TO: **Pharmacy Providers, Physicians, Nurse Practitioners, Dental Providers, Physician Assistants, Optometrists, Podiatrists, Long Term Care Providers, Clinics, and Hospitals**

RE: 1) July 1, 2015 Changes to the Connecticut Medicaid Preferred Drug List (PDL)
2) New Hepatitis C Prior Authorization Criteria - Olysio, Harvoni, Sovaldi and Viekira Pak
3) Reminder About the 5 day Emergency Supply
4) Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)

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1) July 1, 2015 Changes to the Connecticut Medicaid Preferred Drug List (PDL): The Pharmaceutical & Therapeutics (P&T) Committee has modified the list of preferred prescription products. The Committee has determined these preferred products as efficacious, safe, and cost effective choices when prescribing for HUSKY A, HUSKY C, HUSKY D, Tuberculosis (TB), and Family Planning (FAMPL) clients.

Effective July 1, 2015, changes (additions or removals) have been made to select drug classes. (Please note: the additions and removals listed refer to all strengths and dosage forms **unless otherwise stated**.)

The full list of PDL changes is available on the www.ctdssmap.com Web site. From the Home page, go to Pharmacy Information > Preferred Drug List Information > Preferred Drug List Changes.

Beginning March 1, 2015, the Step Therapy PA Request Form must be used to request a PA for any non-preferred drug within the current Step Therapy drug classes. Providers should refer to Provider Bulletin PB 15-08 for more information on Step Therapy.

A new brand or generic entry into an existing PDL class will only appear if it is preferred. Preferred brand name products with a non-preferred generic equivalent will be designated in **bold** print.

Prior Authorization (PA) is required when any *new* or *refill* prescription is filled for a non-preferred product for the first time.

Providers are urged to be proactive in switching clients to a preferred medication, or in obtaining PA, when appropriate. If a claim for a non-preferred medication is submitted and no PA is on file, the pharmacy will receive a message that they should contact the physician to explain that a PA is required.

The pharmacist should consult with the prescriber to see if a preferred drug can be prescribed as an alternative, or explain that the prescriber must obtain PA from HP before a non-preferred medication can be dispensed.

Pharmacists will have the opportunity to dispense a one-time, 14 day supply of medication by entering all 9's in the Prior Authorization Number Submitted field, NCPDP 462-EV, and a numeric value of "1" in the Prior Authorization Type field, NCPDP 461-EU.

Each time a 14 day supply of medication is dispensed, the pharmacist should provide the client with a DSS authorized flier as described in Provider Bulletin PB 12-41.

Prescribers may submit their PA requests via the Pharmacy Web PA feature on the www.ctdssmap.com secure Web portal. For more information, please access Provider

Bulletin PB 14-55, Pharmacy Web Prior Authorization.

PA forms can be found on the www.ctdssmap.com Web site either under Information → Publications → Authorization/Certification Forms → Pharmacy Prior Authorization Form or Step Therapy PA Form; or Pharmacy Information → Pharmacy Program Publications → Pharmacy Prior Authorization Form or Step Therapy PA Form if appropriate.

The full PDL is available on the www.ctdssmap.com Web site. From the Home page, go to Pharmacy Information > Preferred Drug List Information > Current Medicaid Preferred Drug List.

In addition to the standard PDL, an alphabetical listing of all preferred medications is also available on the Pharmacy page of the www.ctdssmap.com Web site. From the Home page, go to Pharmacy Information → Preferred Drug List Information → PDL Alphabetized Medication List.

The PDL formulary can also be downloaded and accessed for those providers who use e-Prescribing. For more information, visit www.surescripts.com or contact Surescripts directly at 1-866-797-3239.

2) New Hepatitis C Prior Authorization Criteria: Effective July 1, 2015, the *Sovaldi PA Request Form* will be replaced by the *Hepatitis C PA Request Form* which must be used for authorization of the following agents:

- Harvoni,
- Olysio
- Sovaldi
- Viekira Pak

Please note: The Department of Social Services (DSS) will honor previous authorizations for drugs newly subject to the Hepatitis C PA criteria approved prior to July 1, 2015 for dates of service on or after July 1, 2015 up to a period of one year.

The new Hepatitis C PA form is attached below and will be available on the www.ctdssmap.com Web site on July 1, 2015. From the Home page, go to Information → Publications → Forms → Authorization/Certification Forms → Hepatitis C Prior Authorization PA Form; or to Pharmacy Information → Pharmacy Program Publications → Hepatitis C Prior Authorization PA Form.

Please discard any previous versions of this PA form and only use the most current, 07/2015.

3) Reminder about the 5 day Emergency Supply: In addition to the one-time 14 day temporary supply, the Department also allows for a **5 day emergency supply** of a medication that requires PA for non-PDL or Brand Medically Necessary (BMN). If the pharmacist or prescriber is unable to obtain a PA and the client requires the medication after the one-time 14 day override has been used, the pharmacist may call the HP Pharmacy Prior Authorization Call Center, available 24 hours a day, 7 days a week, at 1-866-409-8386 to request a one-time 5 day emergency supply of the medication

4) Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL): This serves to provide clarification on billing requirements for a pharmacy when a brand name medication, which is identified as

a preferred product on the Connecticut Medicaid Preferred Drug List (PDL), is dispensed.

If the brand name medication for a multi-source product (a medication that is available as both the brand name and the generic) is identified as the preferred drug on the PDL, and the brand medication is dispensed, the claim does **not** need to be submitted with a Dispense As Written (DAW) code of '1' for the pharmacy to receive brand reimbursement. If the prescriber has not indicated the brand product is medically necessary, the pharmacy may submit the claim with a DAW code of '5' to signify that the pharmacy dispensed the brand as the generic, or '9' to signify that although substitution is allowed by the prescriber, the Connecticut Medical Assistance Program requests the brand and will receive brand reimbursement as long as the brand name product remains preferred on the PDL.

Any pharmacy claim submitted with a DAW of '1' to signify the prescriber specified the brand product is medically necessary is subject to audit. The pharmacy **must** have a prescription with the words 'Brand Medically Necessary' written in the prescriber's handwriting on file; failure to provide written documentation in the event of an audit will result in the recoupment of the claim. A verbal or electronic prescription would need to be followed up by a hard copy prescription sent to the pharmacy with the appropriate documentation.

Should the pharmacy choose to dispense the generic equivalent when the brand is the preferred product, a non-preferred PA would be required for the claim to process.

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
PO BOX 2943 HARTFORD, CT 06104
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035

CT Medical Assistance Program Hepatitis C Prior Authorization (PA) Request Form

[To be used for authorization of Olysio, Harvoni, Sovaldi and Viekira Pak]

To Be Completed By Prescriber

Prescriber Information	**Patient Information**
Prescriber's NPI:	Client Medicaid ID Number:
Prescriber Name:	Patient Name:
Phone # ( )	Patient DOB: / /
Fax # ( )	Primary ICD diagnosis code:
Prescription Information	
Drug Requested:	Dose/frequency:
□ New therapy □ Continuation	Expected Duration:

Payment will be authorized for 2 weeks of medication, with further refills available every 2 weeks.
The prescriber agrees to obtain all FDA recommended tests, including pregnancy tests, if applicable, and to monitor as appropriate according to evidence-based guidelines for the entire duration of therapy.

Clinical Information

Is the patient 18 years of age or older?	□ Yes	□ No
Does the patient have a diagnosis of Chronic Hepatitis C infection of any genotype 1-6 confirmed by HCV ribonucleic acid (RNA) level?	□ Yes	□ No
Does the patient have evidence of or a known malignancy of any organ diagnosed within the last 12 months?	□ Yes	□ No
Is the patient currently receiving or planning to receive chemotherapy or radiation therapy?	□ Yes	□ No
Does the patient have evidence of or a known terminal disease, with life expectancy of fewer than 12 months?	□ Yes	□ No
Is the patient currently enrolled in hospice?	□ Yes	□ No
Does the patient need more than 12 weeks of therapy?	□ Yes	□ No

If you are requesting more than 12 weeks of therapy, please explain and include the patient's specific genotype:
_____
_____

Please note if this patient has hepatocellular carcinoma or provide any other information relating to the medical necessity (see Conn. Gen. Stat. § 17b-259b(a)) of this drug for this patient:_____
_____
_____
_____

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1-13 and 4a-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the client is under my clinic's/practice's ongoing care. I certify that I am a practitioner and hold a current, unrestricted license that allows me to prescribe medication and that I am enrolled in the CT Medical Assistance Program.

Prescriber Signature:
_____Date:_____