EqualityCare Pharmacy News

Dear Providers: April 18, 2011

EMERGENCY SUPPLY REMINDER

In the event of an emergency the pharmacy is authorized to dispense up to a 72 hour emergency supply. An emergency supply may only be used twice for each drug per month. A dispensing fee will not apply. Please refer to the payer sheet in the Pharmacy Provider Manual for instructions for PA code type and PA number field. **Use of the emergency supply for non-emergency situations or to override the Prior Authorization process will result in recovery of claim payment and possibly further Program Integrity actions**.

IMPLANON AND MIRENA

Implanon and Mirena are not covered through the Pharmacy Point-of-Sale (POS) system; however EqualityCare will consider overrides to allow the billing of those medications for residents of Residential Health Care Centers (RHC) and Federally Qualified Health Care Centers (FQHC) through the POS system. If a pharmacy is asked to submit a claim for Implanon or Mirena for a resident of one of these facility types, they will first have to contact GHS POS pharmacy help desk at 877-209-1264 to receive approval and an override. The medication must be delivered/mailed directly to the facility and not dispensed directly to the patient.

COUGH AND COLD PRODUCTS

Wyoming EqualityCare **will not cover** any cough and cold products that are not approved by the Food and Drug Administration (FDA). To determine if a cough and cold product is an FDA approved medication please refer to http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/EnforcementActivitiesbyFDA/SelectedEnforcementActionsonUnapprovedDrugs/ucm245106.htm. In addition, the **only cough and cold products that are covered** by Wyoming EqualityCare can be found at http://wyequalitycare.org/ under cough and cold products.

COVERAGE OF DIAPERS AND UNDERPADS REMINDER

As a reminder, Wyoming EqualityCare does cover diapers with the following limitations: a maximum of 13 diapers per day and a maximum of a 34 day supply at one time, for clients who are 3 years of age and older. However, underpads, liners, shields, etc. are not covered through Wyoming EqualityCare.

LANSOPRAZOLE ORALLY DISINTEGRATING TABLETS BLOCKING FEEDING TUBES AND ORAL SYRINGES

The Food and Drug Administration (FDA) has received reports that Teva's lansoprazole delayed-release orally disintegrating tablet has clogged and blocked oral syringes and feeding tubes, including both gastric and jejunostomy types, when the drug is administered as a suspension through these devices. The tablets may not fully disintegrate when water is added to them and/or they may disintegrate but later form clumps. These clumps can adhere to the inside walls of oral syringes and feeding tubes. In some cases, patients have had to seek emergency medical assistance and their feeding tubes have had to be unclogged or removed and replaced. The FDA recommends that healthcare professionals evaluate their medication stock and ***not dispense the Teva lansoprazole delayed-release ODT product to patients for whom the product will be administered through an oral syringe or feeding tube***.

STATE MAXIMUM ALLOWABLE COSTS AND OTHER PRICING DISPARITIES

The State Maximum Allowable Cost pertains to both multi-source generic and single source drug products. A SMAC price is the maximum allowable cost per unit that will be reimbursed for Wyoming EqualityCare prescriptions. If a SMAC price or other price reimbursement is found to be less than a provider's actual acquisition cost, the provider can submit their invoice and claims data for prescriptions reimbursed below cost to the Wyoming SMAC Help Desk via fax at 877-308-6931. GHS will submit to the Wyoming Department of Health, Office of Pharmacy Services any adjustment to the current SMAC for state approval. To obtain SMAC Review forms please go to http://wyequalitycare.org and submit as instructed. Drugs with a SMAC can be found at http://wyequalitycare.org.

MISCELLANEOUS INFORMATION (EFFECTIVE MAY 4, 2011)

- **Mirena** will no longer be covered by through the pharmacy program.
- **OTC vitamins** will no longer be covered through the pharmacy program.
- **Total Parenteral Nutrition (TPN) products** will no longer be covered through the pharmacy program. This includes the following TPN components: Carbohydrates, Amino Acids, Lipids, Carbohydrates with Electrolytes, Trace Elements, Vitamins, and Proteins. The components should be billed through the Durable Medical Equipment (DME) program.

PREFERRED DRUG LIST CHANGES (EFFECTIVE APRIL 6, 2011)

- **Androgel Pump** will be preferred.
- **Proventil and Xopenex HFA inhalers** will be preferred.

PREFERRED DRUG LIST CHANGES (EFFECTIVE MAY 4, 2011)

- **Bupropion ER/SR/XL, citalopram, fluoxetine, mirtazapine 15mg/30mg/45mg, paroxetine IR/CR, sertraline, and venlafaxine ER TABLETS** will be preferred antidepressants.

- **Aplenzin, Cymbalta, Lexapro, and Pristiq** will be non-preferred antidepressants. To obtain a non-preferred antidepressant, a 6 week trial of ***TWO (2)*** preferred antidepressants will be required.

- **Venlafaxine ER *CAPSULES*** will no longer be covered. Clients will be required to use venlafaxine ER TABLETS

PREFERRED DRUG LIST CHANGES (EFFECTIVE MAY 4, 2011), cont.

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT GHS FOR QUESTIONS
CONTRACEPTIVES	**MONOPHASIC ORAL CONTRACEPTIVES**		APRI RECLIPSEN SOLIA
	DESOGESTEROL-ETHINYL ESTRADIOL		
	ORTHO-CEPT DESOGEN		
	DROSPIRENONE		GIANVI OCELLA ZARAH
	BEYAZ SAFYRAL YASMIN YAZ		
	ETHYNODIL DIACETATE-ETHINYL ESTRODIOL		
	KELNOR ZOVIA		
	LEVONORGESTREL-ETHINYL ESTRADIOL		INTROVALE JOLESSA LEVORA PORTIA QUASENSE
	AVIANE LESSINA LUTERA LYBREL NORDETTE SEASONALE SPRONYX		
	NORETHINDRONE-ETHINYL ESTRADIOL		BREVICON CYCLAFEM 1/35 GILDESS JUNEL MICROGESTIN NECON 0.5/35, 1/35 NORINYL 1/35 NORTREL 0.5/35, 1/35
	BALZIVA FEMCON FE LOESTRIN MODICON ORTHO-NOVUM 1/35 OVCON ZENCHENT		
	NORETHINDRONE-MESTRANOL		
	NECON 1/50 NORINYL 1/50		
	NORGESTIMATE-ETHINYL ESTRADIOL		MONESSA PREVIFEM SPRINTEC
	ORTHO-CYCLEN		
	NORGESTREL-ETHINYL ESTRADIOL		CRYSELLE LOW-OGESTREL NORGEST
	LO/OVRAL OGESTREL		
	BIPHASIC ORAL CONTRACEPTIVES		AZURETTE KARIVA
	DESOGESTEROL-ETHINYL ESTRADIOL		
	MIRCETTE		
	LEVONORGESTREL-ETHINYL ESTRADIOL		
	LO-SEASONIQUE SEASONIQUE		
	NORETHINDRONE-ETHINYL ESTRADIOL		
	NECON 10/11		

THERAPEUTIC CLASS	PREFERRED AGENTS	PREFERRED AGENTS REQUIRING CLINICAL CRITERIA	NON-PREFERRED AGENTS GENERIC MANDATORY POLICY APPLIES THIS LIST IS NOT ALL INCLUSIVE PLEASE CONTACT GHS FOR QUESTIONS
CONTRACEPTIVES *cont.*	**TRIPHASIC ORAL CONTRACEPTIVES**		CAZIANT CESIA VELIVET
	DESOGESTEROL-ETHINYL ESTRADIOL		
	CYCLESSA		
	LEVONORGESTREL-ETHINYL ESTRADIOL		
	ENPRESSE TRIVORA		
	NORETHINDRONE-ETHINYL ESTRADIOL		ARANELLE CYCLAFEM 7/7/7 LEENA NECON 7/7/7 NORTREL 7/7/7 TILIA TRI-LEGEST
	ESTROSTEP ORTHO-NOVUM 7/7/7 TRI-NORINYL		
	NORGESTIMATE-ETHINYL ESTRADIOL		TRI-PREVIFEM TRI-SPRINTEC
	ORTHO TRI-TAB TRINESSA		
	FOUR-PHASIC ORAL CONTRACEPTIVES		
	NATAZIA		