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Medicaid Information

- Salt Lake City area, call 801-538-6155.
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.
- From other states, call 1-801-538-6155.

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Box 143106, Salt Lake City UT 84114-3106

09 - 68 Federally Mandated Payment Error Rate Measurement (PERM) 2010 Cycle

Utah is gearing up for the 2010 PERM audit. PERM is a comprehensive, ongoing federal audit designed to measure the accuracy of Medicaid and CHIP payments made by states for services rendered to Medicaid and CHIP recipients. Each state is reviewed once every three years. Utah is one of the seventeen states scheduled for the 2010 PERM cycle that begins October 2009. The upcoming audit will be the second PERM audit for Utah.

The PERM audit has three specific areas of review: Data Processing, Medical Necessity, and Recipient Eligibility. The majority of errors in the 2007 PERM cycle were due to providers not submitting the requested medical records, submitting inadequate records, or exceeding the allowed time frame for record submission.

It is extremely important for providers to comply with the CMS Audit guidelines. If providers do not, they will be responsible to repay any Medicaid payment they received in relation to the audited claim.

For more information on PERM, visit the Bureau of Program Integrity web page at <http://health.utah.gov/bpi/index.php>.

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09 - 69 Utah Medicaid Identification Card

The identification card for Utah Medicaid recipients has changed. The new ID cards are being issued for more recipients throughout the state. Providers can expect to encounter both versions of the Medicaid cards when seeing Utah Medicaid recipients. Either card is valid for the time period identified on the card.

The new Medicaid ID cards may have an impact on the way Utah Medicaid providers and their office personnel interpret the Medicaid card. Some characteristics of the card will not change. There are, however, many significant differences between the versions currently in use. The new design is intended to more closely conform to the size of medical cards already being used in the healthcare community. The Medicaid card will continue to be printed on 8.5 x 11 size paper and the background color for the body of the card remains the same; Traditional and Emergency Only - purple, Non Traditional - blue, Primary Care Network - yellow, and QMB Only - peach.

The recipient may choose to detach the body of the card from the top address area on the sheet of paper. The card may then be folded to make a smaller version of the Medicaid ID card.

Each quadrant of the card may contain information essential to the provider. The back of the card will be used for spend-down cases with incurred medical bills. It is recommended that you make a copy of the card for your records. The card may be unfolded for copying, and all relevant information will be on a single copy. Spend-down clients with incurred medical bills will have additional information for providers printed on the back of the card.

The card is still valid if the recipient chooses to detach the address section. Either Medicaid ID card type is valid for the time period identified on the card. An example of the new Medicaid card has been published in the July 2009 MIB, [article 09-44](#).

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09 - 70 Non-Emergency Medical Transportation (NEMT)

Over the past year, with changes in covered benefits and expected changes in the UTA Flex Trans services, there seems to be increasing confusion over the role of PickMeUp Medical Transportation in providing NEMT to medical appointments.

PickMeUp Medical Transportation is the provider of last resort for NEMT. This means that if the client has a vehicle and can drive it (or has someone responsible to drive them), can use the bus system, or can qualify for Flex Trans, they would not be eligible to be transported by PickMeUp.

When individuals feels they qualify for PickMeUp, they call PickMeUp to start the process to determine if they are eligible. This process requires the individual to provide information for a provider to whom a medical mobility evaluation can be faxed in for completion. From the time the evaluation form is faxed, the client is allowed up to four weeks of transportation for NEMT. Within that time, PickMeUp should receive the completed evaluation and be able to make a determination if the client is eligible for their service. When a provider fails to return the required evaluation, or does not adequately complete the evaluation, the four-week grace period expires. The client is not allowed to continue services until the documentation is returned and is properly completed. The provider is not allowed to substitute medical records or a doctor's order for door-to-door NEMT in lieu of completing the evaluation form provided to them by PickMeUp.

- If the completed document indicates the client can use the bus to get to medical appointments, the client is notified and should contact their eligibility worker to request bus passes be issued. (Bus passes are bus stop-to-bus stop service.)
- If the completed document indicates the client can use Flex Trans, the client is notified by PickMeUp that they will be allowed up to an additional six weeks of NEMT services while arranging to have an evaluation conducted by Flex Trans to determine if they are eligible for their services. (Flex Trans is curb-to-curb service.)
- The client is responsible to arrange the appointment so as to obtain a determination in the six-week grace period. Flex Trans will, when necessary, provide transportation to their evaluation appointment.
- If the completed documentation indicates the client cannot use bus or Flex Trans services, the client is notified they are eligible for transportation by PickMeUp. (PickMeUp provides door-to-door service.)

Eligibility is reviewed based on the individual's medical circumstances, but no less than annually. Unless there is a change in medical circumstances or services available by the bus system or Flex Trans, a new application for PickMeUp may only be submitted annually. Therefore, it is very important that the provider completely and correctly completes the documentation from PickMeUp.

When a client is approved for any of the above forms of transportation, it must be remembered that transportation is only provided to the closest, appropriate Medicaid provider for Medicaid-covered services.

Reminder: When a benefit is eliminated, transportation can no longer be covered to a provider for that discontinued service. (An example of a recent benefit change is the elimination of dental services for all non-pregnant adults on Traditional Medicaid.)

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09 - 71 Physician Manual Highlights

The following changes to the Physician Manual and attachments will be in effect October 1, 2009:

Echocardiograms

Per the CPT® - AMA - Manual, the code 99307 includes the services of add-on codes 99320 and 99325. Therefore, an incidental edit will post on the claim. The add-on codes 99320 and 99325 cannot be billed alone. They must be accompanied by one of the base codes listed in the CPT® - AMA - Manual, such as 99307.

Add-on Codes

Add-on codes by definition must be submitted with a base code to follow correct coding. The base codes allowed with prolonged service codes 99354 through 99357 are listed in the CPT® - AMA - Manual (i.e. 99201-99215, 99241-99245). Prolonged service codes submitted alone will be denied for incorrect coding. As per the January 2008 MIB, the prolonged service codes 99358 and 99359, services without face-to-face patient contact, were inadvertently left off the CPT list of non-covered codes. These codes will be added to the CPT list.

Brachytherapy

As per the October 2008 MIB, multiple injections using brachytherapy are not covered by Medicaid. Therefore, MammoSite injections (code 19296) is a non-covered service. The brachytherapy codes 77781-77784 were changed to 77785-77787 as of January 1, 2009. These code ranges will be corrected in the Physician Manual.

Modifiers

Modifier 22 will be paid at the fee schedule rate unless supportive documentation is submitted with the claim.

Modifier 62 requires each co-surgeon to submit a separate operative report clearly describing the separate portions of the procedure that each person completed.

Cosmetic Surgery

Reconstruction of the cancer-affected breast may only be approved for a repeated reconstructive surgery based on medical necessity. Examples of medically necessary secondary surgery include implant rupture, wound dehiscence, or wound infection.

B Status Bundled

B status bundled codes are Medicare codes which are considered part of the procedure and not paid separately under Medicare. Currently, Medicaid has followed B status code payment except for after-hours physician service in established patients. The following codes will be added to the B bundled list in Medicaid:

20930 Spinal bone allograft morsel add-on
 20936 Spinal bone allograft local
 22841 Insert spine fixation device

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09 - 72 Genetic Testing Clarification

The Physician Manual is being corrected in the Limitations section, item T, Genetic Testing. The number of newborn genetic tests was increased from six to thirty-six as follows:

- (2.) In Utah, there are thirty-six genetic tests which are recognized for coverage in the newborn. These newborn screening (36) tests, sponsored through the State Laboratory, are covered under the hospital DRG. Sometimes the infant is born outside of the hospital. The code S3620 submitted with the BL modifier is to be used by certified nurse midwives or clinics to bill for the State Laboratory newborn screening kit when the procedure is completed through them instead of the hospital. The State Laboratory newborn screening kit code includes the initial lab tests and a followup test about two weeks from birth. The venipuncture code may be billed in addition to S3620-BL.
- (4.) If the physician reviews the family history and determines a medically necessary reason to complete cytogenetic testing beyond the standard thirty-six tests recognized in Utah, supportive medical record information must be submitted for review of coverage prior to completion of codes 88271 and 88299. The physician is expected to request and review prior medical records to prevent duplication of genetic testing.

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09 - 73 Chronic Pain Management Services Will Not Require PA

Pending approval of the State Plan Amendment, Criteria #45 will be deleted because prior authorization is no longer required. Requirements and recommendations for pain management services will be added to the Physician Manual under Limitations section, item T, including the following:

1. Primary care providers and pain medicine specialists may bill for pain management services using the appropriate evaluation and management code.
2. Medicaid will reimburse an approved psychiatrist or clinical psychologist (PhD) for a comprehensive psychiatric evaluation as a medical benefit when referred directly by a pain specialist or a primary care provider (PCP) treating a patient with chronic pain. The psychiatrist or psychologist will schedule or contact the patient to schedule an appointment.

- a. Services from an approved psychiatrist will be billed under code 99245-HE.
- b. In areas where a psychiatrist is not available, an approved clinical psychologist (PhD) will bill for the psychiatric evaluation using code S5190-HE.
- c. Procedure code 96116 (neurobehavioral status examination) cannot be billed separately. It is considered part of the psychiatric evaluation.
- d. The current approved Utah Medicaid psychiatrists/clinical psychologist pain providers include:
 1. Kelly Lundberg, PhD, phone (801) 532-1850
450 S. 900 E., Suite 300, Salt Lake City, Utah, 84102
 2. Denise Thornhill, PhD, phone (801) 261-5141
715 E. 3900 S., Suite 202, Salt Lake City, Utah, 84107
- e. To be reimbursed correctly, a psychiatrist/clinical psychologist must be identified (approved) in the MMIS system. A psychiatrist or clinical psychologist may call (801) 538-6149 to ask for information to become an approved provider.

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09 - 74 CPT List Update

The CPT List will be updated for October 1, 2009, with the following changes:

Covered

- 55862 Hysteroscopy, surgical, removal of impacted foreign body (take off of prior authorization list)
- 77785 Remote afterloading high dose rate radionuclide brachytherapy; 1 channel
Limited to coverage of one unit per day
- 77786 Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels
Limited to coverage of one unit per day
- 77787 Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels
Limited to coverage of one unit per day

Non-Covered

- 19296 Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
- 19297 Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy
- 19298 Placement of radiotherapy afterloading brachytherapy catheters (multiple and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to partial mastectomy), includes imaging guidance
- 55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
- 55920 Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application
- 99358 Prolonged physician service in inpatient setting without direct patient contact (i.e. review of extensive medical records, communication with staff); first hour
- 99359 Prolonged physician service in inpatient setting without direct patient contact (i.e. review of extensive medical records, communication with staff); each additional 30 minutes

Prior Authorization Required

- 19357 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
Prior Approval: Written ICD-9-CM: 173.5, 198.2
Note: Reconstruction must be medically necessary, additional cosmetic surgery is not covered.
- 19380 Revision of reconstructed breast
Prior Approval: Written ICD-9-CM: 173.5, 198.2
Note: Secondary reconstruction must be medically necessary, not strictly cosmetic.

Covered For Assistant Surgeon

The following code has been removed from the not covered for assistant surgeon list:

- 58542 Laparoscopic supracervical hysterectomy

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09 - 75 Dental Provider Manual Corrections

The following open codes were inadvertently left out of the Dental Provider Manual and will be added, effective October 1, 2009:

D5610 Repair resin denture base
 D5932 Obturator prosthesis; definitive
 D5954 Palatal augmentation prosthesis
 D8690 Orthodontic treatment (alternative billing to a contract fee)
 D8999 Unspecified orthodontic procedure, by report
 D9110 Palliative (emergency) treatment of dental pain - minor procedures

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09 - 76 Audiology Provider Manual Corrections

The following closed or obsolete codes will be removed from the Audiology Provider Manual, effective October 1, 2009:

L8614 Cochlear device, includes all internal and external components
 92630 Auditory rehabilitation; pre-lingual hearing loss
 92633 Auditory rehabilitation; post-lingual hearing loss

The following open codes were inadvertently left out of the manual and will be added, effective October 1, 2009:

92555 Speech audiometry threshold;
 92556 Speech audiometry threshold; with speech recognition

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09 - 77 Vision Code Covered

The following code was opened, effective April 1, 2009, and requires prior authorization. A prior authorization will only be granted when an eligible recipient also requires Lenticular lenses.

V2025 Deluxe frame

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09 - 78 Medical Supplies Updates

Code Modifications

Effective July 1, 2009, physicians and osteopaths are allowed to be reimbursed for the following codes:

A4580 Cast supplies (e.g., plaster)
 A4590 Special casting materials (e.g., fiberglass)

Effective October 1, 2009, the following code will be covered with prior authorization:

E1050 Fully-reclining wheelchair, fixed full length arms, swing away detachable elevating leg rests

Provider Manual Corrections

The following open codes were inadvertently left out of the Medical Supplies List and will be added, effective October 1, 2009:

A7522 Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each
 E0635 Patient lift; electric, with seat or sling
 E0673 Segmental gradient pressure pneumatic appliance, half leg

E2220 Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each
 E2224 Manual wheelchair accessory, propulsion wheel excludes tire, any size, each
 E2227 Manual wheelchair accessory, gear reduction drive wheel, each
 E2291 Back, planar, for pediatric size wheelchair including fixed attaching hardware
 E2292 Seat, planar, for pediatric size wheelchair including fixed attaching hardware
 E2293 Back, contoured, for pediatric size wheelchair including fixed attaching hardware
 E2294 Seat, contoured, for pediatric size wheelchair including fixed attaching hardware
 E2616 Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware

The following discontinued HCPCS code will be removed from the manual, effective October 1, 2009.

A4534 Youth size brief, each

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09 - 79 Oxygen Concentrators

There continues to be some confusion regarding the oxygen concentrator contract. For Medicaid recipients not enrolled with Molina or Healthy U, oxygen concentrators may only be provided by the current contract holder. The recipient must meet all of the following criteria:

1. The client is a Utah Medicaid recipient residing within the State of Utah;
2. The recipient has a physician's order that requires at least six hours of oxygen a day; and
3. The rate prescribed is between 1/16th liters per minute through 10 liters per minute of oxygen.

Petersen Medical holds the current contract for oxygen concentrators. They may be contacted at 1-800-888-5137.

Oxygen needs that do not fall within the above description may be met by any willing Utah Medicaid provider who is licensed to supply oxygen. Please refer to the Medical Supplies Provider Manual and Medical Supplies List regarding specific requirements and limitations before providing oxygen services.

If you have questions or concerns, contact Anita Hall, Health Program Manager, (801) 538-6483 or ahall@utah.gov.

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09 - 80 Home Health Care Updates

Medicaid will reimburse for one IV dressing change or IV site change per seven-day period. When the client is to receive a medication, such as an antibiotic for a 7-10 day period, it is expected that some type of long term IV administration line will be placed. Change of IV site dressing or IV line must have the documentation to support the medical necessity of the service.

The RN assessment, code T1001, must be coordinated with the home health aide visit code S9122 so that patients receiving periodic home health aid care are seen on a different date from the RN assessment. Only patients requiring supportive daily home health care to meet their ADL requirements may receive the RN assessment visit on the same date as the home health care aide visit.

A prior authorization is not required for the initial nursing assessment (T1001) or those required at recertification. One recertification assessment every 60 days is a federal requirement. A prior authorization is not required for the physical therapy assessment (S9131) which is required to determine whether a prior authorization will be given for home physical therapy, or if the patient should be able to receive physical therapy in the outpatient setting.

Home health services requiring minimal time, such as filling a medication box billed under code T1003, should be billed with the modifier UN for two people and the modifier UP for three people. A number of units will be divided among people and the modifier used to indicate the service was shared. When only one person is in the home, there should be two boxes filled for the next two-week period, unless a medically necessary reason is documented for weekly visits.

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09 - 81 Private Duty Nursing Grid Update

The Private Duty Nursing Grid has been updated and will be in the attachments section of the Home Health Manual. The grid scale was also modified to reflect a number of transition units which will be granted to the Home Health Agency. The scoring is applied as follows:

- 20 points or less - If the individual is being transitioned off of eight hours, then 832 units will be approved to the home health agency for the cert period. Otherwise, no private duty nursing hours will be allowed.
 Note: When the patient is decannulated, up to four hours of nursing per day may be expected during the first 24-72 hours for the weaning process.
- 21-35 points - The client may receive up to 8 hours per day of shift care.
- 36-45 points - The client may receive up to 10 hours per day of shift care.
- 46-55 points - The client may receive up to 12 hours per day of shift care.
- 56 points and over - The client may receive up to 14 hours per day of shift care.

The client may receive up to 2-3 days of 20-24 hours of shift care only under the following conditions:

- After initial hospital discharge - family/caregiver(s) need supervision or training in home care procedures.
- After subsequent hospitalization - family/caregiver(s) need training in home care changes.
- Due to caregiver illness or temporary incapacity, an episode of supportive nursing care is needed.

Note: The Private Duty Nursing Grid may not accurately reflect the requirements of a patient who remains in stable condition. Once eight hours is reached, an increase in hours of service will require a change in patient condition which meets the above criteria.

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09 - 82 Negative Pressure Wound Therapy

Criteria #23 in the Criteria for Medical and Surgical Procedures has been updated for October 1, 2009. The criteria will read as follows:

1. Documentation
 - a) Wound characteristics (all)
 - i) Documentation in the patient medical record of evaluation, standard wound care, wound dimensions and volume as measured by a licensed medical professional with training in wound care. Note: Standard wound care includes prevention of fecal/urine contamination, pressure reducing interventions and provision of a moist wound environment.
 - ii) The wound must have been present and treated more than 30 days unless (one)
 - (1) Instituted at the time of surgery during an inpatient stay.
 - (2) Instituted in an intensive skilled nursing facility within two weeks of admission for wounds documented at the time of admission.
 - iii) The wound is located on the trunk.
 - iv) The initial trunk wound dimensions must be greater than 40cc volume at the time of onset of therapy. Photographs are suggested. Note: Wound volume is measured by the amount of saline filling the wound or assessed with the wound scanner. One of the following conditions must be met:
 - (1) A surgical abdominal wound has failed at least one attempt at grafting.
 - (2) Ulcer is stage III or IV.
 - b) Adequate nutrition by: (all)
 - i) Patient history does not indicate anemia, malnutrition, or unexplained weight loss.
 - ii) Laboratory result (all)
 - (1) Prealbumin level greater than 16mg/DL
 - (2) Glycated hemoglobin is < 8.0
 - c) Weekly wound assessment must indicate continued healing and a decrease in wound dimension. Note: This measurement may be accomplished by the wound scan device.
 - d) Negative Pressure Wound Therapy (NPWT) applied during inpatient stay will be continued for 21 days from the time of application as long as continued wound healing is documented.
 - e) For recertification of an additional 21 days, the wound must have shown > 25% reduction in volume since the previous evaluation period.

2. Indications. Note: Covered for wounds located on the trunk.
 - a) Stage III/IV pressure ulcer. Note: Diabetic ulcer patient enrollment in a diabetes self-management training program is recommended.
 - b) Acute or traumatic wound.
 - i) No evidence of healing \geq one week.
 - ii) No preexisting condition or disease (one or more)
 - (1) Collagen vascular disease
 - (2) Immune deficiencies
 - (3) Psychosis/depression affecting compliance with treatment
 - c) Following surgical repair or wound closure.
3. Non-covered
 - a) Fistulas to organs or between body cavities
 - b) Necrotic tissue with eschar
 - c) Untreated osteomyelitis
 - d) Malignancy in the wound
 - e) Placement of the device over exposed arteries or veins
 - f) Application to sites other than trunk

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09 - 83 Preferred Drug List Update

The Medicaid Preferred Drug List (PDL) continues to expand on a monthly basis. The Medicaid P&T Committee has recently considered antiparkinson agents, third generation cephalosporins, and targeted immunomodulators. For more information or to download a list of current NDC's on the Medicaid PDL, visit the Medicaid Pharmacy Website at <http://health.utah.gov/medicaid/pharmacy>.

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09 - 84 P&T Committee Schedule

The P&T Committee meets on the third Thursday of the month in the Cannon Health Building at 7:00 A.M. The schedule of upcoming drug classes for review is as follows:

October 2009: Antihistamines, second generation

November 2009: Fluoroquinolones, oral, second generation (excluding norfloxacin and ofloxacin)

For more information and important updates regarding the P&T Committee schedule, visit the Medicaid Pharmacy Website at <http://health.utah.gov/medicaid/pharmacy>, or email Duane Parke at dparke@utah.gov.

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09 - 85 Pharmacy Coverage Highlights

During the last quarter, prior authorization criteria for the following drugs were amended as follows:

Tasigna®

- Minimum age requirement: 18 years old.
- Diagnosis of chronic or accelerated phase myelogenous leukemia.
- Documented intolerance or resistance to therapy that includes Gleevec.
- Initial authorization is for one year.

Epogen®/Procrit®

- Diagnosis of anemia associated with renal failure, chemotherapy, or HIV; or
- Diagnosis of Hepatitis C and being treated with ribavirin; or
- Blood transfusions, allogenic and anemic surgery patients (approve one time only).
- Patient is not on dialysis.
- Patient does not have a GI bleed.
- Hematocrit < 33% supported by lab work done in the last three months (fax copy).

- Hemoglobin < 11% supported by lab work done in the last three months (fax copy).
- Prescribing authority is granted to hematologist, oncologist, nephrologist, and infectious disease specialists, or based upon a consult with one of these specialists.
- Initial authorization is granted for six months - renewals require that the patient not have GI bleeding, not be on dialysis, and lab work in the last three months showing hematocrit < 39% and hemoglobin 11-13% (fax copies).

Aranesp®

- Diagnosis of anemia associated with renal failure or chemotherapy; or
- Diagnosis of Hepatitis C and being treated with ribavirin.
- Patient is not on dialysis.
- Patient does not have a GI bleed.
- Hematocrit < 33% supported by lab work done in the last three months (fax copy).
- Hemoglobin < 11% supported by lab work done in the last three months (fax copy).
- Prescribing authority is granted to hematologist, oncologist, nephrologist, infectious disease specialists, or gastroenterologist, or based upon a consult with one of these specialists.
- Initial authorization is granted for six months - renewals require that the patient not have GI bleeding, not be on dialysis, and lab work in the last three months showing hematocrit < 39% and hemoglobin 11-13% (fax copies).

Neupogen®/Neulasta®/Leukine®

- Documented myelosuppressive chemotherapy, bone marrow transplant, peripheral blood progenitor cell collection, severe chronic neutropenia; or
- Documented ANC < 750 cells/microliter in patients with Hepatitis C who are being treated with Interferon.
- Not covered for AIDS, hairy cell leukemia, myelodysplasia, drug-induced congenital agranulocytosis, alloimmune neonatal neutropenia.
- Initial authorization is granted for six months - renewals require a telephone request from the physician's office or pharmacy.

Topical Tretinoin (generic Retin-A)

- Diagnosis of cutaneous lesions caused by Kaposi's Sarcoma.
- Pre-pancreatin use.
- Documentation of primary number of KS lesions, estimated total square centimeters, number of lesions flat on baseline, and number of lesions raised on baseline.
- Systemic anti-KS therapy is not yet required.
- Also approved for acne vulgaris, nodular, and/or cystic acne.
- Initial authorization is granted for a 60-day trial period. Re-authorization is given for six-month periods with documentation indicating that the patient has had at least a 25% improvement from baseline.

Effective October 1, 2009, the following drugs will require prior authorization:

Suboxone®

- Minimum age requirement: 16 years old.
- Documented diagnosis of opioid dependence.
- Rule out concomitant use of long-acting opioids or maintenance therapy with short-acting opioids.
- Prescribing physician must have an X-DEA number.
- Authorization is given for an eight-week taper schedule.

Pegasys®/Peg-Intron®

- Documented diagnosis of Hepatitis C.
- Authorization will be given for one 48-week supply. Coverage may be extended to 72 weeks in patients with a documented late viral response (response at 24 weeks).

New and amended prior authorization requirements can be accessed on the Medicaid Pharmacy Website at <http://www.health.utah.gov/medicaid/pharmacy>.

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09 - 86 DUR Board Activities

The Drug Utilization and Review Board (DUR) for Utah Medicaid reports the following:

1. Limit of 30 tablets per month on all strengths of Pristiq®.
2. Age overrides are provided for patients over 20 years of age when prescribed oral Isotretinoin (generic Accutane) for a diagnosis of acne vulgaris, nodular, and/or cystic acne.
3. Topical Benzoyl Peroxide preparations and select vitamin D supplements are covered.

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09 - 87 Rebetrone Drug

The drug Rebetrone has been removed from the Drug Criteria and Limits attachment. It is no longer marketed and not available for Utah Medicaid clients.

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