



Medicaid Pharmacy News

Dear Providers:

December 23, 2014

NEW THERAPEUTIC CATEGORIES/PREFERRED DRUG LIST (PDL) CHANGES (Effective 01/01/2015)

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

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
ADDICTION AGENTS	*Zubsolv will be non-preferred
ALLERGY/ASTHMA Corticosteroid/Bronchodilator Combinations	Advair Disk, Dulera and Symbicort will be preferred *Advair HFA will be non-preferred, unless the client is 6 years of age or younger
ALLERGY/ASTHMA Nasal Antihistamines	*Olopatadine 0.6% will be non-preferred
ALLERGY/ASTHMA Steroid Inhalants	*Qvar will be non-preferred
ANALGESICS Hydrocodone Agents	Lortab Elixir 10-300 mg *Zolvit Solution will be non-preferred
ANTICOAGULANTS Low Molecular Weight Heparin	Enoxaparin *Lovenox (brand name) will be non-preferred, prior authorization will be required for the 300mg/3ml strength
ANTIHYPERTENSIVES Angiotensin Receptor Blockers (ARBs)	*Brand name Benicar will be non-preferred
ANTIHYPERTENSIVES ARBs and Diuretics	*Benicar HCTZ and valsartan HCTZ will be non-preferred
ANTIVIRALS	Norvir CAPSULES will be preferred
CHOLESTEROL Niacin	Niaspan will be preferred *Niacin ER will be non-preferred
CHOLESTEROL Triglyceride Lowering Agents	Fenofibrate 54, 67, 134, 145, 160 & 200 mg and gemfibrozil will be preferred *Fenofibrate 43, 50, 130 & 150 mg will be non-preferred

THERAPEUTIC CATEGORY	PREFERRED MEDICATIONS/PDL CHANGES
CONTRACEPTIVES	azurette, aubra, chateal, delyla, Desogen, deso/ethinyl estradiol, elinest, enskyce, estarylla, falmina, gianvi, gildagia, kariva, kurvelo, larin/FE, levonest, levonor/ethi, Lomedia 24 FE, lyza, marlissa, mono-linyah, myzilra, noreth/ethin FE 1/20, ocella, Ortho-Cept, philith, pimtree, syeda, tri-estaryll, tri-linyah, tri-sprintec, vesture, viorele, vyfemia, zarah *alyacen, dasetta, daysee, deblitane, jencycla, loestrin 21, FE 1/20, FE 1.5/30, Lo minastrin FE, Minastrin 24 FE chewable, modicon, norlyroc, nor-qd, orthomicron, pirmella, quartette, wera & wymzya FE chewable will be non-preferred
DIABETES DPP-4 Inhibitor Combo Agents	Janumet/XR and Kombiglyze will be preferred with clinical criteria (requires PA) *Juvisync will be non-preferred
DIABETES Incretin Mimetics (GLP-1 Receptor Agonists)	Victoza will be preferred with clinical criteria (requires PA) *Bydureon and Byetta will be non-preferred
DIABETES SGLT2 Inhibitors	Farxiga and Invokana will be preferred with clinical criteria (requires PA) *Jardiance will be non-preferred
DIABETES SGLT2 Inhibitor Combo Agents	Invokamet will be preferred with clinical criteria *Xigduo XR will be non-preferred (use separate agents)
DIABETES Long-acting Insulin	Lantus Solostar, Lantus vials and Levemir will be preferred *Lantus Opti-Clik will be non-preferred
EAR	Ciprodex, Neo/Poly/HC Susp and Soln and Ofloxacin will be preferred
GASTROINTESTINAL Mesalamine	Apriso, mesalamine enema and Pentasa 250 mg will be preferred
HEPATITIS C Combination Products	Harvoni will preferred with clinical criteria (requires PA)
IMMUNOMODULATORS	Enbrel and Humira will be preferred with clinical criteria (requires PA) *Simponi and Xeljanz will be non-preferred, Otezla will be non-preferred and require diagnosis of psoriatic arthritis or plaque psoriasis
MULTIPLE SCLEROSIS Interferon	Betaseron and Avonex will be preferred, Gilenya will be preferred with clinical criteria (requires PA) *Rebif will be non-preferred
NSAIDS	*fenoprofen will be non-preferred
CORTICOSTEROIDS Low Potency	Desowen 0.05%(L) and Synalar 0.01% will be preferred *HC butyrate 0.1%(C), prednicarbate 0.1%(C,O), and Texacort 2.5%(S) will be non-preferred
CORTICOSTEROIDS Medium Potency	Cutivate 0.05%(C), Dermatop 0.1%(C), Elocon 0.1%, Synalar 0.025% and Topicort 0.05%(C) will be preferred *fluticasone 0.05%(L) and HC butyrate 0.1%(O) will be non-preferred
CORTICOSTEROIDS High Potency	Diprolene 0.05%(L), Temovate/E, Topicort 0.25%(C) and Ultravate 0.05% will be preferred *amcinonide 0.1%(C,L,O), augmented betamethasone 0.05%(G,L,O), clobetasol 0.05%(L), desoximetasone 0.05%, 0.25%(C,G,O), fluocinonide 0.1%(C) will be non-preferred

ADDITIONAL THERAPEUTIC CHART CHANGES **(Effective 01/01/2015)**

Please refer to <http://wymedicaid.org/> for the complete Additional Therapeutic Chart.

THERAPEUTIC CLASS	CLINICAL CRITERIA CHANGES
CERDELGA	Client must have diagnosis of Gaucher disease type 1, specifically in clients that are not CYP2D6 ultra-rapid metabolizers.
EVZIO	Requires prior authorization.
NORTHERA	Client must have a diagnosis of orthostatic dizziness or lightheadedness with symptomatic neurogenic orthostatic hypotension caused by a primary autonomic failure (Parkinson's disease, multiple system atrophy and pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy.

2015 PHARMACY PROVIDER MANUAL

The 2015 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.

CLIENT ID NUMBERS

Clients may be presenting letters of eligibility to pharmacies that include ID numbers. In some cases, the leading zero has been omitted in those letters, resulting in claims being rejected due to missing/invalid client ID. All client ID numbers begin with a leading zero and contain 10 digits.