Kansas
Medical Assistance
Program

April 2006 **Provider Bulletin Number 623**

Professional Providers

Provider Manual Update

The Drug Restrictions section in the *Professional Provider Manual* now refers providers to the *Pharmacy Provider Manual* for drug restrictions.

Information about the Kansas Medical Assistance Program, as well as provider manuals and other publications, are on the KMAP Web site at https://www.kmap-state-ks.us. For the changes resulting from this provider bulletin, select the *Professional Provider Manual*, pages 8-33 and 8-34.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in-state providers) or 785-274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

8400. Updated 3/06

Preferred Drug List:

The 2002 Legislature passed a law (Kan. Session. L., 200, c.180) permitting Kansas Medicaid to implement a Preferred Drug List (PDL). The Medicaid Department convened an advisory committee of practicing physicians and pharmacists to evaluate drugs in therapeutic drug classes for clinical equivalence, and to make recommendations to the Kansas Department of Social and Rehabilitation Services (SRS), and to the Drug Utilization Review (DUR) Board. Using a PDL will promote clinically appropriate use of drugs in a cost-effective manner. Prescriptions for the non-preferred drugs will require prior authorization. As other therapeutic drug classes are evaluated by the PDL Advisory Committee and the DUR Board, KMAP will publish this information to providers.

The PDL KMAP Coverage List(s) and their corresponding Prior Authorization Request forms can be viewed and downloaded at:
http://www.srskansas.org/hcp/medicalpolicy/pharmacy/

Days Supply:

A 31-day supply of medication per prescription is the **maximum** that may be prescribed and dispensed at one time for medications covered by the program. Refills will be covered only for those drugs which are refillable, as indicated by the ordering physician, and per Kansas Pharmacy Law. KMAP will only allow a refill after 80% of the prescription has been used.

Drug Efficacy Study Implementation:

All drugs classified as Drug Efficacy Study Implementation (DESI), less-than-effective drugs and their Identical, Related, and Similar (IRS) drugs are non-covered by KMAP.

Legend/OTC Drugs:

Most legend drugs are covered for Medicaid beneficiaries. Some over-the-counter products are covered with a prescription.

Legend prenatal vitamins are covered for pregnant females only and up to three months postpartum for lactating women.

Drug Restrictions:

To view KMAP drug restrictions, access the *KMAP Pharmacy Provider Manual* from the KMAP Web site at *https://www.kmap-state-ks.us/Public/Provider.asp*. Click **Manuals** and select Pharmacy from the Manual Type list box. Drug limitations are listed under Benefits and Limitations, Section 8400.

~~Butorphanol Nasal Spray (Stadol® NS) is limited to 12.5 units (five 2.5 ml bottles) per calendar month per beneficiary.~~

~~OxyContin® is limited to a maximum dosage of twice daily for all strengths.~~

8400. Updated 3/06

~~Drug restrictions cont.:~~

~~SMOKING CESSATION DRUGS: Nicotine patches and buproprion SR (Zyban®) are covered for Medicaid beneficiaries. The medication coverage is limited to a maximum of one twelve-week course of therapy (based upon each manufacturer's recommended dosing) per 365 days. Nicotine gum, nicotine oral and nasal inhalers will not be covered. A combination of behavioral and pharmacologic cessation therapies have been shown to be most efficacious in helping patients quit smoking.~~

~~INFLUENZA DRUGS: Prescription drugs claims for neuraminidase inhibitors zanamivir (Relenza®) and oseltamivir (Tamiflu®) will be paid for dates of service during the influenza (flu) season only and will be limited to one course of therapy per beneficiary per flu season. According to the Kansas Department of Health and Environment, the Centers for Disease Control consider the flu season in Kansas to be from mid-October through mid-April. One course of therapy for both Relenza® and Tamiflu® are defined by the company in the package insert as five days of therapy.~~

Prosthetic and Orthotic Devices:

The prosthetic or orthotic device **must** be necessary and appropriate for the treatment of the patient's illness or injury, or replace or improve the functioning of a body part.

Prosthetic devices are covered when:

- Ordered by a physician and supplied by a prosthetic and orthotic provider enrolled in the Kansas Medical Assistance Program, and
- The device will replace all or part of the external body members.

Repairs or replacements are covered.

Orthotic devices are covered when:

- Ordered by a doctor,
- Serve in the treatment of the patient's illness,
- Improve the functioning of a body part.