



01/25/2022

Notice to Providers

Re: Alaska Medicaid Pharmacy Update – January 2022

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

On or after February 1, 2022 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 March 1, 2022. Medications on the PDL in Category C and A (cytokine/CAMs only) have been reviewed by the P&T Committee on or before the January 17, 2022 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. Claims for diabetics not concurrently taking statins was reviewed. As a reminder, ICD-10 codes are required for adjudication of C-II opioid prescriptions. As a reminder, on 06/01/2022, the Morphine Milligram Equivalent (MME) threshold will be reduced by 50 MME to a cumulative MME of 100. Total MME levels that exceed the limits will require prior authorization. ICD-10 codes will also be required for Paxlovid, molnupiravir on 3/1/22 and Ozempic on 4/1/22. A 90 day lookback will be deployed for grandfathering of existing members currently taking Ozempic.

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

Effective on or after 3/1/2022 the following medications have been assigned specific clinical criteria for use and may require prior authorization before payment of the service.

- SPHINGOSINE1-PHOSPHATE RECEPTOR MODULATORS
- OPZELURA
- INHALED PROSTACYCLINS
- RECLAST, ZOMETA
- PROLIA, XGEVA
- NUCALA (CRITERIA UPDATE)
- EUCRISA (REMOVE CRITERIA, RETAIN QL-60gm per 30 days)

The following new to market medications were added to the Interim Prior Authorization List updated 1/17/2022. These medications will require prior authorization and/or step therapy for consideration of approval.

- LEQVIO
- OXBRYTA
- VYVGART
- LIVTENCITY
- BESREMI
- INFLIXIMAB
- OXYCODONE/APAP  
10/300 PER 5ML
- VOXZOGO
- EVEROLIMUS
- ELYXB
- INJECTAFER
- LOFENA
- VUITY
- EPRONTIA
- GVOKE
- SUSVIMO
- FENOFIBRATE (new  
generic strength)

The following medications on the Interim Prior Authorization List will be removed . These medications will no longer require step therapy for consideration of approval.

- NAYZILAM
- VALTOCO

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.

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>