



December 6, 2018

Notice to Providers

Re: Alaska Medicaid Pharmacy Update – December 2018

Alaska Medicaid will incorporate several claims processing edits to the pharmacy point of sale system resulting from the November 16, 2018 DUR committee meeting. Below is a summary of the upcoming changes.

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## NEW PRIOR AUTHORIZATION CRITERIA

Effective on or after 01/15/2018 the following medications have been assigned specific clinical criteria for use and will require prior authorization before payment of the service.

- Orilissa™
- Epidiolex®
- CGRP receptor antagonists
- Xyrem® (currently requires prior authorization due to cost exceeding \$7,500 per month)

The following medications were added to the Interim Prior Authorization List updated 12/05/2018. These medications will require prior authorization effective 01/07/2019.

- Xyosted™
- Takhzyro™
- Diacomit®
- Galafold™
- Xepi™
- Vyzulta®
- Xhance™
- Solosec™
- Baxdela™
- Kevzara®
- Symporic®
- Olumiant®
- Lokelma™
- Palyngiq™
- Ilumya™
- Osmolex ER™
- Ozempic®
- ZTlido™
- Rhopressa®
- Gocovri™

Please visit the DHSS [Medication Prior Authorization](http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx) page for the new criteria and prior authorization forms (<http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx>).

## UPDATED PRIOR AUTHORIZATIONS

The following prior authorization criteria was reviewed, updated, and approved by the Drug Utilization Committee for the following products:

- H.P. Acthar® Gel
- Lidoderm® Patch

The following medications have been removed from the Interim Prior Authorization List effective 12/17/2018.

- Spiriva Respimat®
- Fioricet® with Codeine
- Opsumit®
- Orenitram® ER
- Otezla®
- Striverdi® Respimat®
- Bydureon® Pen
- Incruse® Ellipta®
- Ryanodex®
- Arnuity® Ellipta®
- Trulicity®
- Mitigare®
- Humira®
- Aristada®
- Xeljanz® XR
- Zinbryta®
- Relistor®

Please visit the DHSS [Medication Prior Authorization](http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx) page for the new criteria and prior authorization forms (<http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx>).

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.

Questions regarding these updates and changes? Please contact

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[Clinical Criteria for Use](http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx) (<http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx>)  
[Alaska Medicaid Program Updates](http://manuals.medicaidalaska.com/docs/updates.htm) (<http://manuals.medicaidalaska.com/docs/updates.htm>)