Coverage Rules on Medications:

This is NOT an all-inclusive list of coverage rules on medications. Notably, the following are not included so please see the following links on www.hidesigns.com/ndmedicaid for more information:

- Preferred Drug List (PDL)
- NDC Drug Lookup (search for PA form and quantity limits by NDC or Drug Name)

For questions on specific claims, please contact provider relations at 1-800-755-2604 or email medicaidpharmacy@nd.gov. Please include:

- **Patient's ID:** 000# or ND#, we cannot use Sanford Health Plan numbers: 500#
- **Patient's name:** Please spell it
- **Phone number:** For us to call back
- **Reason for override request**: Especially for therapeutic duplication requests, why has one med changed to another? What was the side effect? Was there not enough response?

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AE – QMB Bill Medicare

Reject Message:
"Patient eligible for Medicare so Medicaid will not pay for this drug – If patient doesn't have a Part D plan, try Humana Linet. Questions call 701-328-2347.

Explanation:
ND Medicaid does not pay for medication if the member is eligible for Medicare A or B. ND Medicaid does not pay secondary to Medicare Part D or if Medicare Part D does not cover prescription medication.

A select number of OTC medications are covered. An override is not necessary to bill these OTC medications to ND Medicaid as the primary payer.

Action:
ND Medicaid recipient does not have a Part D plan: ND Medicaid cannot pay for medications. You may be able to bill Humana LINET. www.humanalinet.com , phone # 800-783-1307, fax: 877-210-5592. County offices can provide eligibility information needed to bill Humana LINET.

19 – Inv Days Supply

Reject Message:
"Please bill daily dose correctly according to prescription. 34 days supply covered for most meds. 90 days for some maintenance. Call 701-328-4086 with questions."

Explanation:
The quantity of medication dispensed shall not exceed a 34-day supply as outlined in the Provider Manual for Pharmacies, unless:

- Another insurance is the primary payer and pays a portion of the claim, then the primary insurance rules apply
- Drug is packaged as a standard or its duration is a standard beyond 34 days
- Drug is a low-cost maintenance medication. Several are set up to allow 90 days.

Action:
Review the rejected, in-process claim and adjust the submitted quantity and days supply accordingly. Please do not bill an incorrect day supply to get the claim to pay without contacting provider relations at 1-800-755-2604.

To request an override due to primary insurance requirements, drug packaging, or standard duration, contact provider relations at 1-800-755-2604.

39 – Inv Diagnosis Code – Diagnosis format invalid

Reject Message:
"First diagnosis code is invalid – we accept valid ICD-10 diagnosis codes."

Explanation:
Verifies a diagnosis code exists and is properly formatted on any claim where a diagnosis code is submitted, whether submission is required or not. Proper format is alpha character followed by two numeric characters. If there is more alpha or numeric character, they are preceded by a decimal (e.g. F90.0).

Action:
Verify and correct format of submitted ICD-10 code as necessary. Alpha, Numeral, Numeral, Decimal, etc. (ex. F90.1) Contact provider relations at 1-800-755-2604 with question.

39 – Inv Diagnosis Code – Diagnosis not covered

Reject Message:
"Please submit ICD-10 diagnosis with claim. Plan covers FDA approved diagnoses. Please verify diagnosis with prescriber."

Explanation:
ICD-10 codes are required for certain drugs to ensure appropriate use, minimize cost, and increase access. ICD-10 code submission at claim adjudication eliminates the need to require prior authorization for diagnosis verification.

If a non-covered ICD-10 code, an invalid ICD-10 code, or no ICD-10 code is submitted, the claim will reject (rejection code and message will post) and require additional follow up.

Action:
Work with the pharmacy's software vendor if clarification needed regarding NCPDP fields required for diagnosis submission:

111-AM	Segment Identification	Use "13" since it is in the clinical segment
491-VE	Diagnosis Code Count	Use the number of diagnosis codes being submitted Example: if submitting one diagnosis code, use "1" in this field
492-WE	Diagnosis Code Qualifier	Use "02" since ND Medicaid accepts ICD-10 codes
424-DO	Diagnosis Code	Use the ICD-10 code(s) provided by the prescriber in this field

Reference ND Medicaid Payer Sheet:
https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/b1-b2-b3-payer-sheet.pdf

If the diagnosis is not included on the prescription:

Contact the prescriber to obtain all applicable ICD-10 codes for use of the drug and document that information on the prescription. Resubmit the claim with diagnosis information.

- Diagnosis codes must be obtained from the prescriber. ND Medicaid cannot provide diagnosis codes.

If the diagnosis code is submitted and claim denies:

Please review the submitted diagnosis codes for accuracy and clarify as needed with prescriber. Federal law requires Medicaid to pay for medications based on FDA approval and compendia-supported drug information. A diagnosis that is not supported in the compendia is not covered.

- Diagnosis codes must be obtained from the prescriber. ND Medicaid cannot provide diagnosis codes.
- If diagnosis code provided is FDA or compendia recommended and it is still denying, please contact provider relations at 1-800-755-2604 so it can be reviewed and added to the coverage list as appropriate.

41 – Submit Bill to Other Processor

Reject Message:
"Member has other insurance – Questions call 701-328-2347."
"Member has worker's comp coverage – If not related to work injury, call 701-328-4086."

Explanation:
Medicaid is the payer of last resort. If there is another payer responsible for the claim, they should be billed first. Many primary insurance companies have PBMs (prescription benefit managers) that administer the prescription benefits (e.g. Prime Therapeutics, Optum Rx, etc.). The phone number for the PBMs can be found by calling the primary insurance company.

Action:

Patient has other insurance, but other insurance does not cover prescribed medication:

Birth Control: Please provide diagnosis code.

- If being used for a medical reason – the prescribing physician will need to submit medical notes to the primary insurance company showing medical need.
- If being used for contraception – please call 701-328-2347 for an override.

Other medication coverage:

- Medicaid cannot pay without primary insurance coverage. Primary insurance policies should be followed, for example:
    - Call primary insurance to find out why medication is not covered
    - Work with primary insurance to find a covered medication
    - Submit a prior authorization/clinical notes to primary insurance

Patient has worker's comp (WSI) coverage:

- Please confirm with prescriber if medication is worker's comp related and its reason for use.
    - Any medication can be WSI related (antidepressants or hypertension medication for police force, benzodiazepine for MRI related to work injury, etc.) so we can't make assumptions based on medication type.
- Members cannot request WSI policies to be closed. ND Medicaid determines when to close a policy from WSI. Members can obtain a closure letter from WSI.

70 – Product/Service Not Covered – Medical Billing Only

Reject Message:
"Drug not covered on pharmacy benefit. Please bill on medical benefit using 837P transactions."

Explanation:
Drugs indicated for inpatient use only or requiring clinic administration should not be billed through the pharmacy point of sale (POS) system. Vaccines and medication therapy management (MTM) are common services pharmacies perform that are billed through medical billing.

Action:
Pleas bill drugs dispensed for administration in the clinic on the medical benefit through clinic buy and bill rather than pharmacy POS even if the claim does not reject when submitted through pharmacy POS.

Please contact the medical claim call center at 701-328-7098 or 877-328-7098 or by email the mmisinfo@nd.gov

- The pharmacy provider relations team does not support these types of claims.

70 – Product/Service Not Covered – Age Not Covered

Sample Message (underlined information is customized to the rejected claim):
"Plan will pay for ages 18 and over"

Explanation:
Due to federal law, patient's age must be within FDA approved or compendia approved recommendations to be covered.

Action:
If drug is not FDA-approved nor compendia-supported for patient's age, contact prescriber for alternative drug therapy.

75 –Prior Authorization Required – Prior Authorized

Reject Message:
"Please visit www.hidesigns.com/ndmedicaid to see PDL and PA criteria. Use NDC drug lookup to access forms. Only forms from this website can be accepted."

Explanation:
Prior authorization is the process to verify that the proposed medical use of a particular drug meets predetermined criteria for coverage. Prior authorization criteria are designed to promote safety, efficacy, and cost-effectiveness of drug utilization.

Action:
Reference the current PDL (www.hidesigns.com/ndmedicaid) for preferred drugs and criteria for coverage of non-preferred drugs. Contact prescriber to switch to preferred drug or initiate prior authorization. Please use PA Form supplied by the website. Forms that are submitted by using quick buttons in pharmacy software can result in delays and unnecessary back and forth communication if not all information requested on state form is supplied.

75 –Prior Authorization Required – Age Requires Prior Authorization

Sample Message (underlined information is customized to the rejected claim):
"Plan will pay for ages 9 and under"

Explanation:
Some ages require prior authorization to verify additional information such as indication or inability to swallow. Examples of indication verification is sildenafil used for pulmonary hypertension. Any use under the age of 12 is assumed to be for pulmonary hypertension with submitted diagnosis, while use above this age requires additional verification of diagnosis as it is also commonly used for other non-covered indications.

Action:

Inability to swallow

Rationale of inability to swallow a solid dosage form must be provided after age 9 for all non-solid oral dosage forms. Reference the current PDL (www.hidesigns.com/ndmedicaid) for non-solid dosage preparations criteria. To dispense a non-solid dosage form in patients 9 years of age and older, please submit the General Prior Authorization Form.

Indication verification

Please submit documentation to support FDA approved or compendia supported indication by submitting General Prior Authorization Form.

75 –Prior Authorization Required – Concurrent Therapy/Step Care Required

Sample Message (entire message is customized to the rejected claim):
"Metformin must be used with DPP4 Inhibitors per ADA guidelines"

Explanation:
Claim history lookback strategies identify total days of drug therapy within a specified time span, and the in-process claim will reject (rejection code and message will post) if the required days of drug therapy are not met.

- Step care requirements look for previous claim in history prior to the first instance of dispensing of a requested drug. Step care may be implemented to ensure appropriate dose titration, minimize PA requirements, etc.
- Concurrent therapy requires previous claim in history to be used on an ongoing bases and verifies the claim history prior to each refill of a requested drug. Concurrent therapy may be implemented when concomitant drug use is recommended by guidelines, drug manufacturer, etc.

Action:
Review rejection message and reference PDL (www.hidesigns.com/ndmedicaid) for additional rationale. Contact prescriber to address concurrent therapy/step care requirements and adjust prescription if needed.

Please have information documenting concurrent therapy/step care requirements (e.g. drug profile, medical history, etc.) have been met or are contraindicated when contacting provider relations at 1-800-755-2604 if requesting an override.

Patient is stable on medication from another plan or from the hospital

Please contact provider relations at 1-800-755-2604 to request an override for step care. Concurrent therapies will likely still be required.

Patient can't tolerate required lookback med

Please submit documentation that the lowest dose has been trialed and still is not tolerated by using the General Prior Authorization Form.

75 –Prior Authorization Required – Brand Preferred

Reject Message:
"Please visit www.hidesigns.com/ndmedicaid to see PDL and PA criteria. Use NDC drug lookup to access forms. Only forms from this website can be accepted."

"Please use brand."

Explanation:
Brand name drugs are preferred when there is a significant cost savings to ND Medicaid or if the requirement increases access to products. If the generic product is billed when ND Medicaid prefers brand name, the claim will reject.

Action:
When a brand name product is preferred by ND Medicaid, use **DAW 9** to be reimbursed at the brand rate.

- Please review claims for proper reimbursement
  - Brand drugs will reimburse at generic rate if not submitted with DAW9.
  - Brand drugs not (or no longer) preferred will reject if DAW9 is used. Generic drug is preferred.
- To dispense brand product when ND Medicaid does not prefer brand, please submit the Dispense as Written PA Form.

First fill

Overrides can be requested to use generic to fulfill first fill requirements to avoid breaking bottles by contacting provider relations at 1-800-755-2604 to request an override.

Primary Insurance

If primary insurance is involved with payment of the claim, an ongoing override can be requested by contacting provider relations at 1-800-755-2604 to request an override for brand preferred rejection.

Wholesaler does not have in stock

Wholesalers often will not stock brand until there is requests or demand for the product. Please contact provider relations at 1-800-755-2604 to request an override and then request your wholesaler to stock the brand name to be ordered for the next fill.

340b and Indian Health Service (IHS) facilities

Please request an ongoing override to use generic products by contacting provider relations at 1-800-755-2604 to request an override. These claims are not included in the rebate process, therefore, do not materialize a financial benefit to be dispensed as brand name.

75 –Prior Authorization Required – Out of State

Reject Message:
"If a drug can be dispensed by a ND pharmacy, it must be dispensed by a ND pharmacy. If not, complete Out of State PA form found at www.hidesigns.com/ndmedicaid."

Explanation:
ND Medicaid requires medications to be dispensed by an enrolled, in-state pharmacy if possible. In-state is defined as pharmacies located within North Dakota or within a border state (Minnesota, South Dakota, or Montana).

Action:
If a retail pharmacy is unable to fill a prescription due to a limited distribution program, verify if another in-state pharmacy has access to the medication. The drug manufacturer and/or in-state specialty pharmacies are good resources to consult.

If a prescription cannot be filled at an in-state pharmacy, the out-of-state pharmacy must be enrolled with ND Medicaid and submit the Out of State Prior Authorization form.

76-Plan Limitations Exceeded - Morphine Milligram Equivalents (MME) Limit

Reject Message:
"Plan will not pay for total morphine milligram equivalents greater than 90 MME/day any given day without prior authorization."

Explanation:
A cumulative maximum of 90 MME/day is allowed without prior authorization. CDC guidelines recommend to avoid increasing opioid doses that exceed 90 MME/day without careful justification. Cancer pain, post-surgical pain, and sickle cell pain are cited as considerations for exceptions.

Action:
Review claim history.

Patient has request regimen that exceeds 90 MME/day:

- Please submit the Opioid Analgesic PA Form with clinical documentation specifying met criteria or contraindication to criteria.

Patient has an early refill on a regimen exceeding 45 MME/day:

- Patient must utilize 100% of medication prior to requesting refill. Early refills that exceed 90 MME/day on overlap days are not allowed.

Early Refill - 90 MME/day Exceeded on Overlap Days Example: Patient is prescribed 15 days of oxycodone 10mg/325mg 4 times per day (60 MME/day). Fill is requested on day 14 for same regimen. Original prescription must be 100% utilized before new prescription is paid because 90 MME/day is exceeded for 2 days.

- Calculation: 60 MME/day (from current prescription day 14 and 15) + 60 MME/day (from new prescription days 1 and 2) = 120 MME/day from overlap of days 14 and 15 + days 1 and 2.

76-Plan Limitations Exceeded - Quantity per day

Sample Message (entire message is customized to the rejected claim):
"Plan will pay for 2 per day"

Explanation:
Quantity per day coverage rules are placed on medications follow FDA and compendia recommended dosages and intervals, thereby reducing regimen complexity as much as possible.

Action:
Review the directions on the prescription and the recommended dosages and intervals in the package insert or compendia. Interval on prescription should match recommendations.

- If the directions (dosage and interval) do not match recommendations, call prescriber to clarify directions to match recommendations.
    - ND Medicaid will not override dosages/intervals based on prescriber preference that do not align with pharmacokinetics and recommended dosing for the drug.

Quantity Per Day Example: Patient A is getting an atorvastatin prescription for 10mg twice daily. Pharmacy reviews recommendations daily dosing of atorvastatin. Pharmacy calls prescriber to change directions to 20mg twice daily.

In between doses

Generally, ND Medicaid will cover commercially available strengths. For dosages in between the strengths, we ask that the recommended dose increase is trialed first. If the recommended lower strength is not enough, and the next highest recommended strength is too much, the in between strength may be considered. In this case, please contact provider relations at 1-800-755-2604.

- Some medications are flat priced ($10 for 5mg, 10mg, and 20mg) so using more than 1 tablet per day against recommendations drastically increases the cost of the medication.

Loading doses

Please contact provider relations at 1-800-755-2604 to obtain a quantity override for loading doses. Please have indication available when requesting override. This override request may be necessary even if a prior authorization for the drug has already been obtained.

- Starter packs usually have built in quantities that align with titration or loading scheduled and do not require overrides. Please use these whenever possible.

Topicals

Quantity for topicals can be evaluated using fingertip units. A fingertip unit is the amount of cream, ointment, etc. that is expressed from a 5 mm diameter nozzle applied from the tip of the index finger of an adult to the distal-skin crease.

- One fingertip unit is enough to cover an area of skin twice the size of an adult's hand with the fingertips together. Two fingertip units are equal to 1 gram on an adult male.
    - An entire adult body is 40 units (20 grams).

Fingertip Unit Calculation: An adult male needs to have a cream applied twice daily over half of his body. Prescription is written for 500 grams for a 10 days supply. 20 grams x ½ the body x 2 times per day x 10 days = 200 grams.

- 500 grams is too large of quantity for this prescription.

76-Plan Limitations Exceeded – Cumulative Duration or Quantity Exceeded

Sample Message (underlined information is customized to the rejected claim):
"The member has been dispensed XXX days supply in the last YYY days, with this claim the member is ZZZ days supply over the limit."

"The member has been dispensed XXX units in the last YYY days, with this claim the member is ZZZ units over the limit."

Explanation:
Claim history lookback identifies cumulative days (or quantity) of drug therapy within a specified time span, and the in-process claim will reject (rejection code and message will post) if the allowed days or quantity of drug therapy are exceeded with that claim. Use of these medications beyond the FDA-approved or compendia-recommended duration of therapy is not covered.

Action:
Review the refill history, verify prescription directions, and reference the current PDL (www.hidesigns.com/ndmedicaid) for coverage information and rationale. Specific information to obtain overrides are also provided in the PDL.

To request an override if extension of therapy duration is appropriate and PA is not required, contact provider relations at 1-800-755-2604.

Duration Example: The recommended duration for Orilissa is for 2 years. Patient has completed 730 days of treatment. In process claim is denied as it would exceed this duration. No more Orilissa will be covered for this patient.

79 – Refill Too Soon

Sample Message (underlined information is customized to the rejected claim):
"Next Fill: 2020-09-26. Last Fill: 2020-09-02 at <pharmacy name>/"same pharmacy"/"name unavailable"/"pharm name missing". Rx <Rx number>, Ph <Phone Number>."

"If dose has changed and 61% or more has been used (i.e. 19 days of 30 days supply fill) on a non-controlled substance, try conflict codes ER, M0, 1B."

Explanation: Identifies when the last dispensed supply for this same medication/form/strength has not been 80% (for non-controlled) or 87% (for controlled) used prior to refilling.

Action:
Review the refill history and verify prescription directions and follow applicable instructions below.

Please have dosing change information (e.g. date of change, current directions, etc.) available when contacting provider relations at 1-800-755-2604 if requesting an override.

Dose change

Applicable only to interval decreases of the same strength of medication (BID to TID). Dosage increases typically are obtained by increasing the strength which would cause a therapeutic duplication rejection.

- If dose has been at least 61% utilized and is not a controlled substance, try DUR conflict codes ER, M0, 1B.
- If dose is less than 61% utilized or a controlled substance, please verify date of direction change, that the patient is out of medication and should be out of medication based on direction change. Please call 1-800-755-2604 to obtain an override.

Dose Change Example: Oxycodone 10mg 3x/day #60 was prescribed on day 1. On day 5, the dose was increased to 5x/day. On day 14, patient requests new fill of oxycodone 10mg. Fill date is appropriate based on direction change date. Pharmacy calls for override.

Vacations

- If dose has been at least 61% utilized and is not a controlled substance, try DUR conflict codes ER, M0, 1B.
- If dose is less than 61% utilized or a controlled substance, please call 1-800-755-2604 to obtain an override.
    - If a vacation override is authorized, the days supply overlap will apply to accumulated days supply. Previous supply and authorized early supply must BOTH be utilized before refilling again.

Lost or Stolen

- Generally, ND Medicaid does not cover lost or stolen medications. Some life preserving exceptions may be made. Please contact the drug manufacturer or search the Drug Repository Program

79 - Refill Too Soon - Accumulation Refill Too Soon

Reject Message:
"With this claim, member has accumulated a 10 (controlled) or 15 (non-controlled) day supply over the last 6 months. Member must use accumulated supply prior to refill."

Explanation: Identifies when patient's may have accumulated unused medication at home through continuously filling early allowed within the typical refill too soon parameters. Claims will reject for accumulation refill to soon if accumulated early fills exceed 10 days for controlled substances and 15 days for non-controlled substances.

Action: Review the refill history and verify prescription directions and follow applicable instructions below.

Directions have changed:

- Please recalculate how many days prescription should last based on direction change, document on previous prescription, and adjust day previous day supply based on dose change information. This may require a quantity override (request by calling 1-800-755-2604).

    - Alternatively call for an override: Please have dosing change information (e.g. date of change, current directions, etc.) available when contacting provider relations at 1-800-755-2604.

Direction Change Example: Patient A has an insulin dose of 20 units per day for 50 days (1000units/10mL dispensed). On day 35 patient asks for new fill with new directions, claim is 15 days early and is rejected. The change is to 40 units per day and occurred on day 20. Pharmacy notes new directions and date of dose change on previous Rx and rebills previous prescription as 35 days supply. New claim for 40 unit/day goes through.

Compound isn't lasting calculated day supply:

- Review prescription refill history and calculate how long prescription is lasting patient on average. Reverse and rebill previous (up to 6 months) compounds for duration it is lasting.

Compound Example: Patient B must have his medications compounded. The calculated day supply for the ingredients is 30 days. The pharmacy has counseled parents on how to maximize dose withdrawal from the bottle and verified the dose being given. No matter how they try, parents are running out early every month. Pharmacy calculates compound is lasting average of 26 days and rebills last 6 months in order as 26 day supplies.

Mail outs:

- Note which day prescription is needed, count back required number of days to mail early. Mail on same date every time (or early for weekends/holidays). A refill override may be requested for the "first" refill to get into the regular filling cycle by calling 1-800-755-2604.

Mail Out Example: Patient C needs prescription on the second and fourth Tuesday of each month and 4 days is needs for mail time, bill on the first and third Friday of each month. Each time, the prescription will be mailed out 4 day early and not run into accumulation. Refills following the first refill should continue on an every 14 days cycle, not an every 11 days which would cause an accumulation rejection.

Patient filling a few days early every month:

- If prescription information is accurate, the accumulated drug supply must be used before refill.

Early Refills Example: Patient A is very on top of things. She fills her lisinopril 3 days early every month to make sure she has it in time. Month 5 has a holiday weekend so she fills 5 days early to make sure she has enough medication to get through the holiday. Now patient has 3 extra days accumulated for 4 months + 5 days from holiday month fill so she has 17 extra days on hand and this accumulated supply should be used before refilling again.

88 – DUR Reject Error - Therapeutic Duplication

Reject Message:
"If changing med, finish day supply if possible. If concurrent therapy, see therapeutic duplication under applicable section in the PDL at www.higdesigns.com/ndmedicaid "

Explanation:
Concurrent drug use may be non-covered for various reasons, such as opposing mechanisms of action, drug-drug interactions, etc. Also, federal law requires Medicaid to pay for medications based on FDA approval and compendia-supported drug information. Practices, such as using multiple medications within the same class or multiple strengths for an "in-between" dose, often lie outside of compendia recommendations and are not covered.

Action:
Reference the current PDL (www.hidesigns.com/ndmedicaid) for coverage information and rationale. Specific information to obtain overrides are also provided in the PDL.

The prescription may require adjustment for ND Medicaid to cover. Contact prescriber if needed.

To request an override due to primary insurance requirements, contact provider relations at 1-800-755-2604.

88 – DUR Reject Error - Underutilization

Sample Message (underlined information is customized to the rejected claim):
"Since 2020-09-23 the patient has missed 020 days of therapy for this drug. Member has taken the drug only 33.33% of the time, and this drug requires 82.00% utilization compliance."

Explanation:
Underutilization is calculated for claims within the past 180 days. When maintenance medications are underutilized, the rejection code will post with the customized sample message. Most of these messages are informative and will pay. However, some medications that have increased risk for safety or efficacy concerns if not used consistently are set up to reject if utilization percentage over the past 180 days is below threshold and the in-process claim is again a late fill.

Due to safety concerns of non-adherence or wasted cost of a regimen that is not effective because it is not being taken, coverage may not be continued after action items are completed (adherence counseling is given, barriers are addressed, etc.)

Action:
Review the refill history and verify prescription directions.

- If prescription information is accurate, evaluate adherence and identify adherence barriers with patient, notify prescriber of non-adherence, and discuss adherence plan if medication is to be continued/resumed.
- If prescription directions have changed, contact prescriber for an updated prescription.

Please have adherence information (e.g. rationale for missed doses, plan to address identified adherence barriers, etc.) available when contacting provider relations at 1-800-755-2604 if requesting an override.

Transportation concerns

North Dakota Medicaid provides transportation to and from medical services, including pharmacy and medical offices. The county worker should be contacted to arrange this for a patient if it is identified as a barrier to adherence.

Summary of Coverage Rules:

If you feel your patient needs to have a medication that is denying, please call and leave as much detail as possible for us to make a determination / exception.

Albuterol (based on GINA and EPR-3 guidelines on rescue albuterol use and controller maintenance therapy):

- ProAir HFA: Quantity limit 1 inhaler per 90 days or 2 inhalers per 180 days
- Ventolin HFA / ProAir Respiclick: Quantity limit 1 inhaler per 60 days or 2 inhalers per 180 days – requires concurrent inhaled steroid for controller medication
- Nebs and Inhalers are not payable together – Inhalers and Nebs have equal efficacy and can lead to unnoticed rescue medication overutilization without notification to clinical care team
    - **Exceptions considered:** optimally treated patients with severe COPD or acute infections where coordination of an inhaler is not possible.

One strength of one medication from each class:

- Please make the following updates for these common dosages:
    - Duloxetine 90 mg/day = use 3 x 30 mg tablets instead of 60mg + 30 mg
    - Escitalopram 30mg/day = 20mg x 1 ½ tablets instead of 10mg + 20mg
    - Fluoxetine 60mg/day: use 3 x 20mg tablets instead of 40mg + 20mg
    - Lisinopril 40mg/day: use 1 x 40mg tablet instead of 2 x 20mg tablets
    - Meloxicam 15mg/day: use 1 x 15mg tablet instead of 2 x 7.5mg tablets
    - Metformin 2000mg/day: use 2 x 1000mg tablets instead of 4 x 500mg tablets
    - Sertraline 150mg/day: use 1 ½ of a 100mg tablet instead of 100mg + 50mg
    - Venlafaxine 225mg ER/day: use 3 x 75mg ER capsules instead of 75mg ER + 150mg ER

Diabetes (based on ADA guidelines):

- Testing Supplies: Testing supplies are covered for patients at risk for hypoglycemia (sulfonylurea or insulin treatment), gestational diabetes (with concurrent prenatal vitamin)
    - An approval for 6 months will also be considered for educational purposes for patients with a new diagnosis of diabetes, co-morbid acute/chronic illness affecting blood sugars, or increased activity (e.g. starting team sport).
    - Quantity limit: 200 test strips per 30 days
- Therapeutic Duplication:
    - Insulin, sulfonylureas, and TZDs (e.g. pioglitazone) are not payable together due to risk of hypoglycemia
    - DPP4- inhibitors (e.g. Januvia) require concurrent metformin and are not payable with insulin or GLP-1 agonists (GLP-1 agonists and DPP4-inhibitors both work to increase activity at the GLP-1 receptor. GLP-1 agonists are more potent)

Gabapentin (based on lack of benefit above 1800mg/day as noted in compendia):

- Max dose allowed is 1800mg. **Exceptions considered:** adjuvant treatment for seizure disorder.
- Quantity limit for 300mg is 4 per day, above this limit, a higher strength tablet must be used.
    - **Tapering schedules** to decrease to 1800mg with a target date will be considered

Proton Pump Inhibitors (based on compendia / FDA approved dosing):

- Quantity limit is 1 per day. **Exceptions considered:** Omeprazole – Refractory GERD; All other agents - Zollinger-Ellison's Syndrome or Pathological Hypersecretion
- Therapeutic Duplication: PPIs and H2Blockers – Override of addition of H2Blocker to PPI is allowed for 2 months for the indication of nocturnal hypersecretion (due to tachyphylaxis of the H2 blocker)
    - **Tapering schedules** (with or without combination H2blocker) to decrease to 1 per day with a target date will be considered

Stimulants (based on compendia and package insert):

- Vyvanse and Adderall XR are not payable with an immediate release stimulant (long acting and short acting methylphenidates are payable together)
- Max dose allowed of Adderall IR is 40mg (20mg x 2 or 30mg x 1)
- Adderall XR with PPI: Adderall XR is not payable with a PPI due to increased rate and peak of Adderall XR. **Alternatives:** Adderall IR or Methylphenidate ER can be used with a PPI

Long acting benzos and Sleeping medications (based on DUR Board recommendation and FDA indications):

- Long acting benzodiazepines and sleeping medications are not payable together due to risk of CNS depression
- Benzodiazepines indicated only for sleep (e.g. temazepam) will only be covered with a tapering plan with a target date of discontinuation to be considered for payment.

Muscle Relaxants and Opioids

- Tizanidine and Antipsychotics: Not payable together as tizanidine increases risk of psychosis and hallucinations. Another muscle relaxant (besides metaxalone and carisoprodol) can be used.
- Opioids and Quetiapine: Not payable due to risk of CNS depression. One time override of opioid may be considered for acute pain following surgery.
- Carisoprodol, Methadone: Alternative products will need to be used
- One muscle relaxant is allowed at a time.
    - **Exception considered:** diagnosis of cerebral palsy
- One short acting and one long acting opioid are allowed at a time (i.e. immediate release tramadol, oxycodone, hydrocodone not payable in combination).