South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.dhhs.state.sc.us

September 21, 2004

MEDICAID BULLETIN

DEN	***04-08***	***PHY-MSP-CBP***	***04-11***
HH-HOSP	***04-05***	***PHY-MSP-HBP***	***04-11***
HOS-IP-GEN	***04-09***	***PHY-OPHT***	***04-11***
HOS-OP	***04-09***	***PHY-PATH***	***04-10***
MC-DHEC	***04-06***	***PHY-PC-FP/GP***	***04-11***
MC-FQHC	***04-07***	***PHY-PC-GER***	***04-11***
MC-MCHC	***04-07***	***PHY-PC-INT***	***04-11***
MC-RHC	***04-07***	***PHY-PC-NEO***	***04-11***
MHRC-ADA	***04-07***	***PHY-PC-OG***	***04-11***
MHRC-MHC	***04-10***	***PHY-PC-PED***	***04-11***
PHARM	***04-04***	***PHY-PC-PED/SUB***	***04-11***
PHY-ALG	***04-09***	***PHY-PS***	***04-10***
PHY-ANES	***04-10***	***PHY-RAD***	***04-09***
PHY-CARD	***04-09***	***PHY-S***	***04-11***
PHY-DERM	***04-09***	***PHY-SPEC***	***04-09***
PHY-ENT	***04-11***	***PHY-SURG***	***04-09***
PHY-ER	***04-09***	***POD***	***04-06***

TO: **Providers Indicated**

SUBJECTS: **I. Medicaid Coverage of Tobacco Cessation Products**
II. South Carolina Medicaid Preferred Drug List – Additional Therapeutic Classes

I. Medicaid Coverage of Tobacco Cessation Products

Effective with dates of service beginning October 1, 2004, the South Carolina Department of Health and Human Services (DHHS) will provide reimbursement for certain pharmaceuticals used to facilitate the discontinuation of tobacco products. A prescription written for a tobacco cessation product specified below is covered within program limitations (e.g., monthly prescription limit) for all Medicaid beneficiaries including SILVERxCARD enrollees who have met their calendar year deductible. Prior authorization (PA) is not required (except where indicated) for reimbursement of the tobacco cessation products listed below, however, there are quantity limitations for these pharmaceuticals as well as a coverage-period limit.

Medicaid coverage of tobacco cessation pharmaceuticals includes prescriptions authorized for any of the following *rebated* drugs:

- Bupropion sustained release products.
- Nicotine Replacement Therapy (NRT) pharmaceutical products: legend and over-the-counter patches and gum. *(NRT lozenges, inhalers and sprays are non-covered unless approved through the prior authorization process.)*

Reimbursement for tobacco cessation products is available for a single twelve-week course of treatment consisting of 90 days (three consecutive months) per beneficiary per calendar year. Medicaid-covered maximum quantity limitations for tobacco cessation products are:

1. Bupropion extended release 150 mg – 180 tablets per 90-day period.
2. Nicotine patches – 90 patches per 90-day period.
3. Nicotine gum – 1,512 pieces per 90-day period.

To request prior authorization for NRT lozenges, nasal inhalers, or sprays, prescribers should contact First Health's Clinical Call Center at 866-247-1181. Documentation verifying the patient's inability to use the patches or gum and the medical necessity of the NRT lozenges, nasal inhaler, or spray will be required.

II. South Carolina Medicaid Preferred Drug List – Additional Therapeutic Classes

During September 2004, implementation of South Carolina Medicaid's Preferred Drug List (PDL) will continue with an additional group of therapeutic classes. Listed in the following table (in the column labeled "September 2004") are the therapeutic classes that will be implemented with soft edits in September 2004. Previously implemented therapeutic classes (May 2004 and August 2004) are also listed in the following table. Attached to this bulletin is a comprehensive listing of all products that currently comprise the South Carolina Medicaid's Preferred Drug List.

PDL Therapeutic Classes

[The following therapeutic classes currently comprise the PDL. Therapeutic classes will continue to be added and providers will be notified accordingly.]

FIRST HEALTH CLINICAL CALL CENTER: 866-247-1181 (toll-free)

September 2004	August 2004	May 2004
Beta Adrenergic Agents: ◆ Short-Acting Inhalers/Inhalation Devices ◆ Long-Acting Metered Dose Inhalers ◆ Short-Acting Nebulizers	ACE Inhibitor (ACEI), Calcium Channel Blocker Combinations	Angiotensin Converting Enzyme Inhibitors (ACEI's)
Inhaled and Nasal Steroids: Glucocorticoids ◆ Inhaled and Inhaled Devices ◆ Glucocorticoids and Long-Acting Beta-2 Adrenergics ◆ Intranasal Steroids	Antihyperkinesis Agents	Angiotensin Receptor Blockers (ARB's)
Leukotriene Receptor Antagonists	Beta Blockers	Biphosphonates for osteoporosis
Antihistamines: ◆ Second Generation and Decongestant Combinations	Calcium Channel Blockers	Cephalosporins (second and third generations)
Anti-Migraine Medications: ◆ Serotonin 5HT1 receptor agonists	Non-Steroidal Anti-Inflammatory Drugs (NSAID's)	Histamine-2 Receptor Antagonists (H2RA's)
Sedative Hypnotics: Non-Barbiturates		Proton Pump Inhibitors (PPI's)

Prescribers are encouraged to write prescriptions for the "preferred" products rather than prescribing those drugs that require PA. However, if a prescriber is concerned that the patient's clinical status necessitates therapy with a PA-required drug, the prescriber should immediately initiate a PA request. A prospective PA request by the prescriber will help to avert the rejection of prescription claims at the pharmacy due to the PA requirement. **All**

PA requests must be telephoned or submitted to the First Health Clinical Call Center by the prescriber or the prescriber's designated office personnel. The telephone number for the Clinical Call Center is 866-247-1181 and the fax number is 888-603-7696.

As with the previously implemented PDL therapeutic classes, pharmacists should note that for approximately four to six weeks during the initial implementation period, soft edits [i.e., electronic messages that are received via point of sale] will be transmitted when pharmacy claims are submitted for products that will require PA when that group of drugs is fully implemented. The soft edit serves as notification to the pharmacist that PA will be necessary in the future. The soft edit will not cause the claim to reject; however, pharmacists are asked to take this opportunity to inform both the beneficiary ***and*** prescriber of the eventual PA requirement. *[It should be noted that PDL-related prior authorization requirements are applicable to all South Carolina Medicaid beneficiaries, including those participating in the SILVERxCARD program.]*

When contacting prescribers, pharmacists are asked to remind prescribers of alternative products within the therapeutic class that *do not require PA* for Medicaid coverage. [Refer to the attached listing or the PDL posting at **http://southcarolina.fhsc.com**. As additional therapeutic classes are added to the PDL, this online information will be revised. Providers should refer to this website often in order to obtain updates.]

Effective with dates of service **November 17, 2004**, hard edits (i.e., pharmacy claims without PA approval will deny) will be activated for **"non-preferred"** products within the therapeutic classes listed below.

Beta Adrenergic Agents: ◆ Short-Acting Inhalers/Inhalation Devices ◆ Long-Acting Metered Dose Inhalers ◆ Short-Acting Nebulizers	Antihistamines: ◆ Second Generation and Decongestant Combinations
Inhaled and Nasal Steroids: Glucocorticoids ◆ Inhaled and Inhaled Devices ◆ Glucocorticoids and Long-Acting Beta-2 Adrenergics ◆ Intranasal Steroids	Anti-Migraine Medications: ◆ Serotonin 5HT1 receptor agonists
Leukotriene Receptor Antagonists	Sedative Hypnotics: Non-Barbiturates

If a pharmacy claim is submitted for a PA-required product that has not been granted approval for Medicaid reimbursement, the claim will reject. If this occurs, the pharmacist should contact the prescriber (or the patient) so that a determination may be made regarding whether a drug *not* requiring PA may be clinically appropriate for the patient. If alternative therapy (a drug *not* requiring PA) is deemed inappropriate, it will be necessary for the *prescriber or the prescriber's designated office personnel* to request prior authorization for that product through First Health's Clinical Call Center.

Notifications will continue to be sent to those prescribers having numerous patients on medications that will require PA as a result of the PDL. Alternative drug choices will be suggested to prescribers of drugs requiring prior authorization. The overall success of the PDL is dependent on the cooperation of South Carolina Medicaid prescribers and pharmacists. Providers' efforts to assist the Medicaid program are needed and appreciated.

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

/s/

Robert M. Kerr
Director

RMK/bgav

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/ResourceLibrary/E-Bulletins.htm**

South Carolina Department of Health and Human Services
Preferred Drug List – May 2004 through present

Products Within The Following Therapeutic Classes Are Available WITHOUT Prior Authorization

(This is a two-page listing)
Updated September 2004

ACEI's (Angiotensin Converting Enzyme Inhibitors)
Captopril
Enalapril
Enalapril/HCTZ
Lisinopril
Lisinopril/HCTZ
Aceon®✳
✳ *(Generic agents should be considered first-line when appropriate)*

ACEI, Calcium Channel Blocker Combinations
Lotrel®
Tarka®

Angiotensin Receptor Blockers (ARB's)
Avapro®
Avalide®
Benicar®
Benicar HCT®
Diovan®
Diovan HCT®

Antihistamines: Second Generation and Decongestant Combinations
Loratadine *OTC*
Loratadine-D *OTC*
Zyrtec® Syrup✳
✳ *(For patients less than 2 years of age)*

Antihyperkinesis
Amphetamine Salt Combination
Dextroamphetamine
Dextroamphetamine SR
Metadate CD®
Metadate ER®
Methylin®
Methylin ER®
Methylphenidate
Methylphenidate SR
Ritalin LA®✳
Adderall XR®✳
Concerta®✳
✳ *(Generic agents should be considered first-line when appropriate)*

Anti-Migraine Medications: Serotonin 5HT1 Receptor Agonists ✳
Amerge®
Axert®
Imitrex® Tablets, Injection, Nasal Spray
Maxalt®, Maxalt-MLT®
Relpax®
Zomig®, Zomig-ZMT®, and Spray
✳ *Monthly quantity limits are in effect for this therapeutic class. At http://southcarolina.fhsc.com click on Providers, then Documents, and then Pharmacy Quantity Limits.*

Beta Adrenergic Agents: Short-Acting Inhalers/Inhalation Devices
Albuterol

Beta Adrenergic Agents: Long-Acting Metered Dose Inhalers
Serevent Diskus®✳
✳*(For maintenance therapy only)*

Beta Adrenergic Agents: Short-Acting Nebulizers
Albuterol
Metaproterenol

Beta Blockers
Acebutolol
Atenolol
Atenolol/Chlorthalidone
Betaxolol
Bisoprolol Fumarate
Bisoprolol/HCTZ
Labetolol
Metoprolol Tartrate
Nadolol
Pindolol
Propranolol
Propranolol/HCTZ
Sotalol
Timolol
Coreg®✳
✳ *(Use of Coreg® should be reserved for hypertension in the presence of heart failure)*

Implementation of the Preferred Drug List is being done gradually with groups of therapeutic classes. For those products not listed in the above classes, prior authorization (PA) will be required using the process currently in place. Please note that all previous PA criteria remain in effect.

First Health Clinical Call Center
Telephone: 866-247-1181 (toll free)
Fax: 888-603-7696 (toll free)

South Carolina Department of Health and Human Services
Preferred Drug List – May 2004 through present

Products Within The Following Therapeutic Classes Are Available WITHOUT Prior Authorization

(This is a two-page listing)
Updated September 2004

Biphosphonates Used for Osteoporosis
Actonel®
Fosamax®

Calcium Channel Blockers Dihydropyridines
Dynacirc®
Dynacirc CR®
Nicardipine
Nefedical XL®
Nifedipine ER
Nifedipine SA
Norvasc®
Plendil®

Calcium Channel Blockers Non-Dihydropyridines
Cartia XT®
Diltia XT®
Diltiazem
Diltiazem ER
Diltiazem XR
Taztia XT®
Verapamil
Verapamil ER
Verapamil SR

Cephalosporins: Second Generation
Ceftin® Suspension
Cefuroxime Tablets
Cefzil® Tablets and Suspension

Cephalosporins: Third Generation
Omnicef® Capsules and Suspension
Spectracef® Tablets

Gastrointestinals: Histamine-2 Receptor Antagonists (H2RA's)
Famotidine
Ranitidine
Zantac® Syrup

Gastrointestinals: Proton Pump Inhibitors (PPI's)
Nexium®
Protonix®
Prilosec OTC®

Note: SC Medicaid has clinical criteria in effect for this class. Once criteria are met, the PPI's listed on the PDL will be preferred; however, ***patients age 12 and younger may receive the proton pump inhibitor, Prevacid®, without PA****.*

Inhaled and Nasal Steroids: Glucocorticoids – Inhaled/Inhaled Devices
Azmacort®
Flovent®
Qvar®

Inhaled and Nasal Steroids: Glucocorticoids – Intranasal Steroids
Flonase®
Nasarel®
Nasonex®
Rhinocort AQ®

Inhaled and Nasal Steroids: Glucocorticoids and Long-Acting Beta-2 Adrenergics
Advair Diskus®

Leukotriene Receptor Antagonists
Accolate®
Singulair®✳
✳ *(No PA is required if used in the treatment of asthma with inhaled steroid or inhaled beta agonist therapy)*

Non-Steroidal Anti-inflammatory Agents (NSAID's)
Diclofenac Potassium
Diclofenac Sodium
Etodolac
Fenoprofen
Flurbiprofen
Ibuprofen
Indomethacin
Indomethacin SR
Ketoprofen
Ketoprofen ER
Ketorolac
Meclofenamate Sodium
Nabumetone
Naproxen
Naproxen Sodium
Oxaprozin
Piroxicam
Sulindac
Tolmetin Sodium

Sedative/Hypnotics: Non-Barbiturate
Temazepam
Triazolam
Sonata®✳
Restoril® 7.5 mg✳
✳ *(Generic agents should be considered first-line when appropriate)*

Implementation of the Preferred Drug List is being done gradually with groups of therapeutic classes. For those products not listed in the above classes, prior authorization (PA) will be required using the process currently in place. Please note that all previous PA criteria remain in effect.

First Health Clinical Call Center
Telephone: 866-247-1181 (toll free)
Fax: 888-603-7696 (toll free)

SOUTH CAROLINA MEDICAID PROGRAM

PRIOR AUTHORIZATION REQUEST

PRESCRIBER: **BENEFICIARY:**

NAME: _____ **NAME:** _____
FIRST LAST FIRST LAST

DEA LICENSE #_____ **MEDICAID#/SSN:** _____

PHONE # (_____)_____ **DATE OF BIRTH:** _____ **SEX:** _____

FAX # (_____)_____ **REQUEST DATE:** _____

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM:_____

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

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

☐ **Anti-Ulcer Therapy**	☐ **Orlistat** (please include information regarding height, weight, diet plans, nutritional counseling, etc., with all orlistat requests)	☐ **Preferred Drug List**
☐ **COX-2 Inhibitor Therapy**	☐ **OxyContin®**	☐ **Quantity Limits**
☐ **Brand Name NSAID Therapy**	☐ **Panretin®/Targretin®**	**Other:** _____
☐ **Erectile Dysfunction Therapy**		*"Brand Medically Necessary" requests require MedWatch form – please submit those requests on appropriate form
☐ **Growth Hormone**		

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: _____/_____/_____ **COMMENTS:** _____
MAP RPh/TECH: _____ _____
NDC: _____ _____

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 2004