AUGUST 2003

Kansas Medical Assistance Program

PHARMACY PROVIDERS
Policy and Procedure Update

BULLETIN

Effective with dates of service on and after July 30, 2003, Loratadine / Pseudoephedrine became a preferred drug and does not require PA.

Reminder: Generic loratadine continues to be a preferred drug and does not require prior authorization

Additions to the non-preferred drug list

Effective with dates of service on and after July 31, 2003, Pravigard Pac® is non-preferred and requires PA.

Effective with dates of service on and after August 21, 2003 - Eletriptan HBr (Relpax®) is non-preferred and will require PA.

Revised Prior Authorization request forms are attached and are also available at : http://www.srskansas.org/hcp/medicalpolicy/pharmacy/

EDS is the fiscal agent and administrator of the Kansas Medical Assistance Program for the Kansas Department of Social and Rehabilitation Services

MAXIMUM ALLOWABLE COST (MAC) AND FEDERAL UPPER LIMIT (FUL) CHANGES

The following MAC or FUL prices are effective for claims with dates-of-service on and after August 24, 2003. The prices may be a decrease (D), an increase (I) and/or new (N). Increases or decreases may be related to previous MAC or FUL prices. Refer to section 8400 of the Pharmacy Provider Manual under "Pharmacy Pricing" for additional reimbursement information.

Acyclovir 200mg, Cap, Oral	0.14780	D	FUL
Baclofen 10mg, Tabs, Oral	0.24700	N	MAC
Baclofen 20mg, Tabs, Oral	0.45500	N	MAC
Desonide 0.05%, Cream, Topical	0.23370	D/N	FUL
Hydrozysine HCl 10mg/5ml, Syrup, Oral	0.03670	I	FUL
Ipratropium Br 0.02%, Solution	0.30300	N	FUL
Medroxyprogesterone Acetate 10mg, Tabs	0.37870	I	FUL
Methylprednisolone 4mg, Tabs, 21 pak	0.15411	N	MAC
Nifedipine HCl 10mg, Cap, Oral	0.18750	I	FUL
Perphenazine 2mg, Tab, Oral	0.34730	I	FUL
Perphenazine 4mg, Tab, Oral	0.37130	I	FUL
Perphenazine8mg, Tab, Oral	0.60000	N	MAC
Perphenasine 16mg Tab,Oral	0.81000	D/N	MAC
Pindolol 5mg, Tab, Oral	0.0960	D	FUL
Pindolol 10mg, Tab, Oral	0.1268	D	FUL
Sulfasalazine 500mg, Tab, Oral	0.1565	D	FUL
Trihexyphenidyl HCl 5mg, Tabs, Oral	0.22950	D	FUL

These most recent MAC changes and the previous MAC and FUL changes are being updated in Appendix I of the Pharmacy Provider Manual. At this time, the Appendix is being modified. Providers will be notified when the Appendix has been updated.

The following products have been deleted from FUL pricing.

Dexamethansone 0.5mg/5ml, Elixer, Oral
Naproxen 375mg, Tab, Delayed-Release, Oral
Trifluoperazine HCl 1mg, Tab, Oral
Trifluoperazine HCl 2mg, Tab, Oral
Trifluoperazine 10mg, Tab, Oral

Revised 7/31/03

HMG-CoA REDUCTASE INHIBITORS - Statins

PRIOR AUTHORIZATION REQUEST FORM

Preferred Drug(s) that ***DO NOT*** require PA: Atorvastatin (Lipitor®), Simvastatin(Zocor®)

Other Drug(s) that ***DO NOT*** require PA: Lovastatin (Mevacor®), Fluvastatin (Lescol®)

Non-Preferred Drug(s) that **DO** require PA: Pravastatin (Pravachol®)
Pravigard Pac®

** ***Indicates REQUIRED information***

CONSUMER INFORMATION

** Name:_____ **Medicaid Number: _____

PHARMACY INFORMATION

** Name:_____ **Phone Number: _____

Medicaid Number #:_____ NDC:_____

PRESCRIBING PHYSICIAN INFORMATION

** Name:_____** Medicaid Number: _____

** Phone Number: _____

** *Indicate:* Non-Preferred Drug prescribed: _____

Other:_____

** *Indicate:* Preferred Drug tried: _____ Length of trial: _____

** *Check* the appropriate box indicating medical necessity for the Non-Preferred Drug:

☐ Medical intolerance to Preferred Drug. Please specify: _____

_____

☐ Inadequate response to Preferred Drug. Please specify: _____

_____

☐ Absence of appropriate formulation or indication of the drug. Please specify: _____

_____

** Prescribing Physician's signature: _____ Date: _____

FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka).
If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied for information not received.

Revised 7/29/03

NON/ LESS-SEDATING ANTIHISTAMINES

PRIOR AUTHORIZATION REQUEST FORM

Preferred Drug(s) that ***DO NOT*** require PA: Cetirizine (Zyrtec®, ZyrtecD®), Loratadine, Loratidine/Pseudoephedrine

Non-Preferred Drug(s) that **DO** require PA: Fexofenadine (Allegra®, AllegraD®), Claritin®, ClaritinD12hr®, ClaritinD24hr® Desloratadine (Clarinex®)

NOTE: ZyrtecD®, AllegraD®, ClaritinD12hr®,ClaritinD24hr® are covered for KBH ONLY

** ***Indicates REQUIRED information***

CONSUMER INFORMATION

** Name:_____ **Medicaid Number: _____

PHARMACY INFORMATION

** Name:_____ **Phone Number: _____

Medicaid Number #:_____ NDC:_____

PRESCRIBING PHYSICIAN INFORMATION

** Name:_____ **Medicaid Number: _____

** Phone Number: _____

** *Indicate:* Non-Preferred Drug prescribed: _____

Other:_____

** *Indicate:* Preferred Drug tried: _____ Length of trial: _____

** *Check* the appropriate box indicating medical necessity for the Non-Preferred Drug:

☐ Medical intolerance to Preferred Drug. Please specify: _____

_____

☐ Inadequate response to Preferred Drug. Please specify: _____

_____

☐ Absence of appropriate formulation or indication of the drug. Please specify: _____

_____

** Prescribing Physician's signature: _____Date: _____

FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka).
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Triptans
PRIOR AUTHORIZATION REQUEST FORM

Preferred Drug(s) that ***DO NOT*** require PA: Rizatriptan Benzoate(Maxalt®, Maxalt-MLT®)
Sumatriptan Succinate (Imitrex®)

Non-Preferred Drug(s) that **DO** require PA: Almotriptan Malate (Axert®)
Frovatriptan Succinate (Frova®)
Naratriptan HCL (Amerge®)
Zolmitriptan (Zomig®, Zomig ZMT®)
Eletriptans-HBr (Relpax®)

** Indicates REQUIRED information

CONSUMER INFORMATION

** Name:_____ **Medicaid Number: _____

PHARMACY INFORMATION

** Name:_____ **Phone Number: _____

Medicaid Number_____NDC:_____

PRESCRIBING PHYSICIAN INFORMATION

** Name:_____ **Medicaid Number: _____

** Phone Number: _____

** *Indicate:* Non-Preferred Drug prescribed: _____

Other:_____

** *Indicate:* Preferred Drug tried: _____ Length of trial: _____

** *Check* the appropriate box indicating medical necessity for the Non-Preferred Drug:

☐ Medical intolerance to Preferred Drug. Please specify: _____
_____

☐ Inadequate response to Preferred Drug. Please specify: _____
_____

☐ Absence of appropriate formulation or indication of the drug. Please specify: _____
_____

** Prescribing Physician's signature: _____Date: _____

FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka).
If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied for information not received.