

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 06/01/05 11/01/06
Section: Pharmacy	Section: 31.12	
Subject: Prior Authorization	Pages: 127	Cross Reference:

DOM requires prior authorization of certain covered drugs that have been approved by the Food and Drug Administration (FDA) for specific medical conditions. The approval criteria are recommended by DOM's Pharmacy and Therapeutics Committee and are based on information from the FDA, manufacturers, and medical literature. The prior authorization process is managed through the DOM Pharmacy Benefits Manager.

Prescription Drugs Requiring Prior Authorization

These prescription drugs were chosen based on the high potential for misuse and/or abuse. Prior authorization allows DOM to ensure that these prescription drugs are used responsibly and as they are intended. The following drugs/drug classes require prior authorization:

- ~~Actiq~~
- ~~Cox-2 Inhibitors~~
- Enbrel
- Enteral Nutrition
- ~~Erectile Dysfunction Oral Agents~~
- Immunosuppressants
- ~~Neurontin (brand name only)~~
- Oral Sustained Release Opioid Agonists (brand name only)
- ~~Proton Pump Inhibitors~~
- Synagis
- Xenical

Prior Authorization Process

Processes related to prior authorization for prescription drugs must be handled according to the procedures set forth by the Pharmacy Benefits Manager.

Refer to Section 1.11 Retrospective DUR Information for information related to the Pharmacy Benefits Manager.

Actiq (Oral Transmucosal Fentanyl Citrate)

Actiq is indicated for the management of breakthrough cancer pain in patients with malignancies who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain. Patients considered opioid tolerant are those who are taking at least 60 mg morphine/day, 50 mcg transdermal fentanyl/ hour, or an equianalgesic dose of another opioid for a week or longer.

Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, Actiq is contraindicated in the management of acute or postoperative pain. This product must not be used in opioid non-tolerant patients.

The FDA recommends Actiq to be used only in the care of cancer patients and only by oncologists and pain specialists who are knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain.

The appropriate dosing and safety of Actiq in opioid tolerant children with breakthrough cancer pain have not been established below the age of sixteen (16) years.

DOM covers Actiq when the following criteria are met:

1. Management of breakthrough cancer pain in patients with malignancies who are already receiving and who are tolerant to opioid therapy.
2. Diagnosis of cancer (ICD-9 codes 141.0-208)

Actiq is contraindicated for those patients with one or more of the following:

- Hypersensitivity to opiates
- Respiratory depression/ hypoxia/ hypercarbia
- Severe asthma or COPD
- Paralytic ileus
- Treatment of acute or postoperative pain
- Treatment of opioid non-tolerant patients
- Use in children below the age of sixteen (16) years

Cox-2 Inhibitors

DOM covers ~~Cox-2 Inhibitors and/or brand name Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) when the following criteria are met:~~

1. ~~The beneficiary must have a diagnosis of one of the following:~~
 - a. ~~Osteoarthritis (OA)~~
 - b. ~~Rheumatoid Arthritis (RA)~~
 - c. ~~Degenerative Joint Disease (DJD)~~
 - d. ~~Systemic Lupus Erythematosus (SLE)~~
 - e. ~~Other joint related diagnosis~~
 - f. ~~Primary dysmenorrhea~~
 - g. ~~Familial adenomatous polyposis~~

2. ~~The beneficiary must have received and failed to adequately respond to a 30-day trial of each of two prior NSAIDS or COX-2 within the past 6 month period prior. (May be generic, OTC, or brand name.)~~

3. ~~For Cox-2 Inhibitors, the beneficiary must not have a documented diagnosis of one of the following:~~
 - a. ~~GI ulcer disease~~
 - b. ~~GERD~~
 - c. ~~Diverticulitis~~
 - d. ~~Anticoagulation therapy~~
 - e. ~~Other diagnosis in which bleeding could occur with NSAID therapy~~

~~NOTE: Generic and DOM covered over the counter products in these classes do not require prior authorization.~~

Enteral Nutrition

Enteral nutrition is used as a nutritional replacement for patients who are unable to get enough nutrients in their diet. These formulas are taken by mouth or through a feeding tube and are used by the body for energy and to form substances needed for normal body functions.

DOM covers enteral nutrition when the following criteria are met:

1. For beneficiaries age 21 and over, the requested enteral nutritional must be the sole source of nutrition.
2. For beneficiaries under the age of 21, specialized feeding must constitute more than 50% of nutritional needs. A qualifying diagnosis is required.
3. The unique composition of the formula must contain nutrients the beneficiary is unable to obtain from food.
4. The composition of the formula must represent an integral part of treatment of the specified diagnosis and/or condition.
5. It must be documented that the beneficiary is unable to tolerate nutrients orally to sufficiently maintain life. The beneficiary is either unable to take oral nutrition or unable to tolerate oral intake.
6. Consideration is not given to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or non-compliance with a specialized diet.

Documentation to support coverage of enteral nutrition must be maintained in the beneficiary's medical record. Documentation must include the following:

- a. Specific diagnosis related to the beneficiary's inability to take or eat regular food
- b. For oral feedings, list economic alternatives that have been tried. For beneficiaries age 21 and over, also list laboratory values for albumin or total protein.
- c. Amount needed per day
- d. Duration of treatment
- e. Height, current weight, and recent weight loss
- f. Specific prescription identifying levels of individual nutrient(s) that is required in increased or restricted amounts.

A prior authorization for enteral nutrition is for the nutritional product only and does not include supplies necessary to administer the nutrient.

Please note that Medicare must be billed first if the beneficiary is dually-eligible for Medicare and Medicaid.

Enteral nutritional replacements are not covered for residents in a long-term care facility, i.e. nursing home, ICF MR, etc. as these products are included in facilities' per diem rate.

Etanercept/Enbrel

DOM covers Etanercept/Enbrel when the following criteria are met on the **initial request**:

1. The beneficiary has a diagnosis of Rheumatoid Arthritis (RA).
2. The beneficiary has failed trials of at least one NSAID and one local/oral steroid without success.
3. The beneficiary has failed a trial of a least one prior DMARD and is currently on or has failed the second DMARD. Other DMARDs include:
 - a. Gold
 - b. Penicillamine
 - c. Plaquenil (Hydroxychloroquine)
 - d. Methotrexate (Rheumatrex)
 - e. Sulfasalazine

DOM covers Etanercept/Enbrel for **renewal requests** with documentation of demonstrated effectiveness.

Erectile Dysfunction Oral Agents

DOM covers ~~erectile dysfunction oral agents~~ when the following criteria are met:

1. ~~The beneficiary must be male and 21 or older.~~
2. ~~The beneficiary must be male from birth.~~
3. ~~The beneficiary must have a diagnosis of one of the following:~~
 - a. ~~Spinal Cord injury~~
 - b. ~~Diabetic neuropathy~~
 - c. ~~Prostatectomy~~
 - d. ~~Irreversible neurological damage due to TURP~~
 - e. ~~Cardiovascular disease (CHD, PVD, HTN)~~
4. ~~The beneficiary must not be receiving nitrates, in any form, or other drugs contraindicated with recommended oral erectile dysfunction treatment.~~

Coverage is limited to one prescription of no more than two units, total, per month for this entire drug category.

Immunosuppressants

DOM covers immunosuppressants when the following criteria are met:

1. The beneficiary must have a diagnosis of one of the following:
 - a. Kidney, liver or heart allogenic transplant
 - b. Rheumatoid arthritis
 - c. Psoriasis
 - d. Nephrotic Syndrome
 - e. Stevens-Johnson Syndrome

2. Documentation must reflect that blood levels are monitored regularly.

The FDA recommends that the prescriber be experienced in managing post-transplant patients on immunosuppressant therapy.

Please note that Medicare must be billed first if the beneficiary is dually-eligible for Medicare and Medicaid.

Neurontin

DOM covers Neurontin when the following criteria are met:

1. The beneficiary must have a diagnosis of:

- Partial/partial complex seizures
- Post-Herpetic Neuralgia
- Diabetic Neuropathy of the lower extremities*
- Treatment of Amyotrophic Lateral Sclerosis, (ALS)**

** Supported by several comparative clinical trials*

*** Granted orphan drug status by the FDA*

2. Corresponding clinical information must be in beneficiary's medical chart and be retrievable.

Generic gabapentin is exempt from prior authorization.

Approval ~~may~~ be granted for up to six months.

Oral Sustained Release Opioid Agonists (~~Brand name only~~)

Patients appropriate for oral sustained release (SR) opioid agonists have chronic, severe pain that has not responded to alternative pain management choices, such as schedule II opioid agonists, physical therapy, cognitive behavioral techniques and/or medical techniques.

DOM covers oral SR opioid agents when the following criteria are met:

1. The beneficiary must have a diagnosis of one of the following:
 - a. Cancer (ICD-9 codes 141.0-208)
 - b. Arthropathies (ICD-9 codes 715.01-715.9)
 - c. Spinal neurological disorders (ICD-9 codes 720-725)
 - d. Other ICD-9 codes with supporting documentation
2. If the beneficiary does not have a diagnosis noted above, the prescriber must provide additional medical justification for the absence of alternative therapies in debilitated patients.
3. The beneficiary must have no contraindications such as:
 - a. Hypersensitivity to opiates
 - b. Respiratory depression/ hypoxia/hypercarbia
 - c. Severe asthma or COPD
 - d. Paralytic Ileus

The daily dosage intervals of oral sustained-release opioid agonists should not exceed manufacturer guidelines or FDA requirements.

For opioid dependent patients, the prescriber must provide documentation of a titration-weaning schedule.

Proton Pump Inhibitors

DOM covers proton pump inhibitors also known as anti-secretory therapy when the following criteria are met:

1. The beneficiary must have a diagnosis of one of the following:
 - a. Heartburn
 - b. H. Pylori
 - c. Gastroesophageal Reflux Disease (GERD)
 - d. Esophagitis
 - e. Peptic Ulcer Disease (PUD)
 - f. Gastric Ulcer
 - g. Barrett's Esophagus
 - h. Zollinger-Ellison Syndrome
 - i. Laryngopharyngeal Reflux (LPR)
 - j. Other Hypersecretory condition (diagnosis with medical justification attached to the request)

2. The beneficiary must have failed two (2) 30-day trials of Antacids, H2 Antagonists, or other PPI. Multiple antacids will be considered as one trial only.

3. The beneficiary must have documentation of testing supporting the diagnosis.

NOTE: DOM covered over-the-counter products in this class do not require prior authorization.

Palvizumab (Synagis)

DOM covers Synagis when a beneficiary meets the criteria in one of the four following categories:

- Category 1 Prematurity of \leq 28 weeks gestation
Age: \leq 1 year old
- Category 2 Prematurity of 29-32 weeks gestation
Age: \leq 6 months at the start of Respiratory Syncytial Virus (RSV) Season
- Category 3 Prematurity of \leq 35 weeks gestation
Age: 0-2 years old
Diagnosis: Chronic Lung Disease (CLD) and ongoing medical treatment for CLD (supplemental oxygen, steroids, bronchodilators or diuretics) within the last 6 months
- Category 4 33-35 weeks gestation
Age: Birth- 6 months old during RSV season
Risk factors as noted below are present and documented
No diagnosis of CLD is required.

Extending beyond age two years may be considered on an individual basis when supported by clinical documentation of extreme necessity.

Prior authorization will end at age two (last day of child's birthday month).

Prior authorization is granted during RSV season only (usually October through March).

RSV Risk Factors:

One of the following is considered sufficient:

- Hemodynamically significant Congenital Heart Disease (simple, small Atrial Septal Defects (ASD), Ventricular Septal Defects (VSD), and Patent Ductus Arteriosus (PDA) are not eligible).
- Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS)

Or

Must have two of the following:

- Exposure to tobacco smoke in the home
- School age siblings
- Multiple birth
- Day care

Xenical

DOM covers Xenical when the following criteria are met:

1. A beneficiary must be at least 21 years of age.
2. For the initial request, a beneficiary must have all of the following criteria:
 - a. A diagnosis of diabetes, hypertension, or hyperlipidemia
 - b. A Body Mass Index (BMI) of 35 or greater
 - c. Documentation in medical record of prior physician supervised exercise/diet regimen
 - d. Has planned adjunctive therapy
 - e. Has been educated and understands risks/adverse reaction/complications
 - f. Have no contraindications such as Chronic Malabsorption Syndrome, Hypothyroidism, Cholestasis, or Hypersensitivity to Xenical or to any of its components.
3. For 1st renewal request, the beneficiary must have documentation of 7% body weight or greater within 3 months.
4. For subsequent renewals, the beneficiary must have documentation of no weight gain.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: -07/01/05 11/01/06
Section: Pharmacy	Section: 31.13	
Subject: Over the Counter (OTC) Drugs	Pages: 4-3	Cross Reference:

DOM covers selected over-the-counter (OTC) drugs pursuant to a legal prescription in writing or verbal order. Only those OTC products manufactured by companies who participate in the Federal Drug Rebate Program are covered.

Prescribing of these OTC drugs is strongly encouraged whenever appropriate.

Acetaminophen-Drops, liquid, Suppositories	Insulin (All)
Acetaminophen Tabs- 325 mg, 500mg	Lacrilube Ophth. Ointment
Al & Mg Hydroxide- Tabs & Suspension	Loperamide Liquid & Tabs
Al & Mg Hydroxide/ Simeth.- Tabs & Suspension	Loratadine (Alavert) Tabs, ODT, 12-hr, Syrup
Ammonium Lactate 12% Cream & Lotion	Mag. Gluc. 500 mg, Mag. Cl.Sr. 64 mg Tab
Aspirin Tabs- 81 & 325 mg (Buff/ Chew, E.C.)	Miconazole 2% Topical Cream
Benzoyl Peroxide Gel- 5% & 10%	Miconazole Vaginal Cream 2%
Brompheniramine/Pseudo-Liquid & Tabs	Naphazoline/Pheniramine Ophth. Drops
Brompheniramine/Pseudo-DM-Liquid	Niacin Tabs & Caps- 50,100,125,250,400,500mg
Calcium Carbonate- 500 mg Tabs, Suspension	Nicotine Gum, lozenges, patches
Powder (Dialysis Pts. Only)*	Omeprazol OTC 20 mg (Prilosec)
Chlorpheniramine Tabs & Syrup	Oral Electrolyte Mixtures (compares to Pedialyte)
Clemastine 1.34 mg Tabs	Permethrin Cream Rinse
Clotrimazole 1 % Topical- Cream & Soln.	Phenazopyridine 95 mg Tab
Clotrimazole Vaginal Cream 1% & 2%	Prenatal Vitamins
Dexbrompheniramine/Pseud 6/120 mg Tabs	Pseudoephedrine- Drops, Liquid & Tabs
Dextromethorphan Polystirex 30/5 ml Suspension	Pyrantel Pamoate Susp 144mg/ml
Dextromethorphan/Pseud Drops & Syrup	Renal Vitamins (Dialysis Pts. Only)*
Diphenhydramine Caps- 25 & 50 mg & Liq.	Tears (Artificial) Ophth. Drops
Ferrous Sulfate-Drops,Liquid,325 mg Tabs, Slow Release Iron Tabs	Tolnaftate Cream and Powder
Guaifenesin Syrup- AC, DAC, DM, Plain	Triple Antibiotic Ointment
Hydrocortisone Cream- 0.5% & 1.0%	Triprolidine/ Pseudo- liquid & tabs
Ibuprofen Suspension	

DOM may not cover all available package sizes.

DOM covers selected over-the-counter (OTC) drugs pursuant to a legal prescription in writing or verbal order. Only those OTC products manufactured by companies who participate in the Federal Drug Rebate Program are covered.

Prescribing of these OTC drugs is strongly encouraged whenever appropriate.

Generic Name	Strength	Common Brand Name	Dosage Form
Acetaminophen	100mg/ml	Tylenol Drops	Drops
Acetaminophen	160 mg/5ml	Tylenol	Elixir
Acetaminophen	160mg/5ml	Tylenol	Liquid
Acetaminophen	80 mg	Feverall Suppository	Suppository
Acetaminophen	120 mg	Tylenol Suppository	Suppository
Acetaminophen	325 mg	Feverall Suppository	Suppository
Acetaminophen	650 mg	Tylenol Suppository	Suppository
Acetaminophen	325 mg	Tylenol	Tablet
Acetaminophen	500 mg	Tylenol	Tablet
Al & Mg Hydroxide		Mylanta	Tablets
Al & Mg Hydroxide		Various	Suspension
Al & Mg Hydroxide/ Simeth.		Various	Suspension
Al & Mg Hydroxide/ Simeth.		Various	Tablets
Ammonium Lactate	12%	Amlactin 12% Cream	Cream
Ammonium Lactate	12%	Amlactin 12% Lotion	Lotion
Aspirin	81mg	Various	Buff/Chew/E.C.
Aspirin	325 mg	Various	Buff/Chew/E.C.
Bacitracin	500 u/G	Various	Topical Ointment
Bactracin/ polymyxin		Polysporin Ointment	Ointment
Benzoyl Peroxide Gel	5%	Benzac AC 5% Gel	Gel
Benzoyl Peroxide Gel	10%	Benzac AC 10% Gel	Gel
Brompheniramine/ Pseudoephedrine		Various	Liquid
Brompheniramine/ Pseudoephedrine		Various	Tablets
Brompheniramine/Pseudo DM		Various	Liquid
Calcium Carbonate (Dialysis Pts. Only)* Denote on prescription for dialysis pt.	500 mg		Tablets
Calcium Carbonate (Dialysis Pts. Only)* Denote on prescription for dialysis pt.			Powder
Chlorpheniramine	2mg/5ml	Chlor-Trimeton	Syrup
Chlorpheniramine	4mg	Chlor-Trimeton	Tablet
Chlorpheniramine	8 mg	Chlor-Trimeton	Tablet
Chlorpheniramine	12 mg	Chlor-Trimeton	Tablet
Clemastine	1.34 mg	Tavist	Tablet
Clotrimazole Topical	1 %	Lotrimine AF 1 %	Cream
Clotrimazole Topical	1%	Lotrimin	Solution
Clotrimazole Vaginal	1%	Mycelex 7	Cream
Clotrimazole Vaginal	2%	Various	Cream
Dexbrompheniramine/Pseudoephedrine	6/120mg	Drixoral	Tablets
Dextromethorphan Polystyrene	30 mg/5ml	Delsym	Suspension
Dextromethorphan/Pseudoephedrine		Various	Drops

Generic Name	Strength	Common Brand Name	Dosage Form
Dextromethorphan/Pseudoephedrine		Various	Syrup
Diphenhydramine	25 mg	Benadryl	Capsule
Diphenhydramine	50 mg	Benadryl	Capsule
Diphenhydramine	12.5/5ml	Benadryl	Elixir, Liq., Sol
Ferrous Sulfate	75 ml/.6ml	Fer-Gen-Sol	Drops
Ferrous Sulfate	220 mg/5 ml	Various	Elixir
Ferrous Sulfate	300 mg/5ml	Various	Liquid
Ferrous Sulfate	325 mg	Iron	Tablet
Ferrous Sulfate Slow Release Tab	160 mg	Slow Fe	Tablet
Guaifenesin Plain	100mg/5 ml	Robitussin Plain	Liquid
Guaifenesin AC	100/10 mg	Robitussin AC	Liquid
Guaifenesin DAC	100/30/10mg	Robitussin DAC	Liquid
Guaifenesin DM	100/10mg	Robitussin DM	Liquid
Hydrocortisone Cream	0.50%	Cortaid	Cream
Hydrocortisone Cream	1%	Cortaid	Cream
Ibuprofen	100mg/5ml	Motrin	Suspension
Insulin (ALL OTC)			
Loperamide	2mg	Imodium	Tablet
Loperamide	1mg/5ml	Imodium	Liquid
Loratadine	10 mg	Claritin	Tablet
Loratadine D-12 hr	120/5mg	Claritin D-12	Tablet
Loratadine D-24 hr	240/10mg	Claritin D-24	Tablet
Loratadine ODT	5mg	Claritin Reditabs	ODT
Loratadine	5mg/5ml	Claritin Syrup	Syrup
Magnesium Gluconate	500 mg	Various	Tablet
Magnesium Chloride Sr	64 mg	Slow-Mag 64	Tablet
Miconazole Topical	2%	Various	Cream
Miconazole Vaginal	2%	Monistat	Cream
Naphazoline/Pheniramine Ophthalmic		Naphcon-A	Drops
Niacin	50mg	Various	Tabs/Caps
Niacin	100mg	Various	Tabs/Caps
Niacin	125mg	Variuos	Tabs/Caps
Niacin	250mg	Various	Tabs/Caps
Niacin	400mg	Various	Tabs/Caps
Niacin	500mg	Various	Tabs/Caps
Nicotine Cessation Products		Nicorette, Commit Lozenges	Gum, lozenges, patch
Ocular Lubricant Ointment			Ointment
Oral Electrolyte Replacement Mixtures		Pedialyte	Solution
Permethrin Cream Rinse	1%	Nix Cream Rinse	Rinse
Piperonyl/Pyrethrins Topical		Lice Treatment	Topical
Phenazopyridine	95mg	Azo Standard	Tablet
Prenatal Vitamins (Pregnant Pts. Only) Denote on prescription for pregnant pt. **		Various	Tablets
Pseudophedrine	15mg/5ml	Dorcol Children's Decongestant	Drops
Pseudophedrine	30mg/5ml	Novafed	Syrup
Pseudophedrine	30mg	Sudafed	Tablet
Pseudophedrine	60mg	Sudafed	Tablet
Pyrantel Pamoate Suspension	144mg/ml	Pin X	Suspension

Generic Name	Strength	Common Brand name	Dosage Form
Renal Vitamins (Dialysis Pts. Only)* Denote on prescription for dialysis pt.		Various	Tablet
Tears Ophthalmic Drops		Various	Ophthalmic Drops
Tolnaftate Cream	1%	Tinactin	Cream
Tolnaftate Powder	1%	Tinactin	Powder
Triple Antibiotic Ointment		Neosporin	Ointment
Tripolidine/Pseudoephrine		Actifed Syrup	Syrup
Tripolidine/Pseudoephrine		Actifed Tablet	Tablet

*For dialysis patients only, document "FOR DIALYSIS PT." on the front of the prescription.

**For pregnant patients only, document "FOR PREGNANT PT." on the front of the prescription.

Drugs which are available over-the-counter (OTC) shall not be billed to DOM with the NDC for the legend product. NDCs of the legend product that remain covered will be subject to PA and POS requirements.

Charges to Medicaid shall be no more than what is charged to the general public for retail sale. DOM reimbursement to providers may be based on the unit price represented by the largest package size if significant cost savings would be realized.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 02/01/04 11/01/06
Section: Pharmacy	Section: 31.15	
Subject: Tobacco Cessation	Pages: 1	Cross Reference:

Tobacco Cessation Medications

The following types of tobacco cessation medications will be covered in the Mississippi Medicaid program:

- ~~Nicotine lozenges~~
- ~~Nicotine gum~~
- ~~Nicotine patches~~
- ~~Nicotine nasal spray~~
- ~~Nicotine oral inhaler~~
- ~~Zyban~~
- Over-the-counter nicotine products
- Legend or prescription nicotine replacement products

A physician's prescription will be required for all legend and over-the-counter tobacco cessation medications. Each prescription will count toward the monthly limit.

DOM ~~is authorizing~~ authorizes benefits for tobacco cessation medications for the purpose of supporting beneficiaries who are trying to quit tobacco use with the temporary assistance of nicotine replacement therapy. ~~and/or Zyban®~~. It is expected that utilization of these products will be in accordance with medical standards of practice, FDA guidelines, and manufacturers' recommendations which generally limit product use to approximately 12 weeks. DOM will monitor the beneficiary's utilization of tobacco cessation products for over utilization or misuse, and in instances where there are patterns suggesting over utilization or misuse, the prescribing physician(s) will be contacted for justification of medical necessity.

Tobacco Cessation Counseling

To maximize the effectiveness of tobacco cessation medications, the Mississippi Tobacco Quitline offers free telephone counseling through a statewide toll-free telephone number (1-877-4US2ACT).

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 06/01/05 11/01/06
Section: Pharmacy	Section: 31.24	
Subject: Preferred Drug List	Pages: 1	Cross Reference:

The Preferred Drug List (PDL) is a list of drugs, which have been reviewed by a committee of physicians, pharmacists and nurse practitioners referred to as the Pharmacy and Therapeutics (P&T) Committee, and proposed by the Pharmacy and Therapeutics (P&T) Committee, a group of physicians, pharmacists, nurse practitioners, and/or health care professionals. Final approval is the responsibility of the Executive Director of the Division of Medicaid. The Division of Medicaid (DOM) recommends that prescribers use the drugs on the PDL list.

The preferred drug list contains a wide range of generic and preferred brand name products that have been approved by the FDA. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness. Drugs on the PDL are as effective as non-preferred drugs, but offer economic benefits for beneficiaries and the State of Mississippi.

The Mississippi Medicaid Preferred Drug List is subject to change. Refer to the Pharmacy Services page on the DOM website at www.dom.state.ms.us for a current listing of prescription drugs on the PDL.

The Division of Medicaid shall not reimburse for brand name drugs if there are equally effective generic equivalents available, and the generic equivalents are the least expensive.

~~The Mississippi Medicaid Preferred Drug List is subject to change. The list will be updated as generic drugs are introduced that are alternatives to preferred brand name drugs and substitute them for the brand name drug on the PDL, as necessary. Therefore, when a brand name drug included on the PDL becomes available generically, the generic equivalent(s) will replace brand name drugs. Brand name drugs will not be included on the PDL when generic equivalents and products are available at a generic price. If the manufacturer discontinues a drug, it will be removed from the PDL.~~

Preferred Drug List Exceptions

The DOM has authorized the Pharmacy Benefits Manager to approve drugs outside the PDL if when one of the following prior authorization criteria are satisfied:

- 1) Beneficiary must have used the preferred agents for at least a ~~thirty (30)~~ 30 day course of treatment per drug ~~each~~ and failed trials, within six ~~(6)~~ months prior to requesting the PA and there is documentation of therapeutic failure of preferred drugs, or
- 2) ~~Documentation of therapeutic failure of preferred drugs, or~~ Adverse event(s) reaction(s) to preferred agents, or
- 3) ~~Documentation of stable therapy as reflected in ninety (90) days of paid Medicaid claims. —~~ Contraindications to preferred agent(s), i.e. drug interaction, existing medical condition preventing the use of preferred agent(s).

Drugs must be prescribed and dispensed in accordance with medically excepted indications for uses and dosages. No payment may be made under the Medicaid program for services, procedures, supplies or drugs which are still in clinical trials and/or investigative or experimental in nature.

Exceptions to the criteria may be considered if there is sufficient documentation of stable therapy as reflected in 90 days of paid Medicaid claims.

PDL exception request will be reviewed and a determination notice provided within 24 hours from receipt of request by telephone or other telecommunications device. In emergency situations, the Division will allow payment for a 72-hour supply of drugs that are to be authorized.

Refer to the Pharmacy Services page on the DOM website @ www.dom.state.ms.us for a Preferred Drug List Exception Request Form.

~~Approval will not be granted for non-FDA approved indications. No payment may be made under the Medicaid program for services, procedures, supplies or drugs which are still in clinical trials and/or investigative or experimental in nature.~~

Criteria Exceptions

~~Exceptions to the PDL criteria may be considered by the Pharmacy Benefits Manager if there is sufficient documentation of:~~

- ~~• Adverse event(s) reactions(s) to preferred agents or~~
- ~~• Therapeutic failure(s) of preferred agents or~~
- ~~• Contraindications to preferred agent(s) i.e. drug interaction, existing medical condition preventing the use of preferred agent(s).~~

~~Refer to the Pharmacy Services page on the DOM website @ www.dom.state.ms.us for a Preferred Drug List Exception Request Form.~~