Provider News Bulletin

Amerigroup Washington, Inc.
https://providers.amerigroup.com/WA
Medicaid providers: 1-800-454-3730
Medicare providers: 1-866-805-4589

February 2017

Table of Contents

Medicaid:

Continuous interstitial glucose monitoring to require prior authorization Page 2

Third quarter pharmacy formulary change notice Page 3

Fourth quarter pharmacy formulary change notice Page 6

Amerivantage:

Hospital observation service limits Page 7

Continuous interstitial glucose monitoring to require prior authorization

Effective April 1, 2017, continuous interstitial glucose monitoring will require prior authorization (PA).

For dates of service on or after April 1, 2017, PA will be required for continuous interstitial glucose monitoring covered by Amerigroup Washington, Inc. for Washington Apple Health members. Federal and state law as well as state contract language and CMS guidelines, including definitions and specific contract provisions/ exclusions, take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to the following codes:

- A9276: sensor — invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system (one unit = one-day supply)
- A9277: transmitter — external, for use with interstitial continuous glucose monitoring system
- A9278: receiver (monitor) — external, for use with interstitial continuous glucose monitoring system
- 95250: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — sensor placement, hook-up, calibration of monitor, patient training, removal of sensor and printout of recording
- 95251: ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours — interpretation and report

To request PA, contact us by phone at 1-800-454-3730 or by fax at 1-800-964-3627.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (https://providers.amerigroup.com/WA > Provider Resources & Documents > Quick Tools > Precertification Lookup Tool).

WA-NL-0017-16

Third quarter pharmacy formulary change notice

The formulary changes listed in the table below were reviewed and approved at our September 27, 2016, Pharmacy and Therapeutics Committee meeting.

Effective February 1, 2017, the changes outlined below apply to all Amerigroup Washington, Inc. patients. Don't forget to read the footnotes at the bottom of the table.

Effective for all patients on February 1, 2017			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
INSULIN THERAPY — LONG-ACTING*	BASAGLAR KWIKPEN	PREFERRED	N/A
INSULIN THERAPY — LONG-ACTING	LANTUS 100 UNITS/ML VIAL LANTUS SOLOSTAR 100 UNITS/ML	NONPREFERRED **NEW STARTS: 02/01/17** CURRENT ULTILIZERS: 05/01/17	BASAGLAR KWIKPEN
ACNE — BENZOYL PEROXIDE COMBOS	CLIND PH-BENZOYL PEROX 1.2-5% CLINDAMYCIN-BENZOYL PEROX 1-5% CLINDA-BENZOYL PEROX 1-5% PUMP	PREFERRED	N/A
ACNE — BENZOYL PEROXIDE COMBOS	ERYTHROMYCIN-BENZOYL GEL	NONPREFERRED STEP THERAPY (ST) REQUIRED	CLINDAMYCIN-BENZOYL PEROX 1-5% GEL
ACNE THERAPY	ERYTHROMYCIN/BENZOYL PEROXIDE ACANYA GEL PUMP ONEXTON GEL PUMP BENZACLIN GEL BENZAMYCIN GEL DUAC GEL	ST (AN APPROVAL FOR NONPREFERRED AGENTS WILL BE CONSIDERED WHERE CLINDAMYCIN/ BENZOYL PEROXIDE GEL IS NOT APPROPRIATE BASED ON A MEMBERS HISTORY OF MEDICAL CONDITIONS.)	CLINDAMYCIN-BENZOYL PEROX 1-5% GEL
ANDROGENS	TESTOSTERONE 25 MG/2.5 GM PKT	ADD QUANTITY LIMIT (QL)	N/A
ANTIEMETICS	EMEND	NONPREFERRED PRIOR AUTHORIZATION (PA) REQUIRED	N/A
ANTINEOPLASTIC AGENTS	TECENTRIQ 1,200 MG/20 ML VIAL	ADD QL	N/A
ANTIVIRALS — MISCELLANEOUS	RELENZA 5 MG DISKHALER TAMIFLU SUSPENSION TAMIFLU CAPSULES	REVISED QL	N/A

Quarterly pharmacy formulary change notice continued

Therapeutic class	Drug	Revised status	Potential alternatives
EMERGENCY CONTRACEPTIVES	ELLA 30 MG TABLET REACT 1.5 MG TABLET	PREFERRED	N/A
EPINEPHRINE — SELF-INJECTED*	EPINEPHRINE 0.15 MG AUTO-INJECT EPINEPHRINE 0.3 MG AUTO-INJECT EPINEPHRINE 0.1 MG/ML SYRINGE EPINEPHRINE 1 MG/ML VIAL	PREFERRED	N/A
EYE ANTI-INFLAMMATORY AGENTS	DICLOFENAC 0.1% EYE DROPS	PREFERRED	N/A
EYE ANTI-INFLAMMATORY AGENTS	KETOROLAC 0.4% OPHTH SOLUTION KETOROLAC 0.5% OPHTH SOLUTION ACUVAIL 0.45% OPHTH SOLUTION	NONPREFERRED ST REQUIRED	DICLOFENAC 0.1% EYE DROPS
GASTROINTESTINAL AGENTS — MISCELLANEOUS	APRISO ER 0.375 GRAM CAPSULE AZULFIDINE 500 MG TABLET AZULFIDINE ENTAB 500 MG CANASA 1,000 MG SUPPOSITORY DELZICOL DR 400 MG CAPSULE DIPENTUM 250 MG CAPSULE ENTOCORT EC 3 MG CAPSULE GIAZO 1.1 GM TABLET LIALDA DR 1.2 GM TABLET PENTASA 250 MG CAPSULE PENTASA 500 MG CAPSULE ROWASA 4 GM/60 ML ENEMA KIT SFROWASA 4 GM/60 ML ENEMA UCERIS 9 MG ER TABLET	ADD QL	N/A
HEPARIN AND RELATED PREPARATIONS	FRAGMIN INJ LOVENOX INJ	ADD QL	N/A
LANCETS	MANUFACTURER: US DIAGNOSTICS LANCETS — MIS 28G LANCETS — MIS 30G SAFETY — MIS LANCETS	NONPREFERRED	LANCETS: MANUFACTURER — TARGET WALGREENS CVS CHAIN DRUG CONS GOOD NEIGHBOR KROGER/PERRIGO
LIPID/CHOLESTEROL-LOWERING AGENTS	NIACOR 500 MG TABLET	ADD QL	N/A

Quarterly pharmacy formulary change notice continued

Therapeutic class	Drug	Revised status	Potential alternatives
NEUROLOGICAL THERAPY — MISCELLANEOUS	NAMZARIC 7 MG-10 MG CAPSULE NAMZARIC 21 MG-10 MG CAPSULE	ADD QL	N/A
OPHTHALMOLOGICS — MISCELLANEOUS	RESTASIS 0.05% EYE EMULSION	ADD QL	N/A
PHTHALMOLOGICS — MISCELLANEOUS	XIIDRA 5% EYE DROPS LACRISERT 5 MG EYE INSERT	ADD QL	N/A
ORAL HYPOGLYCEMIC AGENTS	JENTADUETO XR 2.5 MG-1,000 MG JENTADUETO XR 5 MG-1,000 MG TB	ADD QL	N/A
ORAL SKELETAL MUSCLE RELAXANTS	TIZANIDINE HCL 2 MG CAPSULE TIZANIDINE HCL 4 MG CAPSULE TIZANIDINE HCL 6 MG CAPSULE	NONPREFERRED	TIZANIDINE HCL 2 MG TABLET TIZANIDINE HCL 4 MG TABLET
OTIC STEROID/ ANTIBIOTIC	FLOXIN 0.3% EAR DROPS	PREFERRED	N/A
OTIC STEROID/ ANTIBIOTIC	CIPRODEX OTIC SUSPENSION CORTISPORIN-TC OTIC	NONPREFERRED WITH ST	FLOXIN 0.3% EAR DROPS CIPROFLOXACIN 0.2% OTIC SOLN OFLOXACIN 0.3% EAR DROPS NEOMYCIN-POLYMYXIN-HC EAR SOLN

* These changes will be effective immediately upon the release of the epinephrine authorized generic release and Basaglar release.

What action do I need to take?

Please review these changes and work with your Amerigroup patients to transition them to formulary alternatives. If you determine preferred formulary alternatives are not clinically appropriate for specific patients, you will need to obtain PA to continue coverage beyond the applicable effective date.

What if I need assistance?

We recognize the unique aspects of patients' cases. If for medical reasons your Amerigroup patient cannot be converted to a formulary alternative, call our Pharmacy department at 1-800-454-3730 and follow the voice prompts for pharmacy PA. You can find the Preferred Drug List on our provider website at https://providers.amerigroup.com/WA.

If you need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

WAPEC-1065-17

Fourth quarter pharmacy formulary change notice

The formulary changes listed in the table below were reviewed and approved at our pharmacy & therapeutics committee meeting on December 19, 2016. Effective March 1, 2017, and April 1, 2017, the changes outlined below apply to all Amerigroup Washington, Inc. patients.

Effective for all patients on March 1, 2017			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
HYLAURONIC ACIDS	EUFLEXXA SYRINGE GELSYN SYRINGE SUPRATZ FX SYRINGE	PREFERRED WITH PRIOR AUTHORIZATION	N/A
Effective for all patients on April 1, 2017			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
PEDICULICIDES (HEAD LICE)	SPINOSAD 0.9% TOPICAL SUSPENSION	PREFERRED	N/A
PEDICULICIDES (HEAD LICE)	MALATHION 0.5% LOTION	NONPREFERRED (STEP THERAPY REQUIRED)	SPINOSAD SUSPENSION (OTC) LICE KILLING SHAMPOO (OTC) LICE PYRINYL SHAMPOO (OTC) RID COMPLETE LICE KIT (OTC) RID PEDICULICIDES SPRAY

What action do I need to take?

Please review these changes and work with your Amerigroup patients to transition them to formulary alternatives. If you determine preferred formulary alternatives are not clinically appropriate for specific patients, you will need to obtain prior authorization to continue coverage beyond the applicable effective date.

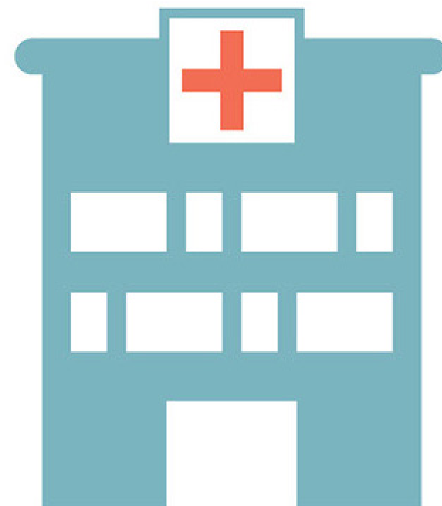
What if I need assistance?

We recognize the unique aspects of patients' cases. If, for medical reasons, your Amerigroup patient cannot be converted to a formulary alternative, call our Pharmacy department at 1-800-454-3730 and follow the voice prompts for pharmacy prior authorization. You can find the preferred drug list on our provider website at https://providers.amerigroup.com.

If you need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

WAPEC-1063-17

Hospital observation service limits



This is a correction to the previous hospital observation service limits newsletter article published in October 2016. Observation services with less than eight hours will be considered a bundled service. Observation services billed over 72 hours will be considered as exceeding limits. This pertains to both contracted and noncontracted providers.

An Amerigroup Amerivantage (Medicare Advantage) member's time in observation (and hospital billing) begins with the member's admission to an observation bed. Time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient. The billed units of service should equal the number of hours the patient receives observation services.

Hospitals should use HCPCS codes G0378 and G0379 to report observation services and direct admission for observation care. Hospitals are reminded not to report CPT codes 99217-99226 for observation services.

Additional information and discussion regarding hospital observation services can be found in the *Medicare Claims Processing Manual*, Chapter 4 — Part B Hospital, 290.2.2.

SSO-NL-0008-16

Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program.