EqualityCare Pharmacy News

Dear Providers: December 16, 2010

Please see below for the following changes to Wyoming EqualityCare:

DATE OF BIRTH REJECTIONS

The Wyoming EqualityCare Pharmacy Program has been monitoring all Date of Birth (DOB) rejections from pharmacy providers with the implementation of our Pharmacy Benefits Manager, Goold Health Systems, Inc (GHS). At the present time, the Point-of-Sale (POS) system provides the pharmacy with the date of birth on file when a claim is submitted to EqualityCare and there is a discrepancy between the DOB submitted and the one on file.

When the Office of Pharmacy Services (OPS) researches the DOB rejections, there are occasions when a pharmacy has entered the correct DOB but the system supplying the information to the POS has an incorrect DOB. In such cases, the OPS will update the system which supplies dates of birth to the POS system. It may take 30 to 60 days for the research and system updates to occur. Once all systems are updated, the OPS will notify the pharmacy of the correction and inform them to start submitting the corrected DOB. **It is the responsibility of the pharmacy to ensure they are filling the prescription for the correct person and verify that the DOB for the client is correct.** If there are any discrepancies between what the client states is their DOB and what is being provided by EqualityCare, you may contact GHS at 1-877-209-1264 to start the research process. This will allow DOB discrepancies to be handled in a more expeditious manner.

The OPS would like to thank all pharmacy providers for taking the time to verify the patient's name, DOB, and EqualityCare number on each prescription filled for our clients.

COMPOUND CLAIM REMINDER

Wyoming EqualityCare is requiring that **all pharmacies** submit all compound claims correctly by **February 1, 2011**. Pharmacies can work with the GHS Helpdesk (877-209-1264) and their respective software vendors to correctly bill compounds. **After February 1, 2011**, all compound claims billed to Wyoming EqualityCare incorrectly are subject to full recovery. **ANY PRESCRIPTION** that is dispensed as a compound must be submitted as a **multi-ingredient** compound claim to ensure the accuracy of the EqualityCare client's profile. Pharmacy lack of understanding of compound claim billing **must not** result in client(s) being required to pay for their compounded prescriptions or payment being waived without claim submission. It is important that each pharmacy staff member who bills Wyoming EqualityCare become fully educated on the proper billing of compound claims. The Compound Training Sheet is available at http://wyequalitycare.org/ and any questions concerning compounds should be directed to the GHS Helpdesk (877-209-1264).

PRESCRIPTION DRUG ASSISTANCE PROGRAM (PDAP)
INSULIN CLAIMS

According to the Wyoming EqualityCare Pharmacy Provider Manual "A prescription's day supply must equal the quantity of drug dispensed divided by the daily dose prescribed". Thus, for PDAP clients, any claim for one insulin vial for which the dosing exceeds a 30 day supply, the correct day supply must be submitted and the pharmacy will have to contact the GHS Helpdesk (877-209-1264) for an override.

COLCHICINE

The Wyoming EqualityCare **Pharmacy** Program has **DISCONTINUED** covering the products below. The Food and Drug Administration (FDA) has determined that the following active single-ingredient oral colchicine NDCs are unapproved new drugs within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act, subject to enforcement action, and cannot be marketed without appropriate FDA approval. According to the FDA, these products do not have approved New Drug Applications; therefore, the NDCs do not meet the definition of a covered outpatient drug as defined in Section 1927(k) of the Social Security Act and are subsequently no longer eligible for inclusion in the rebate program.

PRODUCT NAME	NDC
COLCHICINE TABLET 0.6MG	00143-1201
COLCHICINE 0.6MG TABLETS	64125-0104
COLCHICINE 0.6MG	68013-0001

DEVICE PRODUCTS

CMS has determined that the following device products do not meet the definition of a covered outpatient drug as set forth in Section 1927(k)(2) of the Social Security Act (the Act). The FDA has informed us that labeler 42546 received approval to market these products as devices under section 510(k) of the Federal Food, Drug and Cosmetic Act. As a result, they are no longer eligible for inclusion in the Medicaid Drug Rebate Program.

PRODUCT NAME	NDC
PRUTECT CREAM	42546-0130
PRUCLAIR CREAM	42546-0412

NEW THERAPEUTIC CATEGORIES/PREFERRED DRUG LIST (PDL) CHANGES (EFFECTIVE 01/01/2011)

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

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
ALLERGY/ASTHMA Anticholinergic Bronchodilators	ipratropium and Spiriva **Note: Atrovent HFA is no longer preferred**
ALLERGY/ASTHMA Corticosteroid/Bronchodilator Combinations	Advair/HFA, Dulera, and Symbicort
ALLERGY/ASTHMA Nasal Steroids	fluticasone, Nasacort AQ, and Nasonex **Note: Veramyst is no longer preferred**
ALLERGY/ASTHMA Steroid Inhalants	Asmanex, budesonide, Flovent HFA, FloventDisk, and Qvar **Note: Azmacort and Pulmicort are no longer preferred**
ALZHEIMERS	Aricept 5 or 10mg, Exelon, galantamine/ER, and Namenda **Note: Preferred agents will now require a diagnosis of dementia** **Aricept 23mg/ODT and the generic rivastigmine are non-preferred**
ANALGESICS	Suboxone/Film **Note: Only one (1) narcotic prescription will be allowed between fills and dosage limits do apply. Subutex is non-preferred but will be approved in pregnancy**
ANGIOTENSIN MODULATORS Angiotensin Receptor Blockers (ARBs)	Avapro, Benicar, Diovan, losartan, and Micardis **Note: Brand Cozaar is no longer preferred**
ANGIOTENSIN MODULATORS ARBs and Diuretics	Avalide, Benicar HCT, Diovan HCT, losartan HCT, and Micardis HCT **Note: Brand Hyzaar is no longer preferred**
ANGIOTENSIN MODULATORS ARB Combinations	Azor and Exforge/Exforge HCT **Note: Twynsta is no longer preferred**
ANTICONVULSANTS	Diastat (Brand is preferred)
ANTIDEPRESSANTS	Cymbalta will now be approved for diagnosis of osteoarthritis of the knee
ANTIPSYCHOTICS	Abilify, Geodon, Invega, Invega Sustenna, Risperdal Consta, risperidone, Seroquel, Zyprexa, Zyprexa Relprevv **Note: Seroquel XR and Abilify ODT are no longer preferred**
CHOLESTEROL Statins, Low Potency	Lescol, lovastatin, and pravastatin **Note: Lescol XL is no longer preferred**
CHOLESTEROL Statin Combinations	Caduet and Simcor **Note: Advicor is no longer preferred**
CHOLESTEROL Triglyceride Lowering Agents	fenofibrate, gemfibrozil, and Tricor **Note: Trilipix is no longer preferred**
CHOLESTEROL Bile Acid Sequestrants	cholestyramine/light and colestipol
COLD AND COUGH	Delsym
DIABETES Thiazolidinediones	Actos 15mg **Note: Actos 30 and 45mg are no longer preferred**

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
DIABETES Dipeptidyle Peptidase 4 (DPP-4) Inhibitors	Janumet, Januvia, and Onglyza **Note: Preferred agents will require a 90 day supply of metformin prior to approval**
DIABETES Long-Acting Insulin	Lantus and Levemir
DIABETES Rapid-Acting Insulin	Apidra, Humalog, and Novolog
EAR	Cetraxal, Ciprodex, Cipro HC, Coly-Mycin S, Cortisporin TC, neomycin/polymixin B sulfates/hydrocortisone
ERYTHROPOIETICS	Aranesp and Procrit
GASTROINTESTINAL Digestive Enzymes	Creon Units and Zenpep **Note: Pancreaze and Tri-pase are no longer preferred**
GROWTH HORMONE	Genotropin, Norditropin, and Nutropin/AQ **Note: Omnitrope is no longer preferred**
MIGRAINE	Maxalt MLT, naratriptan, and sumatriptan **Note: Trial and failure of ONE preferred agent will be required for approval of a non-preferred agent**
MULTIPLE SCLEROSIS	Avonex, Beta Seron, Copaxone, and Rebif **Note: Gilenya is non-preferred and requires a trial and failure of 1 interferon agent, Copaxone, and Tysabri.**
OPTHALMICS Anti-inflammatory NSAIDs	flurbiprofen, diclofenac, and ketorolac **Note: Brand Acular is no longer preferred**
OPTHALMICS Mast Cell Stabilizers	azelastine, cromolyn, ketotifen, Pataday, and Patanol **Note: Brand Optivar is no longer preferred**
OSTEOPOROSIS	alendronate **Note: Boniva is no longer preferred**
OVERACTIVE BLADDER	Oxybutynin/ER, Toviaz, trospium, and Vesicare **Note: Enablex and Sanctura XR are non-preferred**
PROSTATE Alpha Blockers	doxazosin, tamsulosin, and terazosin **Note: Uroxatral is no longer preferred**
STIMULANTS Amphetamines (Long-Acting)	**Note: Adderall XR will only be preferred for those clients who have required diagnoses and are <u>currently on the medication</u>**
STIMULANTS Methylphenidates (Long-Acting)	Concerta, Daytrana, Focalin XR, methylin ER, and methylphenidate ER/CR/SR
TOPICAL AGENTS Impetigo Antibiotics	gentamicin and mupirocin **Note: Trial and failure of ALL preferred agents greater than or equal to 7 days in the past 90 days is required for approval of a non-preferred agent**
TOPICAL AGENTS Benzoyl Peroxide/Clindamycin Combinations	benzoyl peroxide/clindamycin **Note: Brand Benzaclin is no longer preferred**
TOPICAL AGENTS Corticosteroids (Low Potency)	alclometasone, desonide, fluocinolone 0.01%, hydrocortisone butyrate 0.1% cream, hydrocortisone 1%/2.5% (C,L,O), prednicarbate

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
TOPICAL AGENTS Corticosteroids (Medium Potency)	betamethasone valerate, desoximetasone 0.05% cream, fluocinolone 0.025%, fluticasone 0.05% cream, hydrocortisone butyrate 0.1% ointment, hydrocortisone probutate0.1% cream, mometasone, and triamcinolone 0.025%/0.1%
TOPICAL AGENTS Corticosteroids (High Potency)	amcinonide, betamethasone dipropionate, clobetasol, desoximetasone 0.25%/0.05% gel, diflorasone, fluocinonide, fluradrenolide, fluticasone 0.005% ointment, halobetasol, triamcinolone 0.5%