Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

MEMORANDUM

DATE: April 24, 2014

TO: All Louisiana Medicaid Providers

FROM: J. Ruth Kennedy, Medicaid Director

SUBJECT: Edits on Victrelis® (boceprevir), Incivek® (telaprevir), Sovaldi® (sofosbuvir), and Olysio® (simeprevir) for Louisiana Legacy Medicaid and Shared Health Plans

The Louisiana Medicaid Pharmacy Program in collaboration with the Louisiana Medicaid Drug Utilization Review (DUR) Board has established limits on Victrelis® (boceprevir), Incivek® (telaprevir), Sovaldi® (sofosbuvir), and Olysio® (simeprevir).

Effective May 12, 2014-Duration of Therapy
Pharmacy claims will deny at the Point of Sale (POS) when the total days supply received by the recipient reaches the following limits:

Medication	Duration allowed
Victrelis® (boceprevir)	24 weeks (168 days)
Incivek® (telaprevir)	12 weeks (84 days)
Sovaldi® (sofosbuvir)	12 weeks (84 days)
Olysio® (simeprevir)	12 weeks (84 days)

Claims will deny at Point of Sale (POS) when duration is exceeded with:

NCPDP rejection code 88 (Drug Reject Error) mapped to EOB 697 (Exceeds Maximum Duration of Therapy)

Overrides for longer durations will be addressed using an Override Request Form (RxPA-16) and through contact with staff at Prior Authorization Unit housed at University of Louisiana at Monroe (ULM).

Effective May 19, 2014-Quantity Limits
Pharmacy claims for Victrelis® (boceprevir), Incivek® (telaprevir), Sovaldi® (sofosbuvir), and Olysio® (simeprevir) will have quantity limits every rolling 28 days as follows:

Medication	Units allowed every 28 days
Victrelis® (boceprevir)	336 units
Incivek® (telaprevir)	168 units
Sovaldi® (sofosbuvir)	28 units
Olysio® (simeprevir)	28 units

Claims will deny at Point of Sale (POS) when quantity limits are exceeded with:

> **NCPDP rejection error 76 (Quantity and/or days supply exceeds program maximum) mapped to**
> **EOB Code 457 (Quantity and/or days supply exceeds program maximum)**

There are no override provisions through the Point of Sale (POS) system using NCPDP service codes.

Compliance associated with program policy will be verified through our Louisiana Medicaid Pharmacy Compliance Audit Program.

Your continued cooperation and support of the Louisiana Medicaid Program efforts to coordinate care and improve health are greatly appreciated.

If you have questions about the contents of this memo, you may contact the Pharmacy Help Desk at (800) 437-9101, send a fax to (225) 342-1980, or refer to www.lamedicaid.com.

MCJ/MBW/ESF

c: Bayou Health Plans
Dr. James Hussey
Dr. Rebekah Gee
Dr. Rochelle Dunham
Magellan of Louisiana (Managed Care)
Melwyn B. Wendt
Molina

FAX OR MAIL this form to:
La Medicaid Rx PA Operations
ULM College of Pharmacy
1800 Bienville Drive
Monroe, LA 71201-3765
FAX 866-RX PAFAX
FAX 866-797-2329

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing
Louisiana Medicaid Prescription Prior Authorization Program
REQUEST FOR PRESCRIPTION OVERRIDE

Form: Rx PA16
Issue Date: 3/01/2013

Voice Phone:
866-730-4357

Please type or print legibly. Incomplete forms will not be approved.

Date of Request	Number of Fax Pages
Prescribing Provider Information	**Recipient Information**
Name (Last, First)	Name (Last, First)
LA Medicaid Prescribing Provider Number / NPI	LA Medicaid CCN or Recipient Number
Provider Specialty	Date of Birth (mm/dd/yy)
Call-Back Phone Number (include area code)	Recipient Weight (kg)
FAX Number (Include area code)	Recipient Height (ft / in)
Office Contact Name	Medication Allergies

Requested Drug Information

Initiation of Therapy ☐ Continuation of Therapy ☐			Projected Duration of Treatment
Drug Name	Drug Strength	Dosage Form	Dosage Interval (sig)
Diagnosis Code (ICD -9-CM) [relevant for this request]		Diagnosis Description	Quantity

This request is for:

☐ **For duration of therapy override**

Diagnosis	
Medical Justification	

☐ **For early refill override**

☐	Medication lost	☐	Physician changed dosage
☐	Medication destroyed	☐	Medication stolen
☐	Patient going out of town for period greater than the day's supply remaining of the previous refill		
Please attach supporting documentation			

☐ **For maximum unit / maximum cost / quantity limit override**

Diagnosis	
Medical Justification	

☐ **For therapeutic duplication**

Diagnosis	
Reason for request	☐ Strength / dosage change* ☐ Titration and concomitant therapy**
Drug name and strength_____ Qty_____ Stop date_____ Drug name and strength_____ Qty_____ Stop date_____	
Reason for change	

*** Stop date is required for strength / dosage change** **** Attach medical justification if both drugs are to be continued (titration / concomitant therapy)**

Practitioner Signature: _____

(If a signature stamp is used, then the prescribing practitioner must initial the signature.)