John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

# State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

**MEMORANDUM**

**DATE:** February 6, 2017

**TO:** All Louisiana Medicaid Providers

**FROM:** Jen Steele, Medicaid Director

**SUBJECT:** Louisiana Fee-for-Service (FFS) Medicaid Pharmacy Clinical Pre-Authorization for Sacubitril/valsartan (Entresto®) and Point of Sale (POS) Edits for Perampanel (Fycompa®) and Cariprazine (Vraylar®)- Effective February 14, 2017

Effective February 14, 2017, the Louisiana Department of Health Pharmacy Program in conjunction with the Louisiana Medicaid Drug Utilization Review (DUR) Board has established clinical pre-authorization criteria for sacubitril/valsartan (Entresto®) and Point of Sale (POS) edits on perampanel (Fycompa®) and cariprazine (Vraylar®).

**SACUBITRIL/VALSARTAN (ENTRESTO®)**

**Clinical Pre-authorization for sacubitril/valsartan (Entresto®)**
Pharmacy claims for sacubitril/valsartan (Entresto®) will be reimbursed at POS when the prescriber has obtained an approved clinical pre-authorization. Prescribers must complete the Pharmacy Clinical Pre-Authorization Form in full and fax to 1-866-797-2329. See the Clinical Pre-Authorization Form following this document or refer to www.lamedicaid.com.

Pharmacy claims without a clinical pre-authorization for sacubitril/valsartan (Entresto®) will deny at POS with:

**NCPDP rejection code 88 (DUR Reject Error) mapped to EOB code 066 (Clinical Pre-Authorization Required- MD Fax Form to 866-797-2329)**

Override provisions should be addressed through the Clinical Pre-Authorization process.

**PERAMPANEL (FYCOMPA®)**

**Age Limit for perampanel (Fycompa®)**
Pharmacy claims for perampanel (Fycompa®) for recipients under 12 years old will deny at POS with:

**NCPDP rejection code 60 (Product/Service Not Covered for Patient Age) mapped to EOB code 234 (P/F Age Restriction)**

After consultation with the prescriber to verify the necessity of prescribing perampanel (Fycompa®) for a recipient under 12 years old, the pharmacist may override the age restriction denial by submitting:

**NCPDP 439-E4 field (Reason for Service Code) PA (Drug-Age)**
**NCPDP 440-E5 field (Professional Service Code) MO (Prescriber Consulted)**
**NCPDP 441-E6 field (Result of Service Code) 1G (Filled with Prescriber Approval)**

## CARIPRAZINE (VRAYLAR®)

### Dose Limit for cariprazine (Vraylar®)

**Recipients 15 years old or less**
All pharmacy claims for any strength of cariprazine (Vraylar®) for recipients 15 years old or less will deny at POS with:

**NCPDP rejection code 88 (DUR Reject Error) mapped to EOB code 325 (Exceeds maximum daily dose-MD Fax Override Form to 866-797-2329)**

Overrides will be addressed using the attached Request for Prescription Override Form (Rx PA16) and through contact with staff at the Prior Authorization Unit at the University of Louisiana at Monroe (ULM).

**Recipients 16 – 17 years old**
Pharmacy claims for cariprazine (Vraylar®) for recipients 16 – 17 years old and a dose greater than 4.5mg/day will deny at POS:

**NCPDP rejection code 88 (DUR Reject Error) mapped to EOB code 325 (Exceeds maximum daily dose-MD Fax Override Form to 866-797-2329)**

Overrides will be addressed using the attached Request for Prescription Override Form (Rx PA16) and through contact with staff at the Prior Authorization Unit at the University of Louisiana at Monroe (ULM).

**Recipients 18 years old or older**
Pharmacy claims for cariprazine (Vraylar®) for recipients 18 years old or older and a dose greater than 6 mg/day will deny at POS with:

**NCPDP rejection code 88 (DUR Reject Error) mapped to EOB code 529 (Exceeds maximum daily dose)**

After consultation with the prescriber to verify the necessity, the pharmacist may override the denial by submitting the following override at POS:

**NCPDP 439-E4 field (Reason for Service Code) HD (High Dose)**
**NCPDP 440-E5 field (Professional Service Code) MO (Prescriber Consulted)**
**NCPDP 441-E6 field (Result of Service Code) 1G (Filled with Prescriber Approval)**

The pharmacist must document the override codes on the hardcopy prescription or in the pharmacy's electronic recordkeeping system.

## CARIPRAZINE (VRAYLAR®) THERAPY PACK

### Age Limit for cariprazine (Vraylar®) Therapy Pack

**For recipients 15 years old or less**
All pharmacy claims for any strength of cariprazine (Vraylar®) Therapy Pack will deny for recipients 15 years old or less at POS with:

**NCPDP rejection code 60 (Product/Service Not Covered for Patient Age) mapped to**
**EOB code 234 (P/F Age Restriction)**

There are no override provisions through the POS system using NCPDP service codes.

### Quantity Limit for cariprazine (Vraylar®) Therapy Pack

Pharmacy claims for cariprazine (Vraylar®) Therapy Pack will have a quantity limit of 1 package per recipient (not to exceed one package per 18 months). Claims exceeding the quantity limit will reject 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 POS system using NCPDP service codes.

## CARIPRAZINE (VRAYLAR®) and CARIPRAZINE (VRAYLAR®) THERAPY PACK

**Diagnosis Requirement for cariprazine (Vraylar®) and cariprazine (Vraylar®) Therapy Pack**

Pharmacy claims for cariprazine (Vraylar®) and cariprazine (Vraylar®) Therapy Pack require a valid ICD-10-CM diagnosis code submitted at POS. The ICD-10-CM diagnosis code must be documented on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The chart below contains the valid ICD-10-CM diagnosis codes for cariprazine (Vraylar®).

| Diagnosis | ICD-10-CM Diagnosis Code(s) |
|---|---|
| Schizophrenia or Schizoaffective Disorder | F20.*, F25.* |
| Major Depressive Disorder, Psychoses in Major Depressive Disorder | F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9 |
| Delusions, Dementia, Psychoses | F01.*, F02.*, F03.*, F04, F05, F06.0, F06.2, F06.30, F06.31, F06.32, F06.33, F06.34, F06.8, F10.150, F10.151, F10.250, F10.251, F10.26, F10.94, F10.950, F10.951, F10.96, F10.97, F11.121, F11.150, F11.151, F11.221, F11.250, F11.251, F11.921, F11.950, F11.951, F12.121, F12.150, F12.151, F12.221, F12.250, F12.251, F12.921, F12.950, F12.951, F13.121, F13.150, F13.151, F13.221, F13.250, F13.251, F13.27, F13.921, F13.950, F13.951, F13.97, F14.121, F14.150, F14.151, F14.221, F14.250, F14.251, F14.921, F14.950, F14.951, F15.121, F15.150, F15.151, F15.221, F15.250, F15.251, F15.921, F15.950, F15.951, F16.121, F16.150, F16.151, F16.221, F16.250, F16.251, F16.921, F16.950, F16.951, F18.121, F18.150, F18.151, F18.17, F18.221, F18.250, F18.251, F18.27, F18.921, F18.950, F18.951, F18.97, F19.121, F19.150, F19.151, F19.17, F19.221, F19.250, F19.251, F19.27, F19.921, F19.950, F19.951, F19.97, F22, F23, F24, F28, F29, F32.3, F33.3, F44.89 |
| Psychoses in Bipolar Disorder, Psychoses in Other Episodic Mood Disorders | F30.*, F31.*, F32.8, F34.8, F34.9, F39 |
| Aggression or Irritability in Pervasive Developmental Disorder (PDD) | F84.* |

Cariprazine (Vraylar®) and cariprazine (Vraylar®) Therapy Pack claims submitted at POS without a valid diagnosis will deny with:

**NCPDP rejection code 39 (Missing or Invalid diagnosis code) mapped to**

**EOB code 575 (Missing or Invalid diagnosis code)**

Prescribing providers may call Louisiana Medicaid RxPA Operations at the University of Louisiana (ULM) at 1-866-730-4357 for guidance when recipients are established on antipsychotic medications but the ICD-10-CM diagnosis codes submitted are not included in the table of covered diagnoses.

When the diagnosis code written on the prescription is not included in the list of covered diagnoses AND when the pharmacist cannot reach the prescriber OR when the RxPA Center is closed, the pharmacist, using his/her professional judgment, may deem the filling of the antipsychotic prescription to be an "emergency". In these emergency cases, the pharmacist must indicate "Emergency Prescription" on the hardcopy prescription or in the pharmacy's electronic recordkeeping system AND may override the diagnosis code requirement by:

**Placing the 'alternative' ICD-10-CM diagnosis code in the NCPDP field 424-DO (Diagnosis Code) and by placing '03' in NCPDP 418-DI field (Level of Service)**

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

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

JS/MBW/GJS
Attachment

c: Healthy Louisiana Plans
Melwyn B. Wendt
Molina

# Louisiana Medicaid
## Pharmacy Clinical Pre-Authorization Form

Fax or Mail this form to:
1-866-797-2329
La Medicaid RxPA Operations
ULM School of Pharmacy
1800 Bienville Drive
Monroe, LA 71201-3765

Revised Date: 2/12/2015

### MEMBER INFORMATION

| | | | |
|---|---|---|---|
| **Patient Name:** Last Name | First Name | MI | |
| **Date of Birth:** | **Sex:** ☐ Male ☐ Female | **Height:** | **Weight:** |
| **Address:** | City | State | Zip Code |
| **Phone #:** | **Medicaid Recipient ID#: (required)** | **Plan Policy ID#: (optional)** | |

### PRESCRIBING PRACTITIONER INFORMATION

| | | | |
|---|---|---|---|
| **Practice Name:** | **Specialty:** | **NPI # (2):** | |
| **Prescribing Practitioner Name:** | **Medicaid Provider ID #: (required)** | **NPI # (1):** | **DEA/License #:** |
| **Address:** | City | State | Zip Code |
| **Phone #:** | **Fax #:** | **Office Contact:** | **EPSDT Support Coordinator (Name / Address): (optional)** |

### MEDICATION INFORMATION

| | | |
|---|---|---|
| **Drug Name:** | **Dosage Form:** | **Quantity:** |
| **Strength:** | **Directions:** | |
| **Dispense as Written:** ☐ Yes ☐ No | **Substitutes Permitted:** ☐ Yes ☐ No | **Number of Refills:** |
| **Currently on This Medication:** ☐ Yes ☐ No | **Other Medications Tried toTreat This Condition:** | **Dates:** |
| **List Other Current Medications:** ☐ ***See attached list*** | | |
| **Reasons for Discontinuation of Tried Therapies:** | | |
| **Diagnosis/Indication:** | | **ICD Diagnosis Code:** |
| **Rationale and/or Other Information Relevant (☐ *included* lab results) to the Review of This Authorization Request:** <br><br> **Drug Allergies:** | | |

### PHARMACY INFORMATION (Optional)

| | | |
|---|---|---|
| **Pharmacy Name:** | **Phone #:** | **Fax #:** |

**Prescribing Practitioner Signature:** _____ **Date:** _____

For more information, refer to www.lamedicaid.com and follow the "Pharmacy and Prescribing Providers" link.

**FAX OR MAIL this form to:**
La Medicaid Rx PA Operations
ULM School 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
Revised Date: 2/12/2015

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) | Recipient Height (ft / in) |
| FAX Number (Include area code) | Medication Allergies | |
| Office Contact Name | EPSDT Support Coordinator (Name / Address) *(optional)* | |

**Requested Drug Information**

Initiation of Therapy ☐ Continuation of Therapy ☐

| Drug Name | Drug Strength | Dosage Form | Dosage Interval (sig) |
|---|---|---|---|
| Diagnosis Code [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 / maximum dose / 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_____<br>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.)*