



11/23/2020

Notice to Providers

Re: Alaska Medicaid Pharmacy Update – November 2020

### **PREFERRED DRUG LIST (PDL)**

On or after December 1, 2020 the updated Alaska Medicaid Preferred Drug List (PDL) will be made available on the [Division of Health Care Services Medication Prior Authorization Web Page](#) and will become effective on or after January 4, 2021. Medications on the PDL in category A have been reviewed by the P&T Committee on or before the November 20, 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 01/06/2021, the Morphine Milligram Equivalent (MME) threshold will be reduced by 50 MME to a cumulative MME of 200. Total MME levels that exceed the limits will require prior authorization. Drug safety communications and FAERS reports were reviewed along with guidance from the FDA regarding the splitting of insulin boxes. The committee was in favor of increasing the allowed day supply of insulin pens up to 90 days, to account for the billing of the correct day supply of the unbroken box of pens.

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### **NEW CLINICAL PRIOR AUTHORIZATION CRITERIA**

Effective on or after 1/11/2021 the following medications have been assigned specific clinical criteria for use and may require prior authorization before payment of the service.

- Reyvow™
- Palforzia®
- Apokyn®, Kynmobi™
- Dojolvi™

The following medications Prior authorization criteria were revised and will be effective 1/11/2021.

- Xyrem®, Xywav™
- Interleukin-5 Inhibitors
- New prescription medication prior authorization

The following new to market medications were added to the Interim Prior Authorization List updated 11/20/2020. These medications will require prior authorization and/or step therapy for consideration of approval.

- QDOLO™
- ALKINDI SPRINKLE®
- CONJUPRI®
- XYWAV™
- LAMPIT®
- SEVENFACT®
- GIMOTI™
- GAVRETO™
- HEMADY™
- ONGENTYS®
- ONUREG®
- SEMGLEE®
- KESIMPTA PEN®
- AIRDUO® DIGIHALER
- ENSPRYNG™
- MYCAPSSA®
- BLENREP™
- INQOVI®
- EVRYSDI™

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.

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with any questions regarding these updates and changes.

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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>