PHARMACY NEWS

PASSPORT HEALTH PLAN

SUPPORTING OUR PROVIDER PARTNERS THROUGH COMMUNICATION AND COLLABORATION.

DATE NOVEMBER 2014
ISSUE 3

HELPFUL NUMBERS FOR PROVIDERS

Passport Health Plan
Magellan: 1-800-846-7971
Bin: 016523
Processor control: 747

HELPFUL NUMBERS FOR MEMBERS

Passport Health Plan
800-578-0603

WEBSITE
www.passporthealthplan.com

NEW IN THIS ISSUE

Formulary Updates

The following changes have been made to the Passport Health Plan Preferred Drug Listing (PDL):

- **Synagis:** Passport Health Plan (Passport) has revised its criteria concerning the use of Synagis to reflect the updated guidance from the American Academy of Pediatrics (AAP) for the prevention of respiratory syncytial virus (RSV). Additional information on the updated guidelines from AAP can be found online at http://pediatrics.aappublications.org/content/134/2/415.full
  - Also, please note the changes in our billing/reimbursement process:
    - All Synagis drug claims must be billed directly to Magellan Health Solutions (Magellan) at www.magellanprovider.com to receive reimbursement.
    - All associated nurse visits must be billed directly to Passport using code 99601.
    - Passport began accepting authorizations for Synagis on October 1, 2014.
- **Ritalin LA:** Passport has revised its criteria to include coverage of Ritalin LA for children up to age 6. Ritalin LA will process at point of sale and requires NO prior authorization for this age group.
- **Levemir FlexPen:** Novo Nordisk will cease production of Levemir FlexPen effective September 30, 2014. After wholesalers' inventory is exhausted, no additional product will be available. The FlexPen is being discontinued due to the launch of Levemir FlexTouch, the first prefilled insulin delivery device with a no push-button extension.
  - Levemir FlexTouch will be a preferred agent for Passport members.
  - Prescriptions for Levemir FlexPen ARE NOT interchangeable with Levemir FlexTouch.
  - All members will require a new prescription for Levemir FlexTouch.

Additional formulary updates may be found in the table beginning on page 4.

All medications may be subject to edits to limit quantities dispensed, day's supply, and drug-drug interactions at the point of service. Pharmacy and Therapeutic Committee decisions are based upon relevant medical literature that is evidence based and peer reviewed. Price(s) listed are calculated based on Wholesale Acquisition Cost (WAC) published by First Data Bank. The cost of therapy is calculated based on a 30 days' supply unless otherwise indicated. This information is to be used as a reference and/or a learning tool for providers.

Pharmacy Tips and Reminders

All Providers: Hydrocodone Changes

- Effective October 6, 2014, all medications containing hydrocodone will move from a "Schedule III" medication to a "Schedule II" controlled substance under federal law. This will change how the medication can be written and how the patient can obtain refills in the future. Passport members who filled a hydrocodone-containing medication in the last 90 days have been notified of changes that can be expected with this move. Here is a summary of the main changes:
    - Prescriptions for medicines containing hydrocodone will require a written prescription and will only be good for 60 days from the date written. (Previously, as a "Schedule III" controlled substance, these prescriptions were good for 6 months.)
    - Prescriptions for medicines with hydrocodone will not be refilled. If a prescription is written before October 6, 2014, members may be able to get refills until April 8, 2015. But keep in mind that a pharmacy's computer system may not be able to process these refills after October 6th. If this is the case, the member will need a new prescription. Additionally, pharmacists will not be able to call prescribers for refill requests.
    - As with all other "Schedule II" controlled substances, the law states that a member must see his or her provider every 3 months to continue receiving a prescription for a medication with hydrocodone.

Pharmacy Providers: Reminder on Processing 90-day Supply Prescriptions

- If a prescription for one of the medications requiring a 90-day supply is submitted for less than a 90-day supply, and the member has had at least 90 days of therapy in the last 180 days, the claim will **DENY** and the following messaging will be displayed - **"Disp 90d Rx or use ovr code."**

Provider Action Needed:

- Contact the prescriber for the 90-day supply.
- If the prescriber does not feel it is appropriate to give the member a 90-day supply of this medication, or if the member currently resides in a Long Term Care Facility, please **enter authorization code 303030** in the Prior Authorization Number Field (**462-EV**) for a 30-day supply override. (**Note: This code will have to be entered EACH MONTH to override the 90 day fill if prescriber denies 90-day authorization**)
- If you cannot contact the prescriber in a reasonable time, please **enter authorization code 909090** in the Prior Authorization Number Field (**462-EV**) to authorize a one-time fill. (Note: This authorization is valid once per medication per year and is not valid if authorization code 303030 has been used for the same medications previously.)

If a Passport member has not had at least a 90-day supply in the last 180 days, the medication will not fill for greater than a 30-day supply.

To see our full list of drugs in our 90-Day Supply Program, please visit our website at http://passporthealthplan.com/pharmacy.

Magellan will monitor the use of the authorization codes to ensure proper utilization and to assess the effectiveness of the initiative. Please contact the Magellan helpdesk at 1-800-846-7971 if you have any questions or concerns regarding these initiatives. We appreciate your cooperation and support.

Pharmacy Providers: Grandfathering Discontinuation

- Effective September 30, 2014, the grandfathering of non-preferred medications will be discontinued.
- Prescriptions that are currently non-preferred will reject upon adjudication with the following message displayed: "Use Submission Clarification Code 2 for Grandfathering PA (submission clarification code field 42Ø-DK)." The new preferred medications will also be displayed for your convenience and for ease of communication with prescribers. **Pharmacies will be able to administer a one-time transition fill to affected members by utilizing this PA override.**
- Use PA code for one-time transition fill.
- Contact prescriber for EITHER a new prescription for the next month OR the prescriber can submit a Prior Authorization to Magellan for the members' current therapy.

Seasonal Flu Vaccine Reimbursement

EFFECTIVE IMMEDIATELY, Passport will reimburse pharmacies for administration of the injectable seasonal flu vaccines listed below to all members between the ages of 19-64 and FluMist to all members between the ages of 19-49. PASSPORT MEMBERS HAVE A $0 COPAY FOR THE FLU VACCINE.

- Fluzone (Vial, Syringe)
- Fluvirin (Vial, Syringe)
- Flulaval (Vial, Syringe)
- Fluarix (Syringe)
- FluMist (Nasal Syringe)

Flu vaccines for children ages 18 and under are provided through the Vaccines for Children (VFC) Program. PHARMACIES MAY NOT ADMINISTER OR BILL FOR CHILDREN'S FLU VACCINES.

For adults, a dispensing fee plus an administration fee of $14.06 per vaccine will be reimbursed for contracted pharmacies when flu vaccine is administered at the pharmacy level.

Recent Federal Drug Administration (FDA) Advisories Affecting Network Pharmacies and Providers

The FDA recently issued the following advisories:

7/11/14 **FDA recommends that health care professionals should immediately check their medical supplies, quarantine any sterile drug products from Unique Pharmaceuticals, and not administer them to patients.** FDA investigators recently inspected Unique Pharmaceuticals laboratories and found unsanitary conditions that could result in unsterile products that have been purported to be sterile. Life-threatening infections or death can result from the administration of a non-sterile product that was intended to be sterile. Unique Pharmaceuticals' products were distributed nationwide with the product labeling: Unique Pharmaceuticals, Temple, TX, USA 76502. Patients who have received these products and have concerns should contact their health care professional.

7/21/14 **FDA recommends patients in possession of affected test strips manufactured by Diabetic Supply of Suncoast, Inc., to contact the manufacturer for further information.** The manufacturer issued a voluntary recall of all BMB-BA006A Advocate Redi-Code+ blood glucose test strip lots manufactured by BroadMaster Bio-Tech Corp due to a labeling error. This error could result in confusion about which meter models the test strips are designed to be used with. If used with the wrong meter, incorrect blood glucose levels could lead to delayed hyperglycemia or hypoglycemia detection.

7/22/14 **FDA warns of mislabeled packaging of Ibuprofen and Oxcarbazepine tablets by American Health Packaging.** Lot #142588, Ibuprofen Tablets USP 600 mg (expiration date 01/2016), was voluntarily recalled by American Health Packaging (AHP) along with lot #142544, Oxcarbazepine Tablets 300 mg (expiration date 02/2016). The mislabeling could result in patients receiving ibuprofen and missing their scheduled dose of oxcarbazepine leading to increased risk of seizures or adverse reactions for patients in whom ibuprofen is contraindicated.

8/28/14 **FDA warns of recall by Solace International, Inc. products Dermatend Original and Dermatend Ultra.** Solace International, Inc. is voluntarily recalling all lots of both products, in all sizes and strengths. It has been marketed for mole, skin tag, and wart removal. Dermatend is not FDA approved and using either of these products instead of consulting a physician could result in delayed diagnosis of dermatologic conditions, including cancer. Consumers who have purchased and used this product should consult their physician. Distributors and wholesalers who have these products should return all units and cases to the manufacturer.

Please visit www.fda.gov/opacom/7alerts.html for more information.

BRAND NAME	GENERIC NAME/ DOSAGE FORMS	INDICATIONS	FORMULARY ALTERNATIVES	PASSPORT HEALTH PLAN STATUS
Orencia®	Abatacept	Rheumatoid Arthritis	Enbrel Humira	NONPREFERRED WITH STEP Must try and fail Humira and Enbrel. Patients on Orencia will be grandfathered.
Axiron®	Testosterone	Testosterone replacement therapy	Androgel; generics	NONPREFERRED WITH STEP Androgel will move to preferred status. Must try preferred product; androgel and generics
Invega Sustenna®	Paliperidone	Schizophrenia	N/A	PREFERRED with STEP Must try 1 oral antipsychotic
Northera™	Droxidopa	Indicated for neurogenic orthostatic hypotension	N/A	PREFERRED with PA and QL **Clinical Edit:** Diagnosis of partial onset seizures or Lennox Gastaut syndrome **Quantity Limit:** One per day

BRAND NAME	GENERIC NAME/ DOSAGE FORMS	INDICATIONS	FORMULARY ALTERNATIVES	PASSPORT HEALTH PLAN STATUS
Qudexy XR™	Topiramate ER	Indicated for partial onset seizures or Lennox Gastaut syndrome	Topiramate	NONPREFERRED with PA and QL **Clinical Edit:** Diagnosis of partial onset seizures or Lennox Gastaut syndrome **Quantity Limit:** One per day
Tanzeum™	albiglutide	Type 2 diabetes mellitus	Byetta, Bydureon	NONPREFERRED with PA and STEP/QL **Clinical Edit:** Require trial/failure of metformin and preferred products in the class, diagnosis of diabetes mellitus type 2, trial and failure of bydureon OR byetta and minimum age = 18 years. **Quantity Limit:** 1 carton of 4 per 28 days
Tivorbex™	Indomethacin ER	Indicated for treatment of mild to moderate acute pain in adults	Indomethacin	NONPREFERRED with PA and STEP/QL **Clinical Edit:** Approve only for analgesia (mild-moderate acute pain), Patient must be ≥17 years of age, trial and failure 2 oral NSAIDS and trial of indomethacin. **Quantity Limit:** Three capsules per day
Zontivity™	Vorapaxar	Indicated for the management of acute pain severe enough to require opioid treatment and for which alternative treatment options are inadequate. Due to the risk of addiction, abuse, misuse, overdose, and death with opioids, the medication should be reserved for patients for whom alternative therapies are ineffective, not tolerated, or have been inadequate.	N/A	PREFERRED with PA and QL **Clinical Edit:** Diagnosis of history of MI or PAD without a history of stroke, TIA, ACS, GI bleed or peptic ulcer. Patients should also be on aspirin and/or clopidogrel. Patients must not be on Effient or Brilinta. **Quantity Limit:** One tablet per day
Zykadia™	Ceritinib	Indicated for the treatment of patients with ALK-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib (Xalkori®).	Xalkori	PREFERRED with PA and QL Coverage for Zykadia is provided in the following conditions: Confirmation patient's liver function is monitored monthly for the duration of therapy; **AND** Patient is at least 18 years old; **AND** diagnosis of Non-small Cell Lung Cancer **Quantity Limitations: All Indications:** Zykadia 150mg capsules: 140 capsules per 28 days (5 capsules per day)

BRAND NAME	GENERIC NAME/ DOSAGE FORMS	INDICATIONS	FORMULARY ALTERNATIVES	PASSPORT HEALTH PLAN STATUS
Hetlioz™	Tasimelteon	Indicated to treat non-24 hour sleep-wake disorder in totally blind individuals	N/A	PREFERRED with PA and QL **Non-24-Hour Sleep-Wake Disorder (Non-24)†** Patient age is at least 18 years; **AND** Patient has a documented diagnosis of complete blindness; **AND** Patient has a documented diagnosis of Non-24-Hour Sleep-Wake Disorder (aka Free Running Disorder) as indicated by one of the following evaluation tools: Circadian phase markers (melatonin) Actigraphy Sleep log or diary; **AND** Documented baseline nighttime sleep time and daytime nap time per sleep log or diary (renewal will require current log/diary results); **AND** Must be prescribed by a sleep specialist, psychiatrist, or neurologist, or sleep specialist, neurology, or psychiatry consult. †FDA Approved Indication(s) **Quantity Limitations:** Hetlioz 20 mg capsule: 1 capsule per day.
Orenitram™	Treprostinil	Indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise capacity.	Adempas®, Opsumit®	NONPREFERRED with PA and QL **Pulmonary arterial hypertension (PAH)** Patient is at least 18 years old; **AND** Diagnosis confirmed by documented right heart catheterization with mean pulmonary artery pressure (mPAP) > 25mm Hg; **AND** Baseline 6 minute walk test performed; **AND** Patient is NOT concurrently on organic nitrates (for example, isosorbide mononitrate, isosorbide dinitrate, nitroglycerin); **AND** Must be used as monotherapy, unless criteria for Combination Therapy (see below) is met; **AND** Diagnosed with pulmonary arterial hypertension and classified as WHO Group 1; **AND** Designated as New York Heart Association (NYHA) or World Health Organization (WHO) functional class. **Quantity Limitations:** • Orenitram 0.125 mg tablet: 90 tablets per 30 days (3 tablets per day) • Orenitram 0.25 mg tablet: 180 tablets per 30 days (3 tablets per day) • Orenitram 1 mg tablet: 120 tablets per 30 days (4 tablets per day) • Orenitram 2.5 mg tablet: 180 tablets per 30 days (6 tablets per day)

BRAND NAME	GENERIC NAME/ DOSAGE FORMS	INDICATIONS	FORMULARY ALTERNATIVES	PASSPORT HEALTH PLAN STATUS
Otezla®	Apremilast	Indicated for the treatment of adult patients with active psoriatic arthritis (PsA)	Enbrel, Humira	NONPREFERRED with PA and STEP/QL **Psoriatic Arthritis** Adult patient (18 years or older); **AND** Documented moderate to severe active disease as indicated by ≥ 3 swollen joints and ≥ 3 tender joints; **AND** Documented number of baseline swollen joints and tender joints; **AND** Documented failure, contraindication, or ineffective response at maximum tolerated doses to a minimum (3) month trial on previous therapy with ONE of the following oral disease-modifying anti-rheumatic agent (DMARD) such as methotrexate, azathioprine, sulfasalazine, or hydroxychloroquine; **AND** Not on concurrent treatment with a biologic DMARD (i.e. etanercept (Enbrel), adalimumab (Humira), certolixumab (Cimzia), golimumab (Simponi), infliximab (Remicade), ustekinumab (Stelara)) **Quantity Limitations:** • Otezla 30 mg tablet (60 count): 60 tablets every 30 days (2 tablets per day) • Otezla 30 mg tablet (28 count): 28 tablets every 14 days (2 tablets per day) • Otezla Two Week Starter Pack (4-10 mg, 4-20mg, 19-30 mg): 27 tablets every 14 days (2 tablets per day)
Purixan™	Mercaptopurine	Indicated to treat acute lymphoblastic leukemia (ALL) as part of a combination regimen	mercaptopurine, cyclophospha-mide, Sprycel, Gleevec	NONPREFERRED with STEP Must try 2 preferred agents
Cayston® – new criteria	Aztreonam	Cystic Fibrosis	Tobramycin	PREFERRED with PA and QL Coverage for Cayston is provided in the following conditions: Patient is at least 7 years old; **AND** Patient has an FEV_1 >25% and <75% predicted; **AND** The patient is not colonized with Burkholderia cepaci; **AND** Confirmation that the patient is not receiving treatment with other inhaled antibiotics and/ or anti-infective agents, including alternating treatment schedules; **AND** The following indication(s): • Cystic Fibrosis • Patient's sputum culture shows resistance to tobramycin **Quantity Limitations:** Cayston 75mg powder for inhalation: 3 vials per day (84 vials per 56 days)

BRAND NAME	GENERIC NAME/ DOSAGE FORMS	INDICATIONS	FORMULARY ALTERNATIVES	PASSPORT HEALTH PLAN STATUS
Sensipar®- new criteria	Cinacalcet Hydrochloride	Secondary Hyperparathyroidism (HPT) Parathyroid Carcinoma (PC) Primary Hyperparathyroidism (HPT)		PREFERRED with PA and QL Patient is at least 18 years of age; **AND** Must have diagnosis of one of the following below; • Secondary Hyperparathyroidism (HPT) • Parathyroid Carcinoma (PC) • Primary Hyperparathyroidism (HPT) **Quantity Limitations:** • Sensipar 30 mg tablet: 60 tablets every 30 days (2 tablets per day) • Sensipar 60 mg tablet: 60 tablets every 30 days (2 tablets per day) • Sensipar 90 mg tablet: 120 tablets every 30 days (4 tablets per day)