Wyoming
Department
of Health

Division of Healthcare Financing

Medicaid Pharmacy News

Dear Providers: December 16, 2016

NEW THERAPEUTIC CATEGORIES/PREFERRED DRUG LIST (PDL) CHANGES (Effective 01/01/2017)

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

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/ PDL CHANGES
ALLERGY/ASTHMA Epinephrine	Epinephrine auto-injector pen will be preferred
CONVULSIONS	Aptiom will be preferred with clinical criteria (requires PA)
DERMATOLOGY Scabicides/Pediculicides	Permethrin 5% cream will be preferred
DIABETES Meglitinides	Nateglinide will be preferred
DIABETES Dipeptidyl Peptidase 4 Inhibitors	Onglyza will be non-preferred
DIABETES DPP 4 Inhibitor Combo Agents	Kombiglyze will be non-preferred
DIABETES Incretin Mimetics	Byetta will be preferred with clinical criteria (requires PA) ***Bydureon will be non-preferred**
DIABETES SGLT2 Inhibitors	Jardiance will be preferred with clinical criteria (requires PA) ***Farxiga will be non-preferred** ***Invokamet, Synjardy and Xigduo XR will be non-preferred (use separate preferred agents)**
GASTROINTESTINAL Digestive Enzymes	***Pancrelipase will be non-preferred**
GASTROINTESTINAL Pregnancy Induced Nausea/Vomiting	Diclegis will be preferred
GASTROINTESTINAL Mesalamine	Pentasa 500mg will be preferred ***Delzicol and Giazo will be non-preferred**
GOUT	Mitigare will be preferred ***Colchicine and Colcrys will be non-preferred**

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
HYPERLIPIDEMIA Statins, High Potency	***Rosuvastatin will be non-preferred**
HYPERTENSION	***Epaned solution will be non-preferred**
INFECTIOUS DISEASE Inhaled Tobramycin	Bethkis will be preferred
INFECTIOUS DISEASE Anti-Retrovirals	Descovy, Evotaz, Genvoya, Odefsey and Prezcobix will be preferred
MENTAL HEALTH Alzheimer Agents	Donepezil/ODT will be preferred ***Namenda XR will be non-preferred, Namzaric will be non-preferred (use separate agents)**
MENTAL HEALTH Long Acting Amphetamines	Adzenys XR ODT will be preferred
MENTAL HEALTH Short Acting Methylphenidates	Dexmethylphenidate IR will be limited to the authorized generics
MIGRAINE	Relpax will be preferred
OPHTHALMICS Anti-Allergics	Olopatadine and Pazeo will be preferred ***Pataday and Patanol will be non-preferred**
OPHTHALMICS Anti-Inflammatories	***Nevanac will be non-preferred**

DOSAGE LIMITATION LIST CHANGES (Effective 01/01/2017)

Nuvigil	375 mg daily
Modafanil	300 mg daily
Treximet 10/60 mg	5 tabs/34 days

ADDITIONAL THERAPEUTIC CRITERIA CHART CHANGES (Effective 01/01/2017)

- Dysport will require prior authorization; client must have diagnosis of cervical dystonia (spasmodic torticollis), upper limb spasticity and lower limb spasticity in pediatric patients two years of age and older.
- Generic naloxone formulations available in quantities of 10ml will require prior authorization. Other generic forms of naloxone including vials, cartridges, and prefilled syringes will not require prior authorization.
- Modafanil/Nuvigil now have dosing limitations - see chart above, all previous criteria still apply.
- Orkambi will require prior authorization; client must have a diagnosis of cystic fibrosis and have lab documentation showing the client is homozygous for the F508del mutations in the CFTR gene and must be six years of age or older.

2017 PHARMACY PROVIDER MANUAL

The 2017 Pharmacy Provider Manual is now available for online viewing at www.wymedicaid.org. Please call the CHC Pharmacy Help Desk with any questions regarding the Pharmacy Provider Manual. If a provider would like a paper copy, the CHC Pharmacy Help Desk will mail a copy upon request.