DC Medicaid Pharmacy Benefit Management Strategies

MCAC Access Subcommittee Presentation

September 8, 2021

Drug Formulary

- a continually updated list of medications and related products supported by current evidence-based medicine, judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health.
- The primary purpose of the formulary is to encourage the use of safe, effective and most affordable medications.
- A formulary system is much more than a list of medications approved for use by a managed health care organization.

Drug Formulary considerations

- A formulary system includes the methodology an organization uses to evaluate clinical and medical literature and the approach for selecting medications for different diseases, conditions and patients.
- Policies and procedures for the procuring, dispensing, administering and appropriate utilization of medications are also included in the system.
- Formulary systems often contain additional prescribing guidelines and clinical information which assist health care professionals to promote high quality, affordable care for patients.
- Finally, for quality assurance purposes, managed health care systems that use formularies have policies in place to give physicians and patients access to non-formulary drugs where medically necessary.

Preferred Drug List (PDL)

- Medications are often designated as preferred or non-preferred drugs by the pharmacy and therapeutics committee (P&T) or DUR board of the state Medicaid agencies or contracted managed care organization.
- In most cases, providers are permitted to prescribe preferred drugs without seeking prior authorization.
- However, if a drug is listed as non-preferred on the PDL, the providers are usually required to obtain approval from the state Medicaid agency or managed care plan before the drug is paid for.
- States may subject a drug to such prior authorization consistent with the requirements of section 1927(d)(5) of the Act.

Prior Authorization

Per the Social Security Act Section 1927(d)(5)

Prior authorization (PA) programs are intended to:

- Impart cost savings by preventing unnecessary prescribing of medically inappropriate drugs
- Provide a response to PA requests for covered outpatient drugs within twenty-four (24) hours
- Allow pharmacies to dispense up to a three (3) day emergency supply of covered outpatient drugs while PA approval is being sought
- Be no more stringent than FFS criteria

Prior Authorization

- Prior authorization typically means that the Medicaid agency or the contracted managed care organization will not pay for Medicaid beneficiaries' medication unless the provider has obtained permission before prescribing the drug.
- The criteria for prior authorization often reflect evidence-based standards consistent with the compendia listed in 1927(g)(1)(B).

Step Therapy

- A Medicaid program may require the trial of another agent prior to the use of a specific drug

- Example: **Alavert®**
- “The request for Alavert Oral Tablet Disintegrating 10 MG does not meet our Second Generation Antihistamines criteria. In order for us to approve this drug, you must meet our criteria.
- To meet our criteria, you must first try one of the following formulary drugs (a formulary is a list of covered drugs) used to treat your condition: ***loratadine (tablets, solution), cetirizine (tablets, solution), levocetirizine tablets.***
    - Our pharmacy records and information sent in by your doctor do not show that formulary drugs were tried and whether or not they helped your condition.
    - If you have already tried these drugs and they caused an adverse effect or did not work, please ask your doctor to provide medical records showing that you have tried these drugs.
    - Otherwise, please see your doctor for a new prescription for a formulary drug.”

Quantity Limits

- A state Medicaid agency or contracted managed care organization may impose quantity limits on medications as a way to promote safe and appropriate use of a medication, ensuring that they are not overprescribed.

- Example: **Fluconazole oral tablet 150 mg**

"The request for Fluconazole Oral Tablet 150 MG does not meet our Quantity Limit Exception Criteria.

Your doctor asked us to approve Fluconazole Oral Tablet 150 MG a quantity of 15 for 90 days. That is more than our limit of 2 per 30 days.

In order for us to approve the drug for the quantity your doctor requested, you must meet our criteria.

To meet our criteria your doctor must: 1) tell us that you have taken the drug at the quantity allowed and it did not work for you, and 2) submit a medical reason why the quantity allowed would not work well for you.

The other strengths of fluconazole tablets do not have a quantity limitation.

Please ask your doctor to send us this information."

Covered Prescription Drug Denial Report

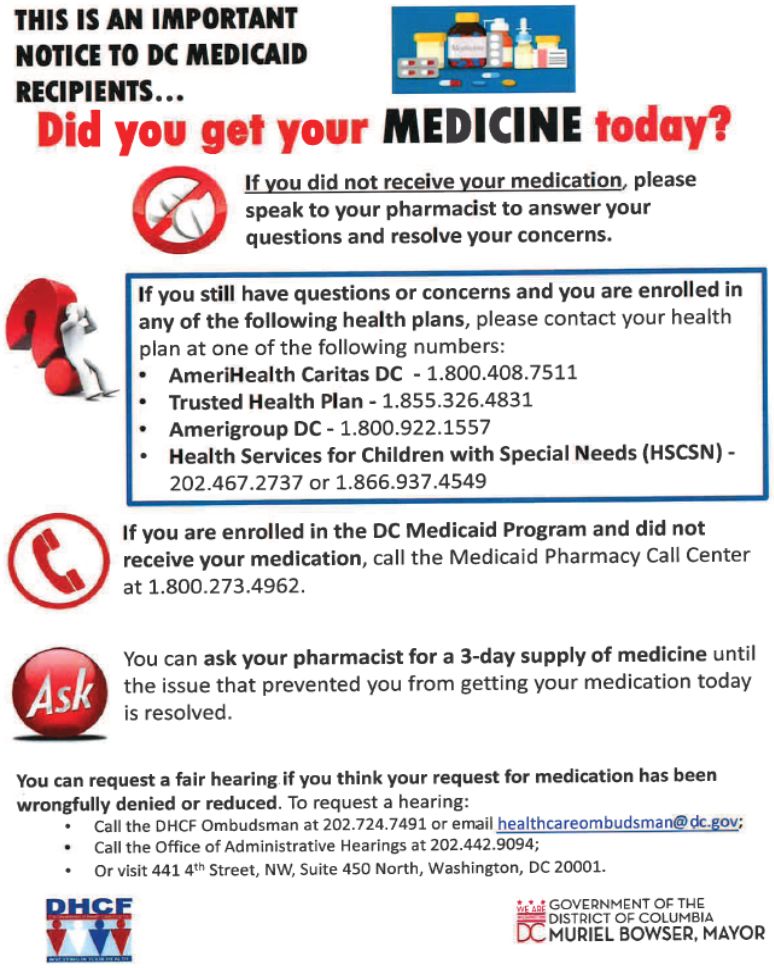
Beneficiary Information				Denied Drug Information								
Medicaid ID	LAST NAME	FIRST NAME	Date of Birth	Drug Name	Strength	Dosage Form	Frequency of Administration	Route of Administration	Therapeutic Category of Denied Drug	Reason(s) for Denial	Denial Notice Sent Yes/ No	Denial L
11111111	JOHNSON	COLE	10/9/1972	Xenical Oral Capsule 120 MG	120 MG	CAPSULE	every 8 hours	ORAL	GI DRUGS, MISCELLANEOUS	The request for, Xenical Oral Capsule 120 MG, is being prescribed for weight loss. Drugs used for weight loss are not covered under your AmeriHealth Caritas District of Columbia pharmacy benefit. Please refer to your Member Handbook for details.	YES	Initial
22222222	DAVIS	BARBARA	07/21/1965	Janumet Oral Tablet 50-500 MG	50-500 MG	TABLET	twice a day	ORAL	DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	The request for Janumet Oral Tablet 50-500 MG does not meet our Formulary Antidiabetic Agents criteria. In order for us to approve this drug, you must meet our criteria. To meet our criteria, you must first try the following formulary drugs (a formulary is a list of covered drugs) used to treat your condition: metformin first then alogliptin (alogliptin requires prior authorization review). Our pharmacy records and information sent in by your doctor do not show that formulary drugs were tried and whether or not they helped your condition. If you have already tried these drugs and they caused an adverse effect or did not work, please ask your doctor to provide medical records showing that you have tried these drugs.	Yes	Initial
33333333	JONES	TOM	03/15/1973	Otezla Oral Tablet 30 MG	30 MG	TABLET	as directed	ORAL	DISEASE-MODIFYING ANTIRHEUMATIC AGENTS	The request for Otezla Oral Tablet 30 MG does not meet our criteria for Specialty Biological Agents for Psoriasis. In order for us to approve this drug, you must meet our criteria. Biological agents are drugs that may slow or stop your condition from getting worse. The requested drug is not one of our preferred biological agents you would also need to try one of our preferred biological agents from two of the following groups: a) either Enbrel, Humira, or Avsola; and b) either Cosentyx or Taltz. Our pharmacy records and information sent in by your doctor do not show that these treatment options have been tried and if they helped your condition. Please see your doctor for a new prescription for a formulary drug (a	Yes	Initial
44444444	YOUNG	CHERYL	03/18/1972	Lynparza Oral Tablet 150 MG	150 MG	TABLET	as directed	ORAL	ANTINEOPLASTIC AGENTS	The request for Lynparza Oral Tablet 150 MG does not meet our Oncology Drugs criteria. In order for us to approve this drug, you must meet our criteria. To meet our criteria, Lynparza Oral Tablet 150 MG must be approved for the treatment of your condition and its use supported by NCCN guidelines (National Comprehensive Cancer Network). We can't approve the request because Lynparza Oral Tablet 150 MG is not approved for the treatment of malignant neoplasm of colon, unspecified, and its use is not supported by NCCN guidelines.	Yes	Initial
55555555	RODRIGUEZ	JOSE	12/28/1962	Cosentyx Subcutaneous Solution Prefilled Syringe 150 MG/ML	150 MG/ML	SYRINGE	as directed	SUBCUTANEOUS	SKIN AND MUCOUS MEMBRANE AGENTS, MISC.	The request for Cosentyx Subcutaneous Solution Prefilled Syringe 150 MG/ML does not meet our criteria for Specialty Biological Agents for Psoriasis. Biological agents are drugs that may slow or stop your condition from getting worse. In order for us to approve this drug, you must meet our criteria. To meet our criteria you must try three of the following treatment options: a topical steroid (like clobetasol, triamcinolone, or betamethasone), a topical medication (topical medications are applied directly to your skin) that is used to treat psoriasis (calcipotriene, Tazorac, anthralin or coal tar), methotrexate, cyclosporine, Soriatane, or UVB phototherapy (ultraviolet light therapy) or PUVA (this is taking the	Yes	Initial
66666666	WALKER	TASHA	06/07/2006	Tacrolimus External Ointment 0.1 %	0.1 %	OINT. (G)	daily	EXTERNAL	SKIN AND MUCOUS MEMBRANE AGENTS, MISC.	The request for Tacrolimus External Ointment 0.1 % does not meet our Safety Edit Exception Criteria for age restrictions. In order for us to approve the requested drug for your age, you must meet our criteria. To meet our criteria your doctor must: 1) submit a medical reason why the drug is needed when your age is below our age limit of 16, and 2) send us current treatment guidelines that support treating someone your age with this drug.	Yes	Initial

Updated Beneficiaries Appeals Notice

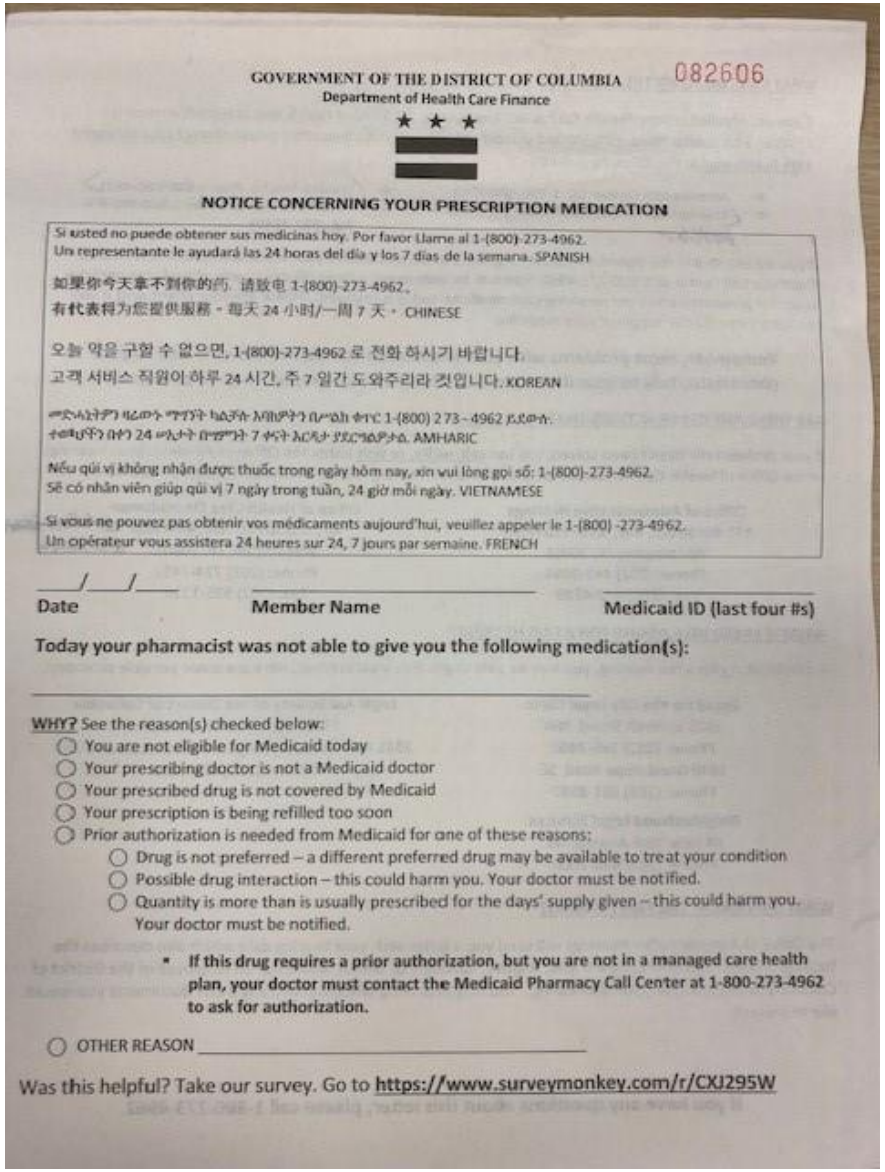
Contact Number for Members:

- AmeriHealth Caritas DC -1-800-408-7511
- MedStar Family Choice DC -1-888-404-3549
- CareFirst CHPDC-1-855-326-4831
- HSCSN -202-467-2737 or
- 1-866-WE-R-4-KIZ (937-4549)
- Fee For Service Medicaid 1-800-273-4962

Beneficiaries notice will be posted in English and Spanish at http://www.dc-pbm.com/provider/documents



Updated Pharmacy POS Triplicate Form for Beneficiary Notification



GOVERNMENT OF THE DISTRICT OF COLUMBIA 082606
Department of Health Care Finance

NOTICE CONCERNING YOUR PRESCRIPTION MEDICATION

Si usted no puede obtener sus medicinas hoy. Por favor Llame al 1-(800)-273-4962.
Un representante le ayudará las 24 horas del día y los 7 días de la semana. SPANISH

如果你今天拿不到你的药，请致电 1-(800)-273-4962。
有代表将为您提供服务，每天 24 小时/一周 7 天。CHINESE

오늘 약을 구할 수 없으면, 1-(800)-273-4962 로 전화 하시기 바랍니다.
고객 서비스 직원이 하루 24 시간, 주 7 일간 도와주리라 것입니다. KOREAN

መድኃኒትዎን ዛሬውኑ ማግኘት ካልቻሉ እባክዎትን በሥልክ ቁጥር 1-(800) 273-4962 ይደውሉ.
ተወካያችን በቀን 24 ሠዓታት በሚሞላ 7 ቀናት አርዳታ ያደርግልዎታል. AMHARIC

Nếu qúi vị không nhận được thuốc trong ngày hôm nay, xin vui lòng gọi số: 1-(800)-273-4962.
Sẽ có nhân viên giúp qúi vị 7 ngày trong tuần, 24 giờ mỗi ngày. VIETNAMESE

Si vous ne pouvez pas obtenir vos médicaments aujourd'hui, veuillez appeler le 1-(800) -273-4962.
Un opérateur vous assistera 24 heures sur 24, 7 jours par semaine. FRENCH

___/___/___ Date | _____ Member Name | _____ Medicaid ID (last four #s)

Today your pharmacist was not able to give you the following medication(s):

_____

WHY? See the reason(s) checked below:

- ◯ You are not eligible for Medicaid today
- ◯ Your prescribing doctor is not a Medicaid doctor
- ◯ Your prescribed drug is not covered by Medicaid
- ◯ Your prescription is being refilled too soon
- ◯ Prior authorization is needed from Medicaid for one of these reasons:
  - ◯ Drug is not preferred – a different preferred drug may be available to treat your condition
  - ◯ Possible drug interaction – this could harm you. Your doctor must be notified.
  - ◯ Quantity is more than is usually prescribed for the days' supply given – this could harm you. Your doctor must be notified.

- **If this drug requires a prior authorization, but you are not in a managed care health plan, your doctor must contact the Medicaid Pharmacy Call Center at 1-800-273-4962 to ask for authorization.**

◯ OTHER REASON _____

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Questions?