



***PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)
PHARMACY UPDATE***

NUMBER 02 - 04

MAY 2004

Introduction

Please keep these updates on file in your Pharmacy Procedure Manual as they will contain valuable information regarding formulary changes and additions, plan parameter changes, billing procedures, the Treatment Authorization Request (TAR) process and other necessary information. Please refer to your Pharmacy Procedure Manual as most of the topics contained in this update are explained in detail in the Manual. If you have not received your copy of the Pharmacy Procedure Manual, you may download it from the PHC website at www.partnershiphp.org or contact the Pharmacy Department at (707) 863-4414 to request a copy.

Contents

- **Pharmacy Survey**
- **Information Submitted on TARs**
- **Deferred TARs**
- **Eligibility Verification**
- **Other Coverage-Removal for Members Without Other Coverage**
- **Carve Out Drugs-Lexiva, Risperdal Consta, Symbyax**
- **Formulary Change: Age Restriction For Generic Darvocet N 100mg**
- **Dispensing Limits**
- **Formulary Additions/Changes**

Pharmacy Survey / Focus Group Meeting

PHC would like to thank those pharmacies who responded to the Pharmacy Provider Satisfaction Survey which was sent out earlier this year. We sent out 111 surveys and received 46 responses for a 41% response rate. We are in the process of compiling the responses and will share the results with you in an upcoming Pharmacy Update.

PHC is in the process of planning three Pharmacy Focus Group meetings, one each in Napa, Solano and Yolo Counties, in the coming months. The intent of the focus group meetings will be to help PHC better understand our pharmacy provider issues and to answer any questions on PHC's policies and procedures. Notice of location, time and place of the meetings will be distributed prior to the meetings.

Information Submitted on TARs

Pharmacy TARs for PHC members must be requested by the pharmacy provider by submitting a completed TAR form to PHC. PHC has the following expectations of the pharmacy provider in regards to information submitted on the TAR:

- The information submitted on the TAR is true, accurate and complete
- A record is maintained that verifies the information submitted on the TAR was provided by the prescriber or the prescriber's representative
- Specifically, the pharmacy is expected to confirm the diagnosis and medical justification such as a treatment failure of a formulary alternative with the prescriber or the prescriber's representative prior to submitting a TAR for a non-formulary medication

Deferred TARs

PHC defers TARs back to providers when requesting additional information to assist in the TAR review. A response to the request for additional information should always be written on or attached to the original deferred TAR and resubmitted to PHC. A new TAR is not required to respond to a deferred request unless there is an NDC number change.

Eligibility Verification

If a prescription claim is rejected by MedImpact for "Non-Matched Cardholder ID", eligibility may be verified by the following procedure:

- 1) Call the State Automated Eligibility Verification System (AEVS) at (800) 456-2387. The AEVS eligibility file is updated throughout the day with the file being sent to PHC each evening. Thus a member may be eligible as verified through AEVS, but the updated file may not have been transferred yet to PHC and MedImpact.
- 2) If AEVS confirms that the member is eligible through PHC, then the pharmacy should complete an eligibility form (Attachment A- in the Pharmacy Manual) and fax it to PHC Member Services at (707) 863-4415 requesting the member be added to the MedImpact eligibility file. The claim may then be resubmitted on-line to MedImpact within 24 hours. If a member's eligibility needs to be updated on an urgent basis, the pharmacy may call PHC Member Services at (707) 863-4120 or (800) 863-4155 and request the eligibility file to be updated as soon as possible.
- 3) Pharmacy providers may also contact the PHC Automated Eligibility System at (707) 863-4140 or (800) 557-5471 to inquire about member eligibility.

During the interim while the member's eligibility status is being researched, pharmacies should exercise appropriate clinical judgment when determining whether to dispense medications pending eligibility verification.

Other Coverage Code-Removal for Members Without Other Coverage

Claims submitted electronically to MedImpact for members who have other primary health insurance with pharmacy benefits will reject with the message: "2ndry Cvrgr-Bill Primary Ins". If the reject message is in error and the pharmacy determines that the member does not have other

pharmacy insurance coverage, the pharmacy should contact PHC Member Services to request the *other coverage code* be removed. Once Member Services confirms that the member does not have other primary pharmacy insurance coverage, the *other coverage code* is temporarily removed from MedImpact and claims are allowed to adjudicate.

In the past pharmacies would have to contact PHC Member Services on a monthly basis (or more often) to request the removal of the *other coverage code* because the monthly eligibility file from the State would override any changes to the PHC and MedImpact systems. Effective May 1, a process has been put in place that enables the PHC and MedImpact systems to retain the updated record until the State eligibility file is updated. Once PHC Member Services removes the *other coverage code*, the eligibility file will be permanently updated within 30 days. Thus pharmacy providers will not have to contact PHC Member Services on a monthly basis to request removal of the *other coverage code*.

Carve Out Drugs-Lexiva, Risperdal Consta, Symbyax

The Department of Health Services (DHS) has informed PHC that Lexiva, Risperdal Consta, and Symbyax are still in the process of being carved out. These drugs have already been removed from PHC's financial responsibility and PHC is not reimbursing pharmacy providers for these drugs. DHS would like to remind pharmacies that they should bill EDS to establish the date of service. They will be able to refer back to the denied claim for full retro reimbursement once the 0242 carve out table is active at EDS. This is important as some of these drugs are going beyond the six month billing limitation referred to in the Medi-Cal Pharmacy Provider Manual. If you have questions regarding billing for these drugs you may contact the EDS Medi-Cal Help Desk at (800) 541-5555.

Formulary Change: Age Restriction For Generic Darvocet N 100mg

Over the last several years a body of literature has developed pointing to the potential dangers of

certain medications in the elderly. Studies have shown the prevalence of inappropriate drug prescribing, using criteria developed by geriatric experts, has been approximately 7-8% in persons older than age 65. The highest frequency of problems has been with five medications - propoxyphene, hydroxyzine, diazepam, amitriptyline and oxybutynin. Propoxyphene is a centrally acting opiate analgesic that has been identified by geriatric experts as potentially inappropriate for use by adults age 65 or older. Common adverse effects include dizziness, sedation, lightheadedness, nausea, vomiting, and constipation. The CNS related side effects may increase the risk of falls and hence fall related fractures. In addition, studies have demonstrated that propoxyphene is no more effective than acetaminophen, aspirin, codeine or ibuprofen in relieving pain and may actually be inferior. **Therefore, the PHC Pharmacy and Therapeutics Committee has recommended requiring prior authorization of propoxyphene 100mg/APAP 650mg (generic Darvocet N 100mg) for members age 65 and older.** This medication will be restricted to treatment for members age 65 and older with mild to moderate pain that have had a documented trial and failure with a nonsteroidal anti-inflammatory agent or alternative analgesic. The drug will remain on formulary for members under the age of 65 with a maximum of 120 tablets per month. It is our expectation that more appropriate use of propoxyphene in the elderly will reduce adverse drug reactions and improve safety for PHC members.

Dispensing Limits

A current list of Dispensing Limits is attached to this Update. The list includes maximum dispensing limits, age restrictions, code 1 restrictions and step edit criteria.

Formulary Additions / Changes

As a result of the April 22, 2004 Pharmacy & Therapeutics (P&T) Committee meeting the attached formulary additions and changes were accepted. Effective date for these additions and changes will be **June 1, 2004**.

PHC FORMULARY: ADDITIONS / CHANGES

Effective June 1, 2004

DRUG	CLASS	FORMULARY STATUS	RESTRICTIONS / LIMITS
ADDITIONS:			
Omnicef (cefdinir) 125mg/5ml Oral Suspension 60ml, 100ml/ Abbott	Cephalosporin Antibiotic	FORMULARY	
Zomig (zolmitriptan) Nasal Spray 5mg- Box of 6 single use units / Astra Zeneca	Migraine Agent	FORMULARY	Limit: 1 unit (6 doses) per month
Monistat-1 (Advanced Care) ; Vagistat-1 (BMS) (tioconazole) single dose applicator	Vaginal Antifungal Agent	FORMULARY	
Isotretinoin (generic Accutane) 10mg, 20mg, 40mg capsule / GENERIC	Retinoid	FORMULARY	Limit: Maximum of 20 weeks of treatment per lifetime
Actonel (risedronate) 35mg tablet / PG	Bisphosphonate	FORMULARY	
Avandamet (rosiglitazone/metformin) 1/500, 2/500, 2/1000, 4/500, 4/1000 tablets / GSK	Antidiabetic Agent	FORMULARY	Limit: Maximum dosing of 2 per day
Psyllium (Generic Metamucil) Bulk Powder / GENERIC	Bulk Laxative	FORMULARY	
CHANGES:			
Tramadol (Generic Ultram) 50mg tablets / GENERIC	Central Analgesic	FORMULARY	New Limit: Max of #120 per month
Cyclobenzaprine (Generic Flexeril) 10mg tablet / GENERIC	Skeletal Muscle Relaxant	FORMULARY	New Limit: Max of #120 per month
Propoxyphene 100mg/ APAP 650mg (Generic Darvocet N 100mg) tablets / GENERIC	Narcotic Analgesic	FORMULARY	Limit: Restricted for use in mbrs less than 65 years old
Topamax (topiramate) 25mg, 50mg, 100mg, tablets / McNeill	Anticonvulsant	FORMULARY	Dose Restriction: Maximum dosing of 3 tablets per day
Lamictal (lamotrigine) 25mg, 100mg, 150mg, / GSK	Anticonvulsant	FORMULARY	Dose Restriction: Maximum dosing of 7 tablets per day for the 25mg & 2 tablets per day for the 100mg & 150mg
Effexor (venlafaxine) 37.5mg, 75mg, 150mg XR capsules / Wyeth-Ayerst)	Antidepressant	STEP-EDIT CONTINUES <i>Must have had a previous trial of fluoxetine or continuing care allowed if mbr continuing on Tx</i>	Dose Restriction: Maximum dosing of 1 capsule per day for the 37.5mg & 75mg capsules & 2 capsules per day for the 150mg
DELETIONS:			
Catapres (clonidine) TTS-1, TTS-2, TTS-3 Transdermal Patch / BI	Antiadrenergic Agent – Centrally Acting	NON-FORMULARY	Continuing Care Allowed if mbr had an Rx filled within the last 120 days.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
FORMULARY DISPENSING LIMITS

6-1-04

DRUG	DISPENSING LIMIT
ACCOLATE (Zafirlukast)	STEP EDIT: Requires previous use of an oral inhaled corticosteroid in the last 120 days
ACCUTANE (Isotretinoin)	Maximum of 20 weeks of treatment per year
ADDERALL (Amphetamine Mixtures)	For use in members between 4 and 16 years old.
ADVAIR (Salmeterol/Fluticasone) DISKUS	STEP EDIT: Requires previous use of an oral inhaled corticosteroid in the last 120 days Maximum of 1 unit per month
ALOMIDE (Lodoxamide)	STEP EDIT: Requires previous use of Naphcon A or Vasocon A in the last 120 days
AMBIEN (zolpidem)	Maximum of 60 tablets per year & limited to 1 tablet per day dosing
AMERGE (Naratriptan)	Maximum of 9 tablets per month of 1 strength
ATIVAN (Lorazepam)	CODE 1: For members who have agitation associated with schizophrenia/bipolar disorder, a diagnosis of cancer or management of anxiety disorders for members residing in a SNF
ATROVENT (Ipratropium) INHALER	Maximum of 2 units per month
AXERT (Almotriptan)	Maximum of 6 tablets per month of 1 strength
AZMACORT (Triamcinolone)	Maximum of 3 units per month
AZOPT (Brinzolamide)	Maximum of 10mls per month
BETAGAN (Levobunolol)	Maximum of 10mls per month
BETOPIC (Betaxolol)	Maximum of 10mls per month
BEXTRA (Valdecoxib)	STEP EDIT: Mbr must be on concurrent warfarin therapy or age 75 years and older
CEFTIN (Cefuroxime) Tablets	Maximum of 20 tablets per month
CELEBREX (Celecoxib)	STEP EDIT: Mbr must be on concurrent warfarin therapy or age 75 years and older Maximum of 100mg bid or 200mg once daily
CIPRO (Ciprofloxacin)	Maximum of 60 tablets per month
CLARITIN (Loratadine) TABLETS	Maximum of 1 tablet per day dosing
COMBIVENT (Albuterol/Ipratropium)	Maximum of 2 units per month
CONCERTA (ER Methylphenidate)	For use in members between 6 and 16 years old
COSOPT (Timolol/Dorzolamide)	Maximum of 10mls per month
COZAAR (Losartan)	CODE 1: For members intolerant of formulary ACE Inhibitors
CYTOTEC (Misoprostol)	Limited to use up to 90 days per year
DALMANE	Maximum of 1 capsule per day dosing
DARVOCET N (Propoxyphene Napsylate/APAP) 100mg Tablets	Restricted for use in mbrs less than 65 years old & Maximum of 120 tablets per month
DIABETIC SUPPLIES (Test Strips & Lancets)	Maximum of 100 per 25 days
DEXEDRINE (Dextroamphetamine)	For use in members between 4 and 16 years old.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
FORMULARY DISPENSING LIMITS

6-1-04

DIFLUCAN (Fluconazole) Tablets, 150mg single dose only	<i>Maximum of 2 tablets per 30 days</i>
DIOVAN (Valsartan)	CODE 1: <i>For members intolerant to ACE Inhibitors</i>
DIOVAN HCT (Valsartan/HCT)	CODE 1: <i>For members intolerant to ACE Inhibitors</i>
EFFEXOR (Venlafaxine) Tablets	STEP EDIT: <i>Must have had a previous trial of fluoxetine in the last 120 days</i> <i>Maximum of 3 tablets per day dosing</i>
EFFEXOR (Venlafaxine) XR	STEP EDIT: <i>Must have had a previous trial of fluoxetine in the last 120 days</i> <i>Maximum of 1 capsule per day for the 37.5mg and 75mg capsules & 2 capsules per day for the 150mg capsule</i>
EMPIRIN W/ CODEINE (Aspirin/Codeine) ¼ gr, ½ gr	<i>Maximum of 240 tablets per month</i>
ESTRACE (Estradiol, Micronized)	<i>Maximum of 1 tablet per day dosing</i>
ESTRATEST (Estrogens, esterified/MT)	<i>Maximum of 1 tablet per day dosing</i>
FIORICET (Butalbital/Caffeine/APAP)	<i>Maximum of 50 tablets per month</i>
FIORINAL (Butalbital/Caffeine/Aspirin)	<i>Maximum of 50 tablets per month</i>
FLEXERIL (cyclobenzaprine)	<i>Maximum of 120 tablets per month</i>
FLONASE (fluticasone) INHALER	<i>Maximum of 1 unit per month</i>
FLOVENT (fluticasone) INHALER	<i>Maximum of 2 units per month</i>
FLOVENT (fluticasone) DI SKUS	<i>Maximum of 1 unit of 60 per month</i>
FLOXIN (Ofloxacin)	<i>Maximum of 28 tablets per month</i>
FORADIL (Formoterol)	<i>Maximum of 1 unit per month</i>
FOSAMAX (Alendronate) Tablets - 35mg, 70mg	<i>35mg & 70 mg Only – Limit of 4 tablets in 28 days.</i>
FROVA (Frovatriptan)	<i>Maximum of 12 tablets per month of 1 strength</i>
HYZAAR (Losartan/HCT)	CODE 1: <i>For members intolerant to ACE Inhibitors</i>
IMITREX SPRAY	<i>Maximum of 1 unit per month</i>
IMITREX INJECTION	<i>Maximum of 4 syringes per month</i>
IMITREX TABLETS	<i>Maximum of 9 tablets per month of 1 strength</i>
INSULIN-All Forms	<i>Maximum of 4 vials per month</i>
INTAL	<i>Maximum of 2 units per month</i>
IOPIDINE	<i>Maximum of 10mls per month</i>
LAMICTAL (Lamotrigine) 25mg, 100mg, 150mg	<i>Maximum of 7 tablets per day for the 25mg & 2 tablets per day for the 100mg & 150mg tablets</i>
LESCOL (Fluvastatin)	<i>Maximum of 1 capsule / tablet per day dosing</i>
LIPITOR (Atorvastatin)	<i>1/2tablet substitution required</i>
LOTREL (amlodipine/benazepril)	<i>Maximum of 1 capsule per day dosing</i>
LOVENOX (Enoxaparin)	<i>Maximum of 20 syringes per fill and maximum of 2 fills per year</i>
MAXAIR (Pirbuterol Acetate) INHALER	<i>Maximum of 2 units per month</i>
MAXALT (rizatriptan)	<i>Maximum of 12 tablets per month of 1 strength</i>
METADATE (Methylphenidate)	<i>For use in members between 6 and 16 years old.</i>

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
FORMULARY DISPENSING LIMITS

6-1-04

MEVACOR (Lovastatin)	<i>Maximum of 1 tablet per day dosing</i>
MIACALCIN (Calcitonin-Salmon) SPRAY	<i>Maximum of 2 units per month</i>
NASACORT AQ (Triamcinolone) INHALER	<i>Maximum of 1 unit per month</i>
NASONEX (Mometasone)	<i>Maximum of 1 unit per month</i>
NEURONTIN (Gabapentin)	<i>Maximum of 3600mg per day</i>
NICOTENE TRANSDERMAL PATCHES	<i>Maximum of up to 90 patches within a 1 year period</i>
NICOTENE GUM	<i>Maximum of up to 180 tablets within a 1 year period</i>
NIX (Permethrin)	<i>Maximum of 60mls every 90 days</i>
NORCO (Hydrocodone 5mg/APAP 325mg)	<i>Maximum of 120 tablets per month</i>
NORVASC (amlodipine)	<i>Maximum of 1 tablet per day dosing</i>
OPTIPRANOLOL (Metipranolol)	<i>Maximum of 10mls per month</i>
OVIDE (Malathion)	<i>Maximum of 60mls every 90 days</i>
PEPCIDE (Famotidine)	<i>Maximum of 60 tablets per month</i>
PILL CUTTER	<i>Maximum of 1 cutter every 180 days</i>
PLAN B (Levonorgestrel)	<i>Maximum of 3 fills of 1 (2) pack per 90 days</i>
POLY VI FLOR (Multi Vitamins/ Sodium Fluoride)	<i>For use in children less than 8 years old</i>
POLY VI SOL (MULTI-VITE)	<i>Limited to use in children under 8 years</i>
PREVEN (Levonorgestrel/Ethinyl Estradiol + Pregnancy Test Kit)	<i>Maximum of 3 kits in 90 days</i>
PRILOSEC (Omeprazole) OTC 20mg TABLET	<i>Maximum of 2 tablets per day dosing</i>
PROPINE (Dipivefrin)	<i>Maximum of 10mls per month</i>
PROZAC (fluoxetine) CAPSULES/TABLETS	<i>Maximum of 80mg per day dosing</i>
PULMICORT (budesonide) RESPULES	<i>Restricted for use in members less than 9 years old Maximum of 60 respules per month</i>
PULMICORT (budesonide) INHALER	<i>Maximum to a maximum of 1 unit per month</i>
QVAR (Beclomethasone) INHALER	<i>Maximum of 1 unit per month</i>
RELENZA (Zanamivir) INHALER	CODE 1: <i>Restricted to members over age 65 or with HIV, transplant, cancer, or chronic respiratory disease. Limit of 1 fill during the months of September thru March</i>
RELPAK (eletriptan)	<i>Maximum of 6 tablets per month of 1 strength</i>
REMERON (Mirtazapine)	<i>Maximum of 1 tablet per day dosing</i>
RESTORIL (Temazepam)	<i>Maximum of 1 capsule per day dosing</i>
RHINOCORT AQUA (Budesonide) INHALER	<i>Maximum of 1 unit per month</i>
RITALIN (Methylphenidate)	<i>For use in members between 4 and 16 years old.</i>

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
FORMULARY DISPENSING LIMITS

6-1-04

ROBAXIN (Methocarbamol)	<i>Maximum of 120 tablets per month</i>
ROXICODONE (Oxycodone)	<i>Maximum of 100 tablets per month</i>
SEREVENT (salmeterol) DISKUS	<i>Maximum of 1 unit of 60 per month</i>
SINGULAIR (Montelukast)	STEP EDIT: <i>Requires previous use of either a nasal corticosteroid or an oral inhaled corticosteroid in the last 120 days</i>
SOMA (Carisoprodol)	<i>Maximum of 120 tablets per month</i>
SONATA (Zaleplon)	<i>Maximum of 60 capsules per year & limited to 1 capsule per day dosing</i>
SUNSCREEN/SUNBLOCK	CODE 1: <i>Restricted to use by members on maintenance photo sensitive drugs. Limit 1 Rx per month & maximum allowable cost of \$8 per container.</i>
TAMIFLU (Oseltamivir)	CODE 1: <i>Restricted to members over age 65 or with HIV, transplant, cancer, or chronic respiratory disease. Limit of 1 fill of 10 tablets during the month of September thru March.</i>
TILADE (Nedocromil)	<i>Maximum of 2 units per month</i>
TIMOPTIC (Timolol Maleate) OPTHALMIC DROPS	<i>Maximum of 10mls per month</i>
TOPAMAX (Topiramate) 25mg, 50mg, 100mg ONLY	<i>Maximum of 3 tablet per day dosing</i>
TRI VI FLOR (Vitamins A,D,C/ Sodium Fluoride)	<i>For use in children less than 8 years old</i>
TRI VI SOL WITH IRON (A,D,C)	<i>Limited to use in children under 8 years old</i>
TYLENOL W/ CODEINE (APAP/Codeine) ¼ gr, ½ gr, liquid	<i>Tablets-Maximum of 120 tablets per month Liquid-Maximum of 480 mls per month</i>
ULTRAM (Tramadol)	<i>Maximum of 120 tablets per month</i>
VICODIN (Hydrocodone/APAP) 5mg/500mg Tablets	<i>Maximum of 240 tablets per month</i>
VIOXX (Rofecoxib)	STEP EDIT: <i>Mbr must be on concurrent warfarin therapy or age 75 years and older Maximum of 25mg per day dosing</i>
VITAMIN E CAPSULES	CODE 1: <i>For treatment of tardive dyskinesia</i>
VITAMINS-PRENATAL	CODE 1: <i>For women who are pregnant or lactating</i>
WELLBUTRIN (Bupropion) TABLETS	<i>Maximum of 3 tablets per day dosing</i>
WELLBUTRIN (Bupropion Sustained Release) SR	<i>Maximum of 2 tablets per day dosing</i>
ZADITOR (Ketotifen Fumarate)	STEP EDIT: <i>Requires previous use of Naphcon A or Vasocon A in the last 120 days</i>
ZOFRAN (Ondansetron) TABLETS	CODE 1: <i>For prophylaxis of nausea and vomiting associated with cancer chemotherapy and radiation therapy. Limit of 9 tablets per fill and 2 fills per month for 6 months</i>
ZOMIG (zolmitriptan) TABLETS	<i>Maximum of 6 tablets per month of 1 strength</i>
ZOMIG (zolmitriptan) Nasal Spray	<i>Maximum of 1 unit (6 doses) per month</i>
ZYBAN (Bupropion-SR)	<i>Maximum of 180 tablets within a 1 year period</i>
ZYRTEC (Cetirizine) Syrup	<i>Restricted for use in mbrs less than 6 years old Maximum of 300mls per month</i>