IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202140 JUNE 1, 2021

Pharmacy updates approved by Drug Utilization Review Board May 2021

The Indiana Health Coverage Programs (IHCP) announces updates to the SilentAuth automated prior authorization (PA) system, PA criteria, mental health utilization edits and the Preferred Drug List (PDL) as approved by the Drug Utilization Review (DUR) Board at its May 21, 2021, meeting. These updates apply to the fee-for-service (FFS) pharmacy benefit.

SilentAuth PA enhancement

The IHCP has enhanced its automated PA system to update the criteria for the Duplicate Stimulants, Sedative-Hypnotic/Benzodiazepines, Antiseizure Agents, Opiate Overutilization and Targeted Immunomodulators. These PA changes will be effective for PA requests submitted on or after July 1, 2021. The PA criteria are posted on the Pharmacy Prior Authorization Criteria and Forms page on the OptumRx Indiana Medicaid website, accessible from the Pharmacy Services page at in.gov/medicaid/providers.

PA changes

PA criteria for the Growth Hormone, Ophthalmic Anti-Inflammatory/Immunomodulator-Type, Allergy-Specific Immunotherapy and Spinal Muscular Atrophy Agents were established and approved by the DUR Board. These PA changes will be effective for PA requests submitted on or after July 1, 2021. The PA criteria are posted on the Pharmacy Prior Authorization Criteria and Forms page on the OptumRx Indiana Medicaid website, accessible from the Pharmacy Services page at in.gov/medicaid/providers.

Mental health utilization edits

Utilization edits for mental health medications are reviewed quarterly by the Mental Health Quality Advisory Committee (MHQAC). The DUR Board approved updates to the utilization edits listed in Table 1. These updates are effective for dates of service (DOS) on or after July 1, 2021.

Table 1 – Updates to utilization edits effective for DOS on or after July 1, 2021

Name and strength of medication	Utilization edit
Azstarys 26.1-5.2 mg caps	Quantity limit 1/day; age 6 years and older
Azstarys 39.2-7.8 mg caps	Quantity limit 1/day; age 6 years and older
Azstarys 52.3-10.4 mg caps	Quantity limit 1/day; age 6 years and older
Qelbree 100 mg caps	Quantity limit 1/day; age 6 years through 17 years
Qelbree 150 mg caps	Quantity limit 2/day; age 6 years through 17 years
Qelbree 200 mg caps	Quantity limit 2/day; age 6 years through 17 years

Changes to the PDL

Changes to the PDL were made at the May 21, 2021, DUR Board meeting. See Table 2 for a summary of PDL changes. Changes are effective for DOS on or after July 1, 2021, unless otherwise noted.

Table 2 – PDL changes effective for DOS on or after July 1, 2021

Drug class	Drug	PDL status
Antiseizure Agents	Lamictal ODT	Preferred (previously nonpreferred)
	Trileptal suspension	Preferred (previously nonpreferred)
Narcotic Antitussive/1st Generation Antihistamine Combinations	Hydrocodone/homatropine	Preferred; add the following age criteria and quantity limits: • Age – 18 years of age and older • QL – 6 oz/Rx
	Hydrocodone/ chlorpheniramine/PSE	Remove from the PDL
Narcotics	Qdolo	Nonpreferred; add the following age criteria and step therapy: • Age – 18 years of age and older • ST – Must be unable to swallow tablets
	Abstral	Remove from the PDL
Testosterones	Androgel 1.62% packets	Nonpreferred (previously preferred)
	Androgel 1% pump	Remove from the PDL
Urinary Tract Antispasmodic/ Anti-Incontinence Agents	Gemtesa	Nonpreferred; add the following step therapy: • ST – Must have trialed and failed Myrbetriq or have intolerance or contraindication to Myrbetriq
Targeted Immunomodulators	Arcalyst	Nonpreferred
Ophthalmic Anti-Inflammatory Agents		Add to preferred that “All legend generic products are preferred unless otherwise specified” Add to nonpreferred that “All legend brand products are nonpreferred unless otherwise specified”
	FML liquifilm	Preferred
	Fluorometholone susp	Nonpreferred
	Lotemax gel/susp	Preferred
	Loteprednol gel/susp	Nonpreferred
	Pred Forte susp	Preferred
	Prednisolone susp	Nonpreferred
Ophthalmic Anti-Inflammatory Agents/Immunomodulator-Type	Eysuvis	Nonpreferred; add the following quantity limit: • QL – 2 bottles/2 weeks; continued use greater than 2 weeks will require additional PA criteria to be met (ophthalmic examination under magnification and examination of intraocular pressure)
Topical Antiparasitics	Ivermectin lotion	Nonpreferred
	VanaLice	Nonpreferred (previously preferred)
	Eurax cream	Preferred (previously nonpreferred)
Wound Care Products		Remove the drug class from the PDL

For more information

The PDL, mental health utilization edits, PA criteria and SilentAuth criteria can be found on the OptumRx Indiana Medicaid website, accessible via the Pharmacy Services page at in.gov/medicaid/providers. Notices of the DUR Board meetings and agendas are posted on the FSSA website at in.gov/fssa. Click **FSSA Calendar** on the left side of the page to access the events calendar.

Please direct FFS PA requests and questions about the FFS PDL or this bulletin to the OptumRx Clinical and Technical Help Desk by calling toll-free 855-577-6317. Questions regarding pharmacy benefits for members in the Healthy Indiana Plan (HIP), Hoosier Healthwise and Hoosier Care Connect should be referred to the managed care entity (MCE) with which the member is enrolled.

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