Alabama Medicaid Pharmacist

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PDL Update

Effective January 1, 2022, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee recommendations as well as quarterly updates. The updates are listed below:

PDL Additions
Jentadueto XR—Dipeptidyl Peptidase-4 Inhibitors
Kazano—Dipeptidyl Peptidase-4 Inhibitors
Nesina—Dipeptidyl Peptidase-4 Inhibitors
Oseni—Dipeptidyl Peptidase-4 Inhibitors
Select-OB + DHA—Prenatal Vitamins
Synjardy—Sodium-Glucose Cotransport 2 Inhibitors
Synjardy XR—Sodium-Glucose Cotransport 2 Inhibitors
Vitafol Fe + Softgel—Prenatal Vitamins
Vitafol-Nano Prenatal Tablet—Prenatal Vitamins
Vitafol-OB Caplet—Prenatal Vitamins
Vitafol-OB + DHA—Prenatal Vitamins
Vitafol-One Softgel—Prenatal Vitamins
Vitafol Prenatal w/ Iron Gummies Soft Chew—Prenatal Vitamins
Vitafol Ultra Softgel—Prenatal Vitamins
Xigduo XR—Sodium-Glucose Cotransport 2 Inhibitors
PDL Deletions
Actos—Thiazolidinediones
Coumadin—Oral Anticoagulants

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Please fax all prior authorization and override requests *directly* to Kepro at 800-748-0116. If you have questions, please call 800-748-0130 to speak with a call center representative.

COVID-19 Monoclonal Antibody Infusion

As Alabama Medicaid continues to monitor the COVID-19 national emergency in Alabama, Medicaid is adding the following procedure codes for coverage:

CPT Code	Summary	Effective Date
Q0240	Injection, casirivimab and imdevimab, 600mg	07/30/2021
M0240	Intravenous infusion, or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses	07/30/2021
M0241	Intravenous infusion, or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency, subsequent repeat doses	07/30/2021
Q0243	Injection, casirivimab and imdevimab, 2400mg	11/21/2020
Q0244	Injection, casirivimab	06/03/2021
M0244	Intravenous infusion, or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency.	05/06/2021
Q0245	Injection, bamianivimab and etesevimab, 2100 mg	02/09/2021
M0245	Intravenous infusion, bamianivimab and etesevimab, includes infusion and post administration monitoring.	02/09/2021
M0246	Intravenous infusion, bamianivimab and etesevimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency.	05/06/2021
Q0247	Injection, sotrovimab, 500mg	05/26/2021
M0247	Intravenous infusion, sotrovimab, includes infusion and post administration monitoring	05/26/2021
M0248	Intravenous infusion, sotrovimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the COVID-19 public health emergency	05/26/2021

COVID-19 Monoclonal Antibody Infusion, continued

Providers may submit claims for dates of service on or after the effective dates for each procedure code as listed above.

FQHCs/RHCs should submit claims for the above procedure codes outside of the encounter rate.

Providers may find the reimbursement rates for the COVID-19 testing procedure codes on Medicaid's website at www.Medicaid.Alabama.gov by selecting Fee Schedules under the Providers tab.

As a reminder, providers must deliver services within their scope of practice and have the proper certification and licensure to perform these tests.

During the COVID-19 emergency, it is important to file claims as quickly as possible to ensure payment from Medicaid to Medicaid providers close to the date of service. The Centers for Medicare and Medicaid Services (CMS) has increased the federal matching percentage for the emergency time frame, but states can only receive the increased match on claims paid during the emergency. Providers should include appropriate COVID-19 diagnosis code(s) on claims submitted to help with tracking of COVID-19.

For questions, please visit the Medicaid website at www.Medicaid.Alabama.gov, or call the Medicaid Fiscal Agent at 1-800-688-7989 .

Physicians, Nurse Practitioners, and Physician Assistants can email questions to Jean.Wackerle@medicaid.alabama.gov.

Laboratory service providers can email questions to Susan.Watkins@medicaid.alabama.gov.

Outpatient service providers can email questions to Lynne.Davenport@medicaid.alabama.gov or Callie.Johnson@medicaid.alabama.gov.

COVID-19 Emergency Expiration Date Extended to January 31, 2022

All previously published expiration dates related to the Coronavirus (COVID-19) emergency are once again extended by the Alabama Medicaid Agency (Medicaid). **The new expiration date is the earlier of January 31, 2022, the conclusion of the COVID-19 National emergency, or any expiration date noticed by the Alabama Medicaid Agency through a subsequent ALERT.**

A listing of previous Provider ALERT and notices related to the health emergency is available by selecting the Agency's COVID-19 page in the link below: https://medicaid.alabama.gov/news_detail.aspx?ID=13729.

During the COVID-19 emergency, it is important to file claims as quickly as possible to ensure payment from Medicaid is made to Medicaid providers close to the date of service. The Centers for Medicare and Medicaid Services has increased the federal matching percentage for the emergency time frame, but states can only receive the increased match on claims that are paid during the emergency. Providers should include appropriate COVID-19 diagnosis code(s) on claims submitted to help with tracking of COVID-19.

2021 Update to Hypertriglyceride Guidelines

The 2021 American College of Cardiology (ACC) Expert Consensus Decision Pathway on the Management of atherosclerotic cardiovascular disease (ASCVD) Risk Reduction in Patients with Persistent Hypertriglyceridemia was developed to target triglyceride therapy ambiguity. It's essential to understand why treating elevated triglyceride is so critical – ASCVD event rates remain high in patients with hypertriglyceridemia despite statin therapy, and severely elevated triglycerides are associated with acute pancreatitis. Therefore, the update aimed to answer five clinical questions.

First, persistent hypertriglyceridemia is defined as fasting triglyceride ≥150 mg/dL that followed 4-12 weeks of lifestyle intervention, optimized statin therapy, and management of any secondary causes. This definition emphasizes the importance of lifestyle modifications before and during pharmacological therapy and transitions into answering the second clinical question. Appropriate lifestyle modifications include sustained weight loss, dietary changes, and increased physical activity, and each intervention can potentially provide significant and sustained triglyceride reduction. Therefore, the expert panel maintains that lifestyle is the foundation of hypertriglyceridemia management.

In addition, the panel recommends addressing other secondary causes such as poor glycemic control. Uncontrolled diabetes induces abnormal fat metabolism that consequently increases triglyceride-carrying lipoproteins, the chylomicrons, and the very-low-density lipoproteins; therefore, a patient must achieve glycemic control before targeting triglycerides directly. To answer the third clinical question, the expert panel describes the importance of optimizing statin therapy to address elevated triglycerides. It is estimated that a 10-30% dose-dependent triglyceride reduction can be observed with statin therapy, especially with statins that have led to significant reduction, such as atorvastatin and rosuvastatin.

There are several groups identified as candidates for triglyceride risk-based non-statin therapy or recommended statin therapy and each group has different recommendations. The first group of patients include adults with ASCVD and fasting triglyceride 150-499 mg/dL (or non-fasting triglyceride 175-499 mg/dL. Because this patient population has a prior ASCVD, LDL control should be targeted first. However, once a patient is at goal LDL (<70 mg/dL), or close to goal (70-99 mg/dL), then non-statin therapy such as icosapent ethyl can be considered in addition to the LDL-C risk-based approach. The second group of patients include adults ≥40 years old with diabetes, no ASCVD, and fasting triglyceride 150-499 mg/dL (or non-fasting triglyceride 175-499 mg/dL). Based on the results of the REDUCE-IT trial, the use of icosapent ethyl in high-risk ASCVD patients demonstrated a significant reduction in 4-point major adverse cardiovascular endpoints. Therefore, the panel agrees that the potential benefit outweighs any associated risk and should be considered for this patient population if they are ≥50 years old with one or more ASCVD high-risk features.

The next and final patient population the expert panel recommends for consideration on triglyceride-risk based non-statin therapy is adults ≥ 20 years old with triglyceride ≥500 mg/dL. Because these patients are at a high risk of acute pancreatitis, patients can be considered for icosapent ethyl, fibrates (e.g., gemfibrozil), or prescription omega-3 fatty acids.

One of the most significant changes implemented by the 2021 ACC expert panel is the recommendation regarding non-prescription fish oil. Due to the available clinical trials (ASCEND, VITAL, and OMEMI) studying non-prescription fish oil in primary and secondary prevention patients, no significant difference in cardiovascular events or death was observed. Therefore, there is evidence that non-prescription fish oil offers no ASCVD risk reduction and should not be utilized.

References:

Virani SS, Morris PB, Agarwala A, Ballantyne CM, Birtcher KK, Kris-Etherton PM, Ladden-Stirling AB, Miller M, Orringer CE, Stone NJ. 2021 ACC Expert Consensus Decision Pathway on the Management of ASCVD Risk Reduction in Patients with Persistent Hypertriglyceridemia: a Report of the American College of Cardiology Solution Set Oversight Committee. J Am Coll Cardiol. 2021 [cited December 23 2021]; 78 (9): 960-993. Available from: https://www.jacc.org/doi/10.1016/j.jacc.2021.06.011.

January 1st Pharmacy Changes

Effective January 1, 2022, the Alabama Medicaid Agency will:

1. **Require Kazano, Nesina, and Oseni to be billed with a Dispense as Written (DAW) Code of 9:** DAW Code of 9 indicates the following: Substitution Allowed by Prescriber but Plan Requests Brand. This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the Plan requests the brand product to be dispensed.

2. **Update the PDL to reflect the quarterly updates. The updates are listed below:**

PDL Additions
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Vitafol Fe + Softgel—Prenatal Vitamins
Vitafol-Nano Prenatal Tablet—Prenatal Vitamins
Vitafol-OB Caplet—Prenatal Vitamins
Vitafol-OB + DHA—Prenatal Vitamins
Vitafol-One Softgel—Prenatal Vitamins
Vitafol Prenatal w/ Iron Gummies Soft Chew—Prenatal Vitamins
Vitafol Ultra Softgel—Prenatal Vitamins
Xigduo XR—Sodium-Glucose Cotransport 2 Inhibitors
PDL Deletions
Actos—Thiazolidinediones
Coumadin—Oral Anticoagulants

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The Prior Authorization (PA) request form and criteria booklet should be utilized by the prescriber or the dispensing pharmacy when requesting a PA. The PA request form can be completed and submitted electronically on the Agency's website at https://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.13_Pharmacy_Forms.aspx.
Policy questions concerning provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding PA procedures should be directed to the Kepro help desk at 1-800-748-0130.