New Hampshire

NEW HAMPSHIRE FEE-FOR-SERVICE MEDICAID PHARMACY PROGRAM

TO: New Hampshire Medicaid Providers
FROM: New Hampshire Department of Health and Human Services/ Magellan Rx Management
DATE: June 14, 2019
SUBJECT: NH Fee-for-Service (FFS) Medicaid Preferred Drug List (PDL)/Clinical Prior Authorization (PA) Updates/ Web Portal Information/E-mail Notifications

This provides notice of changes being made to the New Hampshire Medicaid FFS Pharmacy program effective June 21, 2019.

PREFERRED DRUG LIST CHANGES:
The following addition of new therapeutic drug class has been made to the NH FFS Medicaid PDL.

- **OPHTHALMICS, GLAUCOMA AGENTS –** Rho Kinase Inhibitors
- **ANTIMIGRAINE AGENTS –** Calcitonin Gene-Related Peptide (CGRP) Inhibitors

The following additions of **preferred agents** have been made to the therapeutic drug classes on the NH FFS Medicaid PDL.

- **ANTIBIOTICS –** MACROLIDES - E.E.S®*, Eryped 200 susp®
- **ANTICONVULSANTS –** SECOND GENERATION - clobazam (generic for Onfi®), vigabatrin (generic for Sabril®)
- **BEHAVIORAL HEALTH –** ANTIHYPERKINESIS - Aptensio XR®, Dyanavel XR®, Quillichew ER®, Quillivant XR®
- **CARDIOVASCULAR –** ORAL PULMONARY HYPERTENSION AGENTS - ambrisentan (generic for Letairis®)
- **CENTRAL NERVOUS SYSTEM –** CALCITONIN GENE-RELATED PEPTIDE INHIBITORS - Emgality™
- **CENTRAL NERVOUS SYSTEM** – MULTIPLE SCLEROSIS - Disease Modifying Therapy - Tecfidera®
- **ENDOCRINOLOGY –** GLUCAGON-LIKE PEPTIDE-1 (GLP-1) AGONISTS AND COMBINATIONS - Victoza®
- **ENDOCRINOLOGY** – INSULINS **-** Rapid Acting - insulin lispro vial/kwikpen (generic for Humalog vial/cartridge/pen®)
- **ENDOCRINOLOGY** – INSULINS **-** Premixed Combinations - Novolog Mix 70/30 FlexPen®
- **ENDOCRINOLOGY –** SODIUM GLUCOSE CO-TRANSPORTER 2 INHIBITOR AND COMBINATIONS - Jardiance®
- **GASTROINTESTINAL –** HEPATITIS C AGENTS - ledipasvir-sofosbuvir (generic for Harvoni®), sofosbuvir/velpatasvir (generic for Epclusa®)
- **GASTROINTESTINAL** – ULCERATIVE COLITIS - Oral - Lialda®
- **GASTROINTESTINAL** – ULCERATIVE COLITIS – Rectal **-** mesalamine supp. (generic for Canasa supp.®)
- **GENITOURINARY/RENAL** – ALPHA BLOCKERS FOR BENIGN PROSTATIC HYPERPLASIA - dutasteride/tamsulosin (generic for Jalyn®), silodosin (generic for Rapaflo®)
- **GENITOURINARY/RENAL** – ELECTROLYTE DEPLETERS - sevelamer HCL (generic for Renagel®)
- **HEMATOLOGIC –** HEMATOPOIETIC AGENTS - Epogen®, Retacrit®
- **OPHTHALMIC/GLAUCOMA –** CARBONIC ANHYDRASE INHIBITORS - dorzolamide/timolol PF (generic for Cosopt®* PF)
- **OPHTHALMIC/GLAUCOMA –** RHO KINASE INHIBITOR - Rhopressa™
- **RESPIRATORY –** SHORT ACTING BETA ADRENERGICS & COMBINATIONS – INHALERS/NEBS - albuterol sulfate HFA (generic for ProAir HFA®, Proventil HFA®, Ventolin HFA®)

- **RESPIRATORY –** INHALED CORTICOSTEROIDS - fluticasone-salmeterol (generic for Advair Diskus®) , Wixela Inhub ((generic for Advair Diskus®)
- **TOPICAL –** ANTIPARASITICS - malathion
- **TOPICAL –** ATOPIC DERMATITIS - pimecrolimus (generic for Elidel®)
- **TOPICAL –** STEROIDS - Very High Potency **-** halobetasol propionate foam (generic for Lexette®)
- **TOPICAL –** STEROIDS - High Potency **-** amcinonide
- **TOPICAL –** TOPICAL ANTIVIRALS - acyclovir (generic for Zovirax cream®)
- **TOPICAL –** TOPICAL RETINOIDS - adapalene (generic Plixda™)

The following medications have been added to the NH FFS Medicaid PDL as **non-preferred agents**. Patients currently taking a non-preferred drug should be considered for a transition to a preferred drug. Non-preferred drugs will require **prior authorization**.

- **ANALGESIC –** ANTI-INFLAMMATORY – NON-SELECTIVE NSAIDS - Celebrex®
- **ANALGESICS –** LONG ACTING OPIOIDS - Morphabond ER™
- **ANTIVIRALS –** TREATMENT/PROPHYLAXIS OF INFLUENZA - Xofluza™
- **BEHAVIORAL HEALTH –** ANTIHYPERKINESIS - Adderall XR®
- **BEHAVIORAL HEALTH –** ATYPICAL ANTIPSYCHOTICS & COMBOS - Aristada Initio®, Perseris®
- **CARDIOVASCULAR –** ANGIOTENSIN II RECEPTOR BLOCKERS & COMBINATIONS - Diovan HCT®
- **CARDIOVASCULAR –** BETA-BLOCKERS & COMBINATIONS - Kapspargo Sprinkle®
- **CARDIOVASCULAR –** ORAL PULMONARY HYPERTENSION AGENTS - Tracleer®
- **CARDIOVASCULAR –** STATINS & COMBINATIONS - Zypitamag*
- **CENTRAL NERVOUS SYSTEM –** CALCITONIN GENE-RELATED PEPTIDE INHIBITORS - Aimovig™, Ajovy™
- **CENTRAL NERVOUS SYSTEM** – MULTIPLE SCLEROSIS - Disease Modifying Therapy - Ocrevus®
- **ENDOCRINOLOGY** – INSULINS **-** Rapid Acting - Humalog Junior Kwikpen®
- **ENDOCRINOLOGY** – INSULINS **-** Long Acting - Tresiba vial®
- **HEMATOLOGIC –** HEMATOPOIETIC AGENTS - Aranesp®, Procrit®
- **IMMUNOLOGIC –** SYSTEMIC IMMUNOMODULATORS - Actemra® Actpen, Ilumya ™, Olumiant®
- **OPHTHALMIC/GLAUCOMA –** CARBONIC ANHYDRASE INHIBITORS - Azopt®
- **OPIATE DEPENDENCE TREATMENT -** Lucemyra™
- **RESPIRATORY –** CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) - Yupelri™
- **RESPIRATORY –** INHALED CORTICOSTEROIDS - Asmanex HFA®, Pulmicort® respules, QVAR®
- **RESPIRATORY –** NASAL CORTICOSTEROIDS - Nasonex®
- **RESPIRATORY –** SHORT ACTING BETA ADRENERGICS & COMBINATIONS – INHALERS/NEBS - ProAir Respiclick®
- **SELF INJECTION EPINEPHRINE -** Symjepi™
- **TOPICAL –** ANTIPARASITICS - Crotan®
- **TOPICAL –** STEROIDS - High Potency **-** Silalite Pak®
- **TOPICAL –** TOPICAL RETINOIDS - Altreno™, Plixda™

The following clinical Prior Authorization updates have also been made.

CLINICAL PRIOR AUTHORIZATION REVISIONS:

1. Allergen Extract Criteria
2. Anti-fungal for Onychomycosis Medications Criteria
3. Anti-obesity Criteria
4. Asthma/Allergy Immunomodulators Criteria
5. Atopic Dermatitis Criteria
6. Brand Name Multiple Source Prescription Drugs Criteria
7. Direct Renin Inhibitors & Combinations Criteria
8. Hematopoietic Agents Criteria
9. Hepatitis C Criteria
10. Huntington's Disease Criteria
11. Legend Topical NSAIDs Criteria

12. Long-acting Opioids Criteria
13. Lyrica® Criteria
14. Morphine Milligram Equivalent (MME) Criteria
15. New Drug Product Criteria
16. Oral NSAIDs Legend Criteria
17. Proton Pump Inhibitors Criteria
18. Pulmonary Arterial Hypertension (Phosphodiesterase Type 5 (PDE05) Inhibitors Only) Criteria
19. Short Acting Fentanyl Analgesics Criteria
20. Spinraza® Criteria
21. Syndros™ Criteria
22. Systemic Immunomodulators Criteria

NEW CLINICAL PRIOR AUTHORIZATION CRITERIA ADDITIONS:

1. Carisoprodol & Combination Medications Criteria
2. Calcitonin Gene-Related Peptide (CGRP) Inhibitors Criteria
3. Rho Kinase Inhibitors Criteria

The most recent version of the NH FFS Medicaid PDL and Prior Authorization fax forms are available on line, and may be obtained by visiting the DHHS Medicaid PDL website or the Magellan Rx Management website at: http://www.dhhs.nh.gov/ombp/pharmacy/preferred.htm OR http://newhampshire.magellanmedicaid.com

If you have questions regarding the content of this notice, please contact the Magellan Rx Management Clinical Manager at (603) 892-2060. In addition, the Magellan Rx Management Clinical Call Center is available at (866) 675-7755.

Emergency Drug Coverage

Pharmacies are reminded that federal statute requires Medicaid programs (Fee-for-Service and managed care) provide payment for dispensing of at least a 72-hour supply for any drugs requiring prior authorizations if prior authorization cannot be obtained outside of Medicaid business hours. (*Section 1927 of the Social Security Act. Codified as Section 1396r-8 of Title 42.(d)(5) (B)*)
Pharmacies must request payment for the 72-hour supply from the client's prescription plan, either Fee-For-Service or the appropriate Medicaid MCO.

New Hampshire Medicaid Web Portal

Prescribers and pharmacies have access to NH FFS Medicaid drug specific data including coverage, prior authorization required, preferred drugs, quantity limits, dose optimization and the pharmacy provider manual. You can access this information at http://newhampshire.magellanmedicaid.com

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Email notifications

If you wish to receive e-mail notifications regarding New Hampshire FFS Medicaid Pharmacy Program changes, please enter your e-mail address at http://newhampshire.magellanmedicaid.com under the documentation tab, notifications, e-mail notification.