Hidrodenitis Suppurativa	Humira will be preferred with clinical criteria (requires PA)
IMMUNOMODULATORS Plaque Psoriasis	Cosentyx will preferred with clinical criteria (requires PA)
MULTIPLE SCLEROSIS Interferon	Aubagio and Rebif will be preferred with clinical criteria (requires PA)
OPHTHALMICS Anti-inflammatory NSAIDS	Ilevro and Nevanac will be preferred
PHOSPHATE BINDERS	Renagel 400mg will be preferred ***Renagel 800mg will be non-preferred (use preferred)**
STIMULANTS Long Acting Amphetamines	Adderall XR and Vyvanse will be preferred with clinical criteria (requires PA) ***Amphetamine salts combo XR will be non-preferred (brand is preferred)**
STIMULANTS Long Acting Methylphenidates	Only authorized generics of Concerta will be covered
STIMULANT-LIKE AGENTS Guanfacine Agents	If clients meet the clinical requirements to receive extended release guanfacine, Intuniv will be the non-preferred agent that will be allowed instead of the generic
TOPICAL AGENTS Scabicides/Pediculocides	Sklice will be preferred ***Lindane will be non-preferred**