South Carolina
Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.dhhs.state.sc.us

March 16, 2006

DEN	*06-01*
HH-HOSP	*06-01*
HOS-IP-GEN	*06-06*
HOS-IP-IMD	*06-02*
HOS-IP-RTF	*06-02*
HOS-OP	*06-07*
MC-DHEC	*06-04*
MC-FQHC	*06-03*
MC-MCHC	*06-03*
MC-RHC	*06-03*
MHRC-ADA	*06-02*
MCRC-MHC	*06-02*
PHARM	*06-01*
PHY-ALG	*06-01*
PHY-ANES	*06-01*
PHY-CARD	*06-01*
PHY-DERM	*06-01*
PHY-ENT	*06-01*
PHY-ER	*06-03*
PHY-MSP-CBP	*06-03*
PHY-MSP-HBP	*06-03*
PHY-OPHT	*06-02*
PHY-PATH	*06-01*
PHY-PC-FP/GP	*06-03*
PHY-PC-GER	*06-03*
PHY-PC-INT	*06-02*
PHY-PC-NEO	*06-05*
PHY-PC-OG	*06-04*
PHY-PC-PED	*06-03*
PHY-PC-PED/SUB	*06-03*
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PHY-RAD	*06-01*
PHY-S	*06-02*
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PHY-SURG	*06-02*
POD	*06-01*

MEDICAID BULLETIN

TO: **Providers Indicated**

SUBJECTS: **I. Medicare Part B Drugs - Clarification Of Pharmacy Provider Billing Instructions For "Secondary Payer" Pharmacy Claims**
II. South Carolina Medicaid Preferred Drug List

I. Medicare Part B Drugs - Clarification of Pharmacy Provider Billing Instructions For "Secondary Payer" Pharmacy Claims

As noted in the Pharmacy Services Medicaid bulletin dated December 15, 2005 [PHARM 05-12], Medicare Part B coverage remains viable for certain designated drugs under specific conditions (*e.g.,* immunosuppressants following a Medicare-sponsored organ transplant, oral chemotherapy agents, oral anti-emetics, etc.). Therefore, for dually eligible beneficiaries, pharmacists will continue to submit such claims (using their respective *supplier* billing numbers) to Medicare Part B for payment consideration. In some circumstances, however, these drugs may be deemed non-covered by Medicare Part B. An example would be an oral chemotherapy drug such as methotrexate when used to treat rheumatoid arthritis. *If Medicare Part B denies payment because the drug is considered non-covered for the diagnosis indicated, the claim should then be submitted to the beneficiary's Medicare Part D prescription drug plan (PDP).* To facilitate claims submission, it may be necessary for the pharmacist to contact the prescriber for additional diagnostic or patient-specific information in order to determine which payer (Part B or Part D) should be billed as primary.

If Medicare Part B reimburses any portion of the Pharmacy Services provider's submitted charge (or if the claim paid amount was applied to the Medicare Part B annual deductible), the pharmacist may request prior authorization (PA) to bill *Medicaid* (rather than the beneficiary's PDP, as communicated in the December 15, 2005, bulletin) secondarily using First Health's point-of-sale system. Pharmacists may request prior authorization by contacting the First Health Clinical Call Center at 866-247-1181 (toll-free). When the initial PA request for a specific drug therapy is made, a copy of the Medicare explanation of benefits (EOB), documenting the Medicare Part B payment or the application of an amount toward the annual deductible, must be faxed to the First Health Clinical Call Center at 888-603-7696 (toll-free). To facilitate the PA process, pharmacists are encouraged to indicate the beneficiary's 10-digit Medicaid identification number on the Medicare EOB. While subsequent fills for that specific drug therapy will continue to require PA, faxing additional copies of the Medicare EOB will not be necessary each time the prescription is refilled.

When billing a prior authorized claim secondarily to Medicaid, the coordination of benefits (COB) data elements are applicable and must be appropriately populated. Medicaid will reimburse pharmacists *up to the Medicaid allowed amount, less payment received from Medicare Part B*. This reimbursement is considered payment in full. The carrier code used to designate Medicare Part B is 90798. (Pharmacy providers are reminded that only rebated drugs may be considered for reimbursement by the Medicaid program.) For further instructions pertaining to COB claims filing, pharmacists may contact the First Health Technical Call Center at 866-254-1669 (toll-free).

II. South Carolina Medicaid Preferred Drug List

The Preferred Drug List (PDL) has been revised to include several changes in the therapeutic category of Anti-Infectives, specifically the "Quinolones." Therefore, **effective with dates of service April 5, 2006**, hard edits will be activated (*i.e.*, pharmacy claims without prior authorization [PA] approval will deny) for newly designated non-preferred products within the "Quinolone" drug class. The ***complete PDL*** (attached to this bulletin) includes the following changes:

REVISED PDL DRUGS: Effective April 5, 2006		
PREFERRED		**NON-PREFERRED**
QUINOLONES: 2nd, 3rd, and 4th Generations		
Avelox®	*Added to PDL*	*Cipro®*
Ciprofloxin	Remains on PDL	*Cipro XR®*
Factive®	*Added to PDL*	*Floxin®*
Levaquin®	Remains on PDL	*Maxaquin®*
Ofloxacin	Remains on PDL	*Noroxin®*
		Tequin®
		Zagam®

Prescribers are strongly encouraged to write prescriptions for ***"***preferred***"*** products. However, if a prescriber deems that the patient's clinical status necessitates therapy with a PA-required drug, the prescriber (or his/her designated office personnel) is responsible for initiating the prior authorization request. A prospective, approved PA request will prevent rejection of prescription claims at the pharmacy due to the PA requirement.

All PA requests should be telephoned or submitted by fax to the First Health Clinical Call Center by the prescriber or the prescriber's designated office personnel. The toll-free telephone and fax numbers for the Clinical Call Center are 866-247-1181 and 888-603-7696, respectively. The First Health Clinical Call Center telephone number is reserved for use by healthcare professionals and should not be furnished directly to beneficiaries. [First Health's South Carolina Medicaid *beneficiary call center* telephone number for questions regarding Pharmacy Services-related issues is 800-834-2680; providers may furnish the beneficiary call center telephone number to Medicaid beneficiaries *for Pharmacy Services-related issues only*.]

A pharmacy claim submitted for a PA-required product that has not been approved for Medicaid reimbursement will reject. If this occurs, the pharmacist should contact the prescriber so that a determination may be made regarding whether a drug *not* requiring PA is clinically appropriate for the patient.

Questions regarding this bulletin should be directed to the Department of Pharmacy Services at (803) 898-2876.

/s/

Robert M. Kerr
Director

RMK/bgam

Attachments

NOTE: To receive Medicaid bulletins by email or to sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions: http://www.dhhs.state.sc.us/dhhsnew/QLEbulletins.asp

South Carolina Department of Health and Human Services Preferred Drug List

Products Within PDL Therapeutic Classes Are Available Without Prior Authorization (PA)

{Non-listed products belonging to therapeutic classes that comprise the PDL require PA}

{Note that ALL therapeutic classes are not included on the PDL.}

Listing Updated: March 2006

ANALGESIC

NSAID's

Diclofenac Potassium
Diclofenac Sodium
Diflunisal
Etodolac
Fenoprofen
Flurbiprofen
Ibuprofen
Indomethacin
Indomethacin SR
Ketoprofen
Ketoprofen ER
Ketorolac
Meclofenamate Sod.
Nabumetone
Naproxen
Naproxen Sodium
Oxaprozin
Piroxicam
Sulindac
Tolmetin Sodium

OPIOIDS, EXTENDED RELEASE

Avinza®
Duragesic® Patch
Kadian®
Morphine Sulfate ER✳

✳ *Generic MS Contin®*

ANTI-INFECTIVE

ANTIBACTERIALS

Cephalosporins, 2nd Generation

Ceftin® Suspension
Cefuroxime Tablets
Cefzil ® Tablets
Cefzil ® Suspension

Cephalosporins, 3rd Generation

Omnicef® Capsules
Omnicef® Suspension
Spectracef® Tablets

Macrolides / Ketolides

Biaxin® *(all forms)*
Biaxin XL®
EryPed®
Ery-Tab®
Erythromycin Base
Erythromycin Estolate
Erythromycin Ethylsuc.
Erythromycin Stearate
Erythrocin Stearate
Erythromycin & Sulfisox.
Zithromax®

Quinolones, 2nd and 3rd Generation

Avelox®
Ciprofloxacin
Factive®
Levaquin®
Ofloxacin

ANTIFUNGALS, ORAL

Onychomycosis Agents

Gris-Peg®
Grifulvin V®
Lamisil®

ANTIVIRALS, ORAL

Herpes Antivirals

Acyclovir
Famvir®
Valtrex®

CARDIOVASCULAR

ACE INHIBITORS (ACEI)

Benazepril
Benazepril/HCTZ
Captopril
Enalapril
Enalapril/HCTZ
Lisinopril
Lisinopril/HCTZ

ACEI, CALCIUM CHANNEL BLOCKER COMBINATIONS

Lotrel®
Tarka®

ANGIOTENSIN RECEPTOR BLOCKERS✳

Cozaar®
Diovan®
Diovan HCT®
Hyzaar®
Micardis®
Micardis HCT®
Teveten
Teveten HCT®

✳ *Patients maintained on non-preferred ARBs are "grandfathered" (i.e., current therapy may be continued without PA).*

BETA BLOCKERS

Acebutolol
Atenolol
Atenolol/Chlorthalidone
Betaxolol
Bisoprolol Fumarate
Bisoprolol/HCTZ
Labetolol
Metoprolol Tartrate
Nadolol
Pindolol
Propranolol
Propranolol/HCTZ
Sotalol
Timolol
Coreg®✳

✳ *The use of Coreg® should be reserved for the treatment of hypertension in the presence of heart failure.*

CALCIUM CHANNEL BLOCKERS, DIHYDROPYRIDINE

Dynacirc®
Dynacirc CR®
Nicardipine
Nifedical XL®
Nifedipine ER and SA
Norvasc®
Plendil ®

CALCIUM CHANNEL BLOCKERS, NON-DIHYDROPYRIDINES

Cartia XT®
Diltia XT®
Diltiazem
Diltiazem ER and XR
Taztia XT®
Verapamil
Verapamil ER
Verapamil SR

LIPOTROPICS

Bile Acid Sequestering Resins

Cholestyramine
Cholestyramine Light
Colestid®
Welchol®

Fibric Acid Derivatives

Gemfibrozil
Tricor®

Niacin Derivatives

Niacor®
Niaspan®

Statins

Advicor®
Altoprev®
Crestor®
Lescol ®
Lescol XL®
Lipitor®
Lovastatin
Pravachol ®
Zocor®

Cholesterol-Absorption Inhibitors

Vytorin®
Zetia®

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South Carolina Department of Health and Human Services Preferred Drug List

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CENTRAL NERVOUS SYSTEM

ALZHEIMER'S AGENTS

Cholinesterase Inhibitors

Aricept®
Exelon®
Razadyne®

ANTI-MIGRAINE AGENTS

Selective Serotonin Agonists

Amerge®
Axert®
Imitrex® Tablets,
Imitrex® Injection
Imitrex® Nasal Spray
Maxalt®
Maxalt-MLT®
Relpax®
Zomig® Tablets
Zomig-ZMT®
Zomig® Nasal Spray

✳ See the listing at http://southcarolina.com *for the quantity limits for this class. (Click on Providers, then Documents, then Pharmacy Quantity Limits.)*

ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS

Amphetamine Salt Combination
Dextroamphetamine
Dextroamphetamine SR
Metadate CD®
Metadate ER®
Methylin®
Methylin ER®
Methylphenidate
Methylphenidate SR
Ritalin LA®✳
Adderall XR®✳
Concerta®✳

✳ *Generic agents considered "first-line" when appropriate.*

SEDATIVE/HYPNOTICS, NON-BARBITURATES

Temazepam
Restoril ® 7.5 mg✳
Ambien®✳

✳ *Generics should be considered "first-line" when appropriate.*

ENDOCRINE AND METABOLIC

ANTI-DIABETICS

Alpha-Glucosidase Inhibitors

Glyset®
Precose®

Biguanides

Metformin
Metformin ER®

Biguanide Combination

ActoPlus Met®
Avandamet®
Glucovance®
Glyburide/Metformin

Insulins

Novolin® N
Novolin® R
Novolin® 70/30
Novolog®
Novolog® 70/30
Humalog® 75/25
Humulin® 50/50
Lantus®

Meglitinides

Starlix®

Sulfonylureas, 2nd Generation

Glipizide
Glipizide ER
Glyburide
Glyburide Micronized

Thiazolidinediones

Actos®
Avandia®

BIPHOSPHONATES - OSTEOPOROSIS

Fosamax®

GASTROINTESTINAL

ANTI-EMETICS (ORAL)

Serotonin Receptor Antagonists

Kytril ®
Zofran®
Zofran ODT®

Histamine-2 Receptor Antagonists

Famotidine
Ranitidine
Zantac® Syrup

Proton Pump Inhibitors✳

Nexium®
Protonix®
Prilosec OTC®

✳ *Clinical criteria are in effect for this class. Once criteria are met, the PPI's listed on the PDL will be preferred. Patients* ***age 12 and younger*** *may receive the PPI, Prevacid®, without PA.*

GENITOURINARY

ANTISPASMODICS

Detrol LA®
Enablex®
Oxybutynin
Oxytrol ®
Sanctura®
Vesicare®

IMMUNOLOGICS

IMMUNOMODULATORS, ORAL

Hepatitis C Therapy, Pegylated Interferons

Pegasys®
Pegasys® Conv. Pack
Peg-Intron®
Peg-Intron® Redipen™

Hepatitis C Therapy, Ribavirins

Rebetol ®
Ribavirin 200mg tablets

IMMUNOMODULATORS, TOPICAL

Elidel® ✳
Protopic® ✳

✳ *Prescribers are reminded to use these agents as advised by the respective manufacturers and reserve for only those patients who have failed traditional eczema therapy.*

OPHTHALMICS

GLAUCOMA THERAPY

Alpha-2 Adrenergics

Brimonidine Tartrate

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Beta Blockers

Betaxolol HCl
Carteolol HCl
Levobunolol HCl
Metipranolol
Timolol Maleate
Timolol Maleate gel-forming

Carbonic Anhydrase Inhibitors

Azopt®
Cosopt®
Trusopt®

Prostaglandin Agonists

Lumigan®
Travatan®
Xalatan®

RESPIRATORY

ANTI-CHOLINERGICS

Atrovent®
Combivent®
Spiriva®

ANTIHISTAMINES, 2nd GENERATION AND DECONGESTANT COMBINATIONS

Allegra®
Allegra-D®
Loratadine *OTC (Tabs, Rapid Dissolve, Syrup)*
Loratadine-D *OTC*
Zyrtec® *(all formulations)*
Zyrtec D®

BETA ADRENERGIC DEVICES, SHORT-ACTING INHALERS, INHALATION

Albuterol

BETA ADRENERGIC DEVICES, LONG-ACTING METERED DOSE INHALERS

Serevent®✳

✳ Prescribers are reminded of the revised labeling for long acting beta adrenergic agents "These medicines may increase the chance of severe asthma episodes, and death when those episodes occur."

BETA ADRENERGIC AGENTS, SHORT-ACTING NEBULIZERS

Albuterol
Metaproterenol
Xopenex®✳

✳ *Generic agents should be considered as" first-line" therapy when appropriate.*

GLUCOCORTICOIDS

Inhaled, Inhalation Devices

Azmacort®
Flovent HFA®
Qvar®

Intranasal Steroids

Flonase®
Nasacort AQ®
Nasonex®

Glococorticoids and Long-Acting Beta-2 Adrenergics

Advair® Diskus

✳ Prescribers are reminded of the revised labeling for long acting beta adrenergic agents "These medicines may increase the chance of severe asthma episodes, and death when those episodes occur."

Leukotriene Receptor Antagonists

Accolate®
Singulair®✳

✳ *No PA is required if used in the treatment of asthma with inhaled steroid or beta agonist therapy or after trial of a second generation antihistamine or nasal steroid therapy.*

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A

ACCOLATE
ACEBUTOLOL
ACTOS
ACTOPLUS MET
ACYCLOVIR
ADDERALL XR
ADVAIR DISKUS
ADVICOR
ALBUTEROL INHALATION
ALBUTEROL NEBULIZER
ALLEGRA
ALLEGRA-D
ALTOPREV
AMBIEN
AMERGE
AMPHETAMINE SALT COMBINATION
ARICEPT
ATENOLOL
ATENOLOL/CHLORTHALIDONE
ATROVENT
AVANDAMET
AVANDIA
AVELOX
AVINZA
AXERT
AZMACORT
AZOPT

B

BENAZEPRIL
BENAZEPRIL/HCTZ
BETAXOLOL
BETAXOLOL HCL OPHTHALMIC
BIAXIN (ALL FORMULATIONS)
BIAXIN XL
BISOPROLOL FUMARATE
BISOPROLOL/HCTZ
BRIMONIDINE TARTRATE OPHTH.

C

CAPTOPRIL
CARTEOLOL HCL OPHTHALMIC
CARTIA XT
CEFTIN SUSPENSION
CEFUROXIME TABLETS
CEFZIL SUSPENSION
CEFZIL TABLETS
CHOLESTYRAMINE
CHOLESTYRAMINE LIGHT
CIPROFLOXACIN
COLESTID
COMBIVENT
CONCERTA
COREG
COSOPT
COZAAR
CRESTOR

D

DETROL LA
DEXTROAMPHETAMINE
DEXTROAMPHETAMINE SR
DICLOFENAC POTASSIUM
DICLOFENAC SODIUM
DIFLUNISAL
DILTIA XT
DILTIAZEM
DILTIAZEM ER
DILTIAZEM XR
DIOVAN
DIOVAN HCT
DURAGESIC PATCH
DYNACIRC
DYNACIRC CR

E

ELIDEL
ENABLEX
ENALAPRIL
ENALAPRIL/HCTZ
ERYPED
ERY-TAB
ERYTHROCIN STEARATE
ERYTHROMYCIN BASE
ERYTHROMYCIN ESTOLATE
ERYTHROMYCIN ETHYLSUCCINATE
ERYTHROMYCIN STEARATE
ERYTHROMYCIN WITH SULFISOXAZOLE
ETODOLAC
EXELON

F

FACTIVE
FAMOTIDINE
FAMVIR
FENOPROFEN
FLONASE
FLOVENT HFA
FLURBIPROFEN
FOSAMAX

G

GEMFIBROZIL
GLIPIZIDE
GLIPIZIDE ER
GLUCOVANCE
GLYBURIDE
GLYBURIDE MICRONIZED
GLYBURIDE/METFORMIN
GLYSET
GRIFULVIN V
GRIS-PEG

H

HUMALOG 75/25
HUMULIN 50/50
HYZAAR

I

IBUPROFEN
IMITREX INJECTION
IMITREX NASAL SPRAY
IMITREX TABLETS
INDOMETHACIN
INDOMETHACIN SR

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J

K

KADIAN
KETOPROFEN
KETOPROFEN ER
KETOROLAC
KYTRIL

L

LABETOLOL
LAMISIL
LANTUS
LESCOL
LESCOL XL
LEVAQUIN
LEVOBUNOLOL HCL OPHTHALMIC
LIPITOR
LISINOPRIL
LISINOPRIL/HCTZ
LORATADINE OTC (ALL FORMS)
LORATADINE-D OTC
LOTREL
LOVASTATIN
LUMIGAN

M

MAXALT
MAXALT-MLT
MECLOFENAMATE SODIUM
METADATE CD
METADATE ER
METAPROTERENOL NEBULIZER
METFORMIN
METFORMIN ER
METHYLIN
METHYLIN ER
METHYLPHENIDATE
METHYLPHENIDATE SR
METIPRANOLOL OPHTHALMIC
METOPROLOL TARTRATE
MICARDIS
MICARDIS HCT
MORPHINE SULFATE ER

N

NABUMETONE
NADOLOL
NAPROXEN
NAPROXEN SODIUM
NASACORT AQ
NASONEX
NEXIUM
NIACOR
NIASPAN
NICARDIPINE
NIFEDICAL XL
NIFEDIPINE ER
NIFEDIPINE SA
NORVASC
NOVOLIN 70/30
NOVOLIN N
NOVOLIN R
NOVOLOG
NOVOLOG 70/30

O

OFLOXACIN
OMNICEF CAPSULES
OMNICEF SUSPENSION
OXAPROZIN
OXYBUTININ
OXYTROL

P

PEGASYS
PEGASYS CONVENIENCE PACK
PEG-INTRON
PEG-INTRON REDIPEN
PINDOLOL
PIROXICAM
PLENDIL
PRAVACHOL
PRECOSE
PREVACID (< AGE 12)
PRILOSEC OTC
PROPRANOLOL
PROPRANOLOL/HCTZ
PROTONIX
PROTOPIC

Q

QVAR

R

RANITIDINE
RAZADYNE
REBETOL
RELPAX
RESTORIL (7.5 MG STRENGTH ONLY)
RIBAVIRIN TABLETS
RITALIN LA

S

SANCTURA
SEREVENT
SINGULAIR
SOTALOL
SPECTRACEF TABLETS
SPIRIVA
STARLIX
SULINDAC

T

TARKA
TAZTIA XT
TEMAZEPAM
TEVETEN
TEVETEN HCT
TIMOLOL
TIMOLOL MALEATE GEL-FORMING
TIMOLOL MALEATE OPHTHALMIC
TOLMETIN SODIUM
TRAVATAN
TRICOR
TRUSOPT

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U

V

VALTREX
VERAPAMIL
VERAPAMIL ER
VERAPAMIL SR
VESICARE
VYTORIN

W

WELCHOL

X

XALATAN
XOPENEX

Y

Z

ZANTAC SYRUP
ZETIA
ZITHROMAX
ZOCOR
ZOFRAN
ZOFRAN ODT
ZOMIG
ZOMIG NASAL SPRAY
ZOMIG-ZMT
ZYRTEC (ALL FORMULATIONS)
ZYRTEC D

SOUTH CAROLINA MEDICAID PROGRAM

PRIOR AUTHORIZATION REQUEST

PRESCRIBER:

NAME: _____
FIRST LAST

DEA LICENSE # _____

PHONE # (_____) _____

FAX # (_____) _____

BENEFICIARY:

NAME: _____
FIRST LAST

MEDICAID # / SSN: _____

DATE OF BIRTH: _____ **SEX:** _____

REQUEST DATE: _____

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____

PHARMACY: _____ **PHONE:** ( ) _____

PRIOR AUTHORIZATION REQUESTED FOR: (Please check appropriate prior authorization type)

- ☐ **Anti-Ulcer Therapy**
- ☐ **COX-2 Inhibitor Therapy**
- ☐ **Orlistat** (Include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests.)
- ☐ **Panretin®/Targretin®**
- ☐ **Preferred Drug List**
- ☐ **Quantity Limits**
- ☐ **Sildenafil for Pulmonary Arterial Hypertension**

Other: _____

NOTE:

"Brand Medically Necessary" PA requests require a *South Carolina Medicaid MedWatch form*.

"Growth Hormone" PA requests require a *Growth Hormone request form*.

DRUG NAME	DOSE	STRENGTH	LENGTH OF THERAPY

DIAGNOSIS: _____

DIAGNOSTIC PROCEDURES AND FINDINGS (please list dates): _____

_____

MEDICAL JUSTIFICATION FOR PRODUCT USE: _____

_____

PRESCRIBER'S SIGNATURE AND SPECIALTY: _____

FIRST HEALTH SERVICES USE ONLY: ☐ **APPROVED** ☐ **DENIED**

DATE: _____/_____/_____
MAP RPh/TECH: _____
NDC: _____

COMMENTS: _____
_____
_____

SUBMIT REQUESTS TO: **FIRST HEALTH SERVICES** **FAX: (888) 603-7696**
All Fax requests will be processed in one business day. To check on the status you may call: TELEPHONE: (866) 247-1181

Revised: July 2005