

Pharmacy and Therapeutics (P&T) Committee Helpful Hints/Reference Document

P&T Charge

As defined by §22-6-122

The Medicaid Pharmacy and Therapeutics (P&T) Committee shall review and recommend classes of drugs to the Medicaid Commissioner for inclusion in the Medicaid Preferred Drug Plan. Class means a therapeutic group of pharmaceutical agents approved by the FDA as defined by the American Hospital Formulary Service.

The P&T Committee shall develop its preferred drug list recommendations by considering the clinical efficacy, safety and cost effectiveness of a product. Within each covered class, the Committee shall review and recommend drugs to the Medicaid Commissioner for inclusion on a preferred drug list. Medicaid should strive to insure any restriction on pharmaceutical use does not increase overall health care costs to Medicaid.

The recommendations of the P&T Committee regarding any limitations to be imposed on any drug or its use for a specific indication shall be based on sound clinical evidence found in labeling, drug compendia and peer reviewed clinical literature pertaining to use of the drug. Recommendations shall be based upon use in the general population. Medicaid shall make provisions in the prior approval criteria for approval of non-preferred drugs that address needs of sub-populations among Medicaid beneficiaries. The clinical basis for recommendations regarding the PDL shall be made available through a written report that is publicly available. If the recommendation of the P&T Committee is contrary to prevailing clinical evidence found in labeling, drug compendia and/or peer-reviewed literature, such recommendation shall be justified in writing.

Preferred Drug List/Program Definitions

Preferred Drug: Listed on the Agency's Preferred Drug Lists and will not require a prior authorization (PA).

Non Preferred Drug: Covered by the Agency, if it is determined and supported by medical records to be medically necessary, but will require a PA.

Non Covered Drug: In accordance with Medicaid Drug Amendments contained in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90 federal legislation), the Agency has the option to not cover (or pay for) some drugs. Alabama Medicaid does not cover/pay for the following:

- Drugs used for anorexia, weight loss or weight gain, with the exception of those specified by the Alabama Medicaid Agency
- Drugs used to promote fertility with the exception of those specified by the Alabama Medicaid Agency
- Drugs used for cosmetic purposes or hair growth
- Over the counter/non prescription drugs, with the exception of those specified by the Alabama Medicaid Agency
- Covered outpatient drugs when the manufacturer requires as a condition of sale that associated test and/or monitoring services be purchased exclusively from the manufacturer or designee
- DESI (Drug Efficacy Study Implementation [less than effective drugs identified by the FDA]) and IRS (Identical, Related and Similar [drugs removed from the market]) drugs which may be restricted in accordance with Section 1927(d) (2) of the Social Security Act
- Agents when used for the symptomatic relief of cough and colds except for those specified by the Alabama Medicaid Agency

- Prescription vitamin and mineral products, except prenatal vitamins and fluoride preparations and others as specified by the Alabama Medicaid Agency
- Benzodiazepines and barbiturates with the exception of those specified by the Alabama Medicaid Agency
- Agents used to promote smoking cessation
- Agents when used for the treatment of sexual or erectile dysfunction, unless authorized for pulmonary hypertension.

(From Alabama Medicaid Agency Administrative Code, Chapter 16 and Alabama Medicaid Agency Provider Billing Manual, Chapter 27.)

Prior Authorization (PA): Process that allows drugs that require approval prior to payment to be reimbursed for an individual patient. Drugs may require PA if they are in Non-preferred status or if they required PA prior to the PDL

Medicaid may require prior authorization for generic drugs only in instances when the cost of the generic product is significantly greater than the net cost of the brand product in the same AHFS therapeutic class or when there is a clinical concern regarding safety, overuse or abuse of the product.

Although a product may require PA, the product is considered a covered product and Medicaid will pay for the product only once the PA has been approved.

Override: Process where drugs require approval prior to payment to be reimbursed for an individual patient if the claim falls outside a predetermined limit or criteria. Overrides differ from PA in that drugs or drug classes that require an override will automatically allow payment of the drug unless something on the claim hits a predetermined limit or criteria. The different types of overrides include:

- Maximum Unit Limitations
- Early Refill
- Brand Limit Switchover
- Therapeutic Duplication

Electronic PA (EPA): The EPA system checks patient-specific claims history to determine if pharmacy and medical PA requirements are met at the Point-of-Sale claim submission for a non-preferred drug. If it is determined that all criteria are met and the request is approved, the claim will pay and no manual PA request will be required. Electronic PA results in a reduction in workload for providers because the claim is electronically approved within a matter of seconds with no manual PA required.

Prior Authorization Criteria Definitions

Appropriate Diagnosis: Diagnosis(es) that justifies the need for the drug requested. Diagnosis(es) or ICD-9 code(s) may be used. Use of ICD-9 codes provides specificity and legibility and will usually expedite review.

Prior Treatment Trials: Prior authorization requires that two (2) prescribed generic, OTC or brand name drugs have been utilized unsuccessfully relative to efficacy and/or safety within six (6) months prior to requesting the PA. The PA request must indicate that two (2) generic, OTC or other brand drugs have been utilized for a period of at least thirty (30) days each (14 days for Triptans, 3 days for EENT Vasoconstrictor Agents), unless there is an adverse/allergic response or contraindication. If the prescribing practitioner feels there is a medical reason for which the patient should not be on a generic, OTC or brand drug or drug trial, medical justification may be

submitted in lieu of previous drug therapy. One prior therapy is acceptable in those instances when a class has only one preferred agent, either generic, OTC, or brand.

Stable Therapy: Allows for approval of a PA for patients who have been determined to be stable on a medication (same drug, same strength) for a specified timeframe and who continue to require therapy. Medications provided through a government or state sponsored drug assistance program for uninsured patients may be counted toward the stable therapy requirement. Medications paid for through insurance, private pay or Medicaid are also counted toward the requirement. Providers will be required to document this information on the PA request form and note the program or method through which the medication was dispensed.

Medical Justification: An explanation of the reason the drug is required and any additional information necessary. Medical justification is documentation to support the physician's choice of the requested course of treatment. Documentation from the patient record (history and physical, tests, past or current medication/treatments, patient's response to treatment, etc) illustrates and supports the physician's request for the drug specified. For example, if a recommended therapy trial is contraindicated by the patient's condition or a history of allergy to a first-line drug, and the physician wants to order a non-preferred drug, documentation from the patient record would support that decision. In addition, medical justification may include peer reviewed literature to support the use of a non-preferred medication.