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Dear Provider:

This letter provides important information about changes to the Medicaid Pharmacy Program, including the implementation of new drug prior authorization (PA) requirements. The changes are based on approved recommendations from the Pharmacy and Therapeutics Advisory Committee.

Atypical Antipsychotics: The following changes are effective August 25, 2004.

- The following atypical antipsychotics will be placed on the preferred drug list and will be available without prior authorization (quantity limit, duplicate therapy, and ICD-9 requirements will apply):
 - Risperdal (oral)
 - Risperdal-M (oral)
 - Seroquel (oral)
 - Geodon (oral)
 - Clozaril (oral)
- There will be no preferred drug list of atypical antipsychotics for a recipient less than 18 years of age (quantity limit, duplicate therapy, and ICD-9 requirements will apply).
- All prescriptions, pediatric and adult, for atypical antipsychotics will only be filled for a psychosis or bipolar disorder. The prescriber must write either the appropriate ICD-9 code or the diagnosis on the prescription. If the prescriber chooses not to include the ICD-9 code or a diagnosis on the prescription, a prior authorization form must be completed with the ICD-9 code or diagnosis included on the prior authorization form. The pharmacy provider will be required to submit an ICD-9 code when submitting a claim to Medicaid. The ICD-9 code will be submitted in Field 424-DO.

- Acceptable ICD-9 Codes:
 - 295 Schizophrenic disorders
 - 296 Affective psychoses (bipolar disorders)
 - 299 Psychoses - pediatric
 - 301.20 Schizoid personality disorders
 - 301.21 Schizoid personality disorders
 - 301.22 Schizoid personality disorders
- Duplicate Therapy Criteria: The utilization of atypical antipsychotics will be limited to one (1) atypical antipsychotic medication per patient, with the exception of a 1-month crossover for medication changes which will allow for titrating off the existing medication and titrating up with a new medication. This requirement will apply to all recipients including those currently on an atypical medication.
- Quantity limits: Applies to all recipients.
 - Abilify 1 tablet per day
 - Zyprexa 1 tablet per day
 - Zyprexa Zydys 1 tablet per day
 - Symbyax 1 capsule per day
 - Geodon 2 capsules per day
 - Risperdal 2 tablet per day
 - Risperdal-M 2 tablets per day
 - Seroquel 2 tablets per day
 - Clozaril 3 tablets per day
- Patients currently on a non-preferred atypical will be permitted to continue with their current medication as long as quantity limits, duplicate therapy, and ICD-9 requirements are met.

Clarification on Oral Hypoglycemic Agents

Glucovance, and generic equivalents, will require a prior authorization and may be approved based on failure of, or medical contraindications or intolerance, to the Preferred Oral Hypoglycemic Agents.

Internet Web Site:

Medicaid's web site at <http://chs.ky.gov/dms/> provides information about the Medicaid Pharmacy Program and related topics such as pharmacy provider letters, Pharmacy and Therapeutics Advisory Committee meetings and recommendations, Drug Management Review Advisory Board meetings and recommendations. You are encouraged to use this web site.

Contact Information:

<u>For Questions About</u>	<u>Contact</u>	<u>Phone</u>
Previously sent drug PA requests	Prior Authorization Help Desk	800-807-1273
Billing of pharmacy claims	Provider Relations	800-807-1232
This letter or Medicaid policies	Pharmacy Department	502-564-7940

Sincerely,



Russ Fendley
Commissioner