

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF HEALTH CARE SERVICES

Frank H. Murkowski, Governor

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IMPORTANT INFORMATION for Alaska Medical Assistance Program Providers

May 26, 2006

Letter number: FY2006-001-All

To: Alaska Medical Assistance Program Participating Providers: Dentists, Podiatrists, Physicians, Pharmacies, Advanced Nurse Practitioners, Nurse Midwives, Inpatient and Outpatient Hospitals.

Dear Providers:

The Department of Health and Social Services (The Department) announces several changes to Medicaid and CAMA pharmacy claims administration.

Prior-authorization Required: Effective June 28, 2006, prior-authorization is required for Actiq®, Botox®, Byetta®, Carisprodolol, Proton Pump Inhibitors, and Transderm Scop®. Patient groups exempted from this policy include: patients with cancer, patients in a long term care facility, and patients in hospice. 7 AAC 43.594(a)

Restriction on number of units: Effective June 28, 2006, maximum units per thirty day period applied to Triptans (Serotonin Receptor Agonists), and Anti-emetics are shown on the attachment. The listed quantities may be exceeded if the prescriber obtains a prior-authorization from the First Health Managed Access Program (MAP) desk. 7 AAC 43.594 (b)

Change in coverage: for those eligible for CAMA (eligibility code 21): Triptans (Serotonin Receptor Agonists) are no-longer covered. The following medications require prior-authorization for CAMA recipients: all analgesics, all interferons, and ribavirin. The CAMA patient's prior-authorizations may be obtained from the MAP desk. The CAMA patient's analgesic prior-authorization may be obtained when the analgesic is used for the treatment of pain associated with diabetic neuropathy, terminal cancer, or terminal AIDS.

Background

It is necessary to enhance our Drug Utilization Review (DUR) program by placing restrictions on medications to limit use to labeled indications and quantities to assure prescriptions and claims for these medications are medically necessary and prescribed in an appropriate manner.

Obtain Prior-authorization as follows:

Prior-authorization (PA) requests must be initiated by the **prescribing physician, nurse practitioner or the licensed health care provider with prescriptive authority.** The pharmacy may not request the prior approval. The completed PA request will be reviewed by Clinical Pharmacists with the First Health Managed Access Program (MAP) at 1-800-331-4475. The PA form is attached.

If there are any questions, please call me at 907-334-2425.

Sincerely,



Dave Campana, R.Ph.
Medicaid Pharmacy Program Manager

cc: Dwayne Peeples, Director
DUR Committee Members
Melinda Sater, Pharm D, Clinical Manager First Health Services Corporation
Kelly Hause, Facilities Program Manager
Cindy Christensen, Practitioner Program Manager

Enclosures

MAP PA Form
Maximum Units per Month

ALASKA DIVISION OF HEALTH CARE SERVICES REQUEST FOR PRIOR AUTHORIZATION

PRESCRIBING PHYSICIAN:	
FIRST NAME	LAST NAME
PHONE NUMBER	MEDICAID ID NUMBER
FAX NUMBER	

MEDICAID PATIENT:	
FIRST NAME	LAST NAME
DIVISION OF MEDICAL ASSISTANCE ID NUMBER	
DATE OF BIRTH	SEX

DISPENSING PHARMACY:		
NAME	PHONE NUMBER	FAX NUMBER

AUTHORIZATION DATES:	
REQUEST DATE	BEGIN DATE

PLEASE DOCUMENT BELOW THE APPROPRIATE CLINICAL INFORMATION FOR AUTHORIZING THIS MEDICATION AND RETURN TO THE FAX NUMBER LISTED BELOW. THANK YOU FOR YOUR COOPERATION.
NOTE: INCOMPLETE REQUESTS WILL BE DENIED UNTIL ALL REQUIRED INFORMATION IS RECEIVED.

REQUESTED MEDICATION

*CHECK BOX TO LEFT OF REQUESTED MEDICATION AND SUPPLY STRENGTH AND DAILY DOSE
 This form may also be used for requesting to exceed the maximum allowed units.*

		STRENGTH	DAILY DOSE
		STRENGTH	DAILY DOSE
		STRENGTH	DAILY DOSE

DIAGNOSIS FOR REQUESTED MEDICATION

OTHER PERTINENT MEDICATION PREVIOUSLY TAKEN

MEDICATION NAME	STRENGTH	DAILY DOSE	DATE STARTED	DATE STOPPED

PRESCRIBER'S SIGNATURE	SPECIALTY
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FIRST HEALTH SERVICES USE ONLY:		[] APPROVED [] CHANGED [] DENIED
DATE	LENGTH OF AUTHORIZATION	
MAP PHARMACIST / TECHNICIAN	COMMENTS	
NDC NUMBER		

SUBMIT REQUESTS TO: FIRST HEALTH SERVICES FAX: (888) 603-7696 TELEPHONE: (800) 331-4475

Letter number: FY2006-001-All; Attachment – Maximum Units per Month

Quantity limits

<u>Anti-emetic</u>	
Aloxi® injection:	4 vials per month
Anzemet® tablets:	50mg and 100mg: 5 tablets per month
Anzemet® injection:	4 vials 100mg/5ml or 8 amps 12.5mg/0.625ml per mo
Emend® capsules:	4 Tri-packs: (12 capsules) per month
Kytril® tablets:	1mg: 8 tablets per month
Kytril® liquid	1mg/5ml: 30ml per month
Kytril® injection:	1mg/ml vials: 8 vials 8ml (8mg) per month
Marinol 2.5 mg, 5 mg, 10 mg	# 30 capsules per month of each strength
Zofran® tablets: 4mg and 8mg:	12 tablets per month
Zofran® ODT tablets: 4mg and 8 mg:	12 tablets per month
Zofran® tablets: 24mg:	4 tablets per month
Zofran® liquid 4 mg/5 ml:	50ml per month
Zofran® injection: 2mg/ml vials:	4 vials 20ml(40mg) or 8 vials 2ml(4mg) per month

<u>Triptan's (Serotonin Receptor Agonists)</u>	
Amerge® tablets: 1 mg and 2.5 mg	9 tablets per 30 days
Axert® tablets: 6.25 mg and 12.5 mg	6 tablets per 30 days
Frova® tablets: 2.5 mg	9 tablets per 30 days
Imitrex® tablets: 25 mg, 50 mg, and 100 mg	9 tablets per 30 days
Imitrex® nasal spray: 5 mg and 20 mg	6 unit dose sprays per 30 days
Maxalt® tablets: 5 mg and 10 mg	9 tablets per 30 days
Maxalt MLT® tablets: 5 mg and 10 mg	9 tablets per 30 days
Relpax® tablets: 20mg and 40mg	6 tablets per 30 days
Zomig® tablets: 2.5 mg and 5 mg	6 tablets per 30 days
Zomig ZMT® tablets: 2.5 mg and 5 mg	6 tablets per 30 days
Zomig® Nasal Spray 5mg	6 unit dose sprays per 30 days
Imitrex ®6mg/0.5ml Injection	4 injections per 30 days