THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

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4/22/2020

Notice to Providers

Re: Alaska Medicaid Pharmacy Update – April 2020

PREFERRED DRUG LIST (PDL)

On or after June 1, 2020 the updated Alaska Medicaid Preferred Drug List (PDL) will made available on the Division of Health Care Services Medication Prior Authorization Web Page and will become effective on or after July 1, 2020. Medications on the PDL in category D have been reviewed by the P&T Committee on or before the 4/17/2020 meeting will be reflected on the updated PDL.

DRUG UTILIZATION REVIEW (DUR)

Alaska Medicaid DUR committee reviewed the utilization of opioids, along with interacting benzodiazepines and antipsychotics. As a reminder, on 06/01/2020, the Morphine Milligram Equivalent (MME) threshold will be reduced by 50 MME to a cumulative MME of 250. Total MME levels that exceed the limits will require prior authorization. Effective 06/01/2020 prescriptions written for Schedule II adult stimulants (age 21 and over) will require an ICD-10 diagnosis code to be present on the prescription. Pharmacists may contact the prescriber to obtain the ICD-10 code if it is not on the prescription. Prescriptions that do not have a diagnosis code may be subject to prior authorization to determine medical necessity.

NEW CLINICAL PRIOR AUTHORIZATION CRITERIA

Effective on or after 06/15/2020 the following medications have been assigned specific clinical criteria for use and may require prior authorization before payment of the service.

- Dupixent®
- Oxbryta™
- Xolair®
- Interleukin-5 inhibitors (Nucala®, Cinqair®, Fasenra®)

The following medications Prior authorization criteria were revised and will be effective 06/15/2020.

- Orexin receptor antagonists (Belsomera®, Dayvigo™)

The following new to market medications were added to the Interim Prior Authorization List updated 04/17/2020. These medications will require prior authorization and/or step therapy for consideration of approval.

- ARAZLO™
- TRIJARDY™ XR
- NEXLETOL™
- NURTEC™ ODT
- VYEPTI™
- ZERVIATE™
- PALFORZIA™
- REYVOW™
- RIOMET ER™
- CAPLYTA™ CAPSULE
- VALTOCO®
- QUZYTTIR™
- UBRELVY™
- ESPEROCT®
- ABSORICA LD™
- TALICIA®
- SECUADO®
- CONSENSI™

Please visit http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx for the new criteria and prior authorization forms.

References:

Alaska Medicaid prior authorization clinical criteria for use and standards of care are developed under the authority granted to the Alaska Medicaid Drug Utilization Review Committee in compliance with 7 AAC 120.120, 7 AAC 120.130, 7 AAC 120.140, 42 USC 1396r-8, and 42 CFR 456 Subpart K. The Committee considers each of the following in the development of clinical criteria for use as outlined in 7 AAC 105.230(c): medical necessity, clinical effectiveness, cost-effectiveness, and likelihood of adverse effects as well as service-specific requirements. Drugs which fall into a specific therapeutic category but are approved by the FDA after the most recent revision of that therapeutic drug class review will be subject to the same standards set by DUR Committee for the relevant therapeutic category's prior authorization clinical criteria for use. This includes a requirement to utilize or trial preferred agents prior to the utilization of a non-preferred agent within a given therapeutic category unless a documented clinical contraindication exists.

Covered outpatient drugs must meet the parameters defined in 7 AAC 120.110. Drugs which the FDA has approved but clinical benefit has not been established will not be approved.

Please contact Charles Semling, PharmD, RPh at 907.334.2458 charles.semling@alaska.gov
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with any questions regarding these updates and changes.

Clinical Criteria for Use may be found at:
http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx.
Alaska Medicaid Program Updates may be found at:
http://manuals.medicaidalaska.com/docs/updates.htm