Prior Authorization Required from Gainwell Technologies

Listed below are the situations where prior authorization must be requested from Gainwell Technologies.

Brand Medically Necessary Prior Authorization

Brand Name Medically Necessary prescriptions written with "Brand Medically Necessary" when two or more A-rated therapeutically equivalent "PDL Preferred" generics exist, will require Brand Medically Necessary (BMN) Prior Authorization. Dispense as Written code 1 denotes that substitution is not allowed by Prescriber.

Brand name medications that are not reviewed in a therapeutic class by the P&T Committee or those being prescribed to a CHIP Husky B client, will require Brand Medically Necessary (BMN) Prior Authorization if two or more A-rated therapeutically equivalent generics exist.

Prior Authorization requests should be submitted for Brand Medically Necessary with section #13 filled out on the Prior Authorization Form, and will be granted in cases where documentation indicates the following:

- Allergic reaction to excipients (inactive ingredients) in the generic products - FDA 3500 MedWatch form must be submitted when reporting allergic reaction to the generic product.
- A therapeutic failure to the generic product - Explanation requested either on prior authorization form or on a second page with additional comments.

Approvals will be given a duration of 6 months for controlled substances and 12 months for non-controlled substances.

A complete prescription history will be reviewed to determine dosing and compliance issues. Examples of approved documentation of therapeutic failure include adequate time for generic trials (greater than 24 hours use of at least one generic product, unless it is documented that the 1-day trial will be life-threatening), trial on multiple generic manufacturers' products, and the therapeutic failure cannot be attributed to inadequate dosing.

DSS reserves the right to deny or approve on a case-by-case basis depending upon extenuating circumstances. For example, if no other prescribers in the state have reported problems with a certain generic drug and every patient of the prescriber requesting PA is reporting problems, then the problem may not be a failure of the generic product.

Patient requests for brand name drugs will not be accepted for review.

Early Refill Prior Authorization

Early Refill is defined as any prescription in which less than 93% of the medication should have been utilized at the time the prescription is submitted for refill. The 93% early refill criteria will apply to prescriptions filled for a day supply of 16 days or greater. Prescriptions for a day supply less than or equal to 15 days will be subject to the 85% utilization rate. Prescriptions filled by out-of-state mail order pharmacies will be subject to the 85% utilization rate.

For a non-controlled substance, the pharmacy or prescriber may call Gainwell Technologies to request Early Refill Prior Authorization. Explanation for the loss or damage must be explained over the phone. For stolen medications, the pharmacy must provide police report number and the name of the town where the report was filed. For controlled substances, the prescriber must provide documentation when required on the form or on a second page with additional comments at the time of submission. For stolen medications, the prescriber must provide police report documentation and an explanation on the Prior Authorization form.

Prior Authorization for Early Refill Request section #14 on the Prior Authorization Form should be completed by the provider, and will be granted for either controlled substances or non-controlled substances in cases where the form indicates the following:

- Change in Direction
  - Prior Authorization will be granted if there has been a change in the directions of the medication that substantiates the over-utilization of the prescription. The new prescription must demonstrate the increase in dosing with a change in the number of units per day supply ratio.

- Vacation Supply
    - Prior Authorization will be granted to a client for a specific medication only once every six months and only a quantity equal to one refill will be authorized.
- Lost/Stolen/Destroyed/Other Medication
    - Appropriate documentation of lost/stolen controlled substances includes:
        - Insurance report
        - Police report number and the name of the town where the report was filed
        - Documentation from pharmacy or prescriber on the prior authorization form or formal practice site letterhead explaining the circumstances of loss
        - Documentation of admittance to institutional facility, such as a hospital
        - Documentation of arrest or incarceration

    - Appropriate documentation of lost/stolen non-controlled substances can be explained verbally via phone by the pharmacy filling the medication
        - Stolen scenarios still require police report number and the name of the town where the report was filed

    - Appropriate documentation of destroyed controlled substances includes:
        - Insurance report
        - Police report number or fire marshal's report and the name of the town where the report was filed
        - Documentation from pharmacy or prescriber on formal practice site letterhead explaining the circumstances of loss
        - Documentation of admittance to a long-term care facility
        - Documentation of an institutional facility destruction of a medication in the presence of a witness

    - Appropriate documentation of destroyed non-controlled substances can be explained verbally via phone by the pharmacy filling the medication
        - Fire scenarios still require fire report information or Police report number

Exceptions for documentation can be made in the case of natural disaster, such as flood, hurricane, or tornado.

Non-Preferred Medication Prior Authorization

New prescriptions for a non-Preferred medication will require Prior Authorization. Prescribers may switch the recipient to a preferred product to avoid point of sale (POS) issues at the pharmacy or must submit a Prior Authorization request.

Prior Authorization requests should be submitted for Non-Preferred Medication with section #15 filled out on the Prior Authorization Form, and will be granted in cases where documentation indicates the following:

- Intolerance to Preferred Drugs – symptoms of intolerance must be noted on the PA form
- Adverse reaction to Preferred Drugs – symptoms of intolerance must be noted on the PA form
- Inadequate response to Preferred Drugs
- Absence of appropriate formulation with Preferred Drugs
- Deemed medically necessary or medically appropriate

Approvals will be given a duration of 6 months for controlled substances and 12 months for non-controlled substances.

In situations where a non-PDL request also requires a BMN override, the prescriber can request a prior authorization for both situations on the same form.

Optimal Dosage Prior Authorization

New prescriptions for medications which exceed the Optimal Dosage will require Prior Authorization. Prescribers may switch the recipient to the preferred dosage of the product to avoid point of sale (POS) issues at the pharmacy or must submit a Prior Authorization request.

Prior Authorization requests should be submitted for Optimal Dose Prior Authorization with section #16 filled out on the Prior Authorization Form, and will be granted in cases where documentation indicates the following:

- Therapeutic Failure to once daily dosing
- Deemed medically necessary or medically appropriate

Approvals will be given a duration of 6 months for controlled substances and 12 months for non-controlled substances.

Opioid (Long and Short Acting) Prior Authorization

New prescriptions for Long-Acting Opioid (LAO) and Short Acting Opioid (SAO) medication will require prior authorization. Pharmacy claims for opioid prescriptions and refills with dates of service on or after September 1, 2016 are subject to the MME audit. Compound drug claims are not subject to the MME audit.

The calculation of the daily MME will include any relevant claim(s) in history submitted over the previous 30 days, regardless of the billing pharmacy provider or the prescribing provider.

The maximum manufacturer recommended dose of morphine in adults for acute pain is 15- 30mg every 4 hours, which equates to 180 MME. According to the CDC, the mortality rate rises rapidly in patients whose prescribed MME dose approaches 200 MME/day.

Connecticut law prohibits a provider from prescribing an opioid drug for more than a seven (7) day supply (Public Act 16-43, Section 7). This law was based upon the Center for Disease Control and Prevention's Guidelines for Prescribing Opioids for Chronic Pain. The law allows limited exceptions for certain documented medical conditions.

The Department of Social Services (DSS) is required to dispense a temporary 14 day supply for all medications that require Prior Authorization (PA) for which an authorization is not received. This is to allow a prescriber to submit authorization for the medication without interrupting care pending receipt of the request for authorization.

Long and Short Acting Opioid Prior Authorization requests should be submitted on the Opioid PA Form, and will be granted in cases where provider documentation indicates the following:

- The patient is age 12 or older
- The patient has one of the following diagnoses:
    - cancer-associated pain syndrome
    - sickle cell pain syndrome
    - severe arthritis
    - post-traumatic pain syndrome
    - renal colic
    - pancreatitis
    - avascular necrosis
    - spinal compression fracture(s)
    - painful cutaneous ulcers/wounds;

- All the following factors or conditions concerning this patient are true:
    - Non-opioid alternatives are either inappropriate or have not been effective without concurrent opioid therapy
    - An initial 7-day prescription has already been given, the patient reassessed, and a decision made that ongoing opioid treatment is medically necessary
    - The patient has not previously sustained and survived an opioid overdose and does not have untreated opioid use disorder
    - The CT Prescription Monitoring Program has been checked and a risk assessment for opioid misuse, diversion, and addiction has been done
    - The patient does not have known severe respiratory depression/hypercarbia likely to be worsened using opioid therapy

In instances where the individual does not meet all 3 criteria, the prescriber may write a Letter of Medical Necessity and submit with the Opioid PA form to the Department's Medical Director for consideration via email at rx.lmn@CT.gov or to DSS fax at (860) 424-4822.

Please note that prescribing providers with the following taxonomies, who are actively enrolled in the Connecticut Medical Assistance Program (CMAP) and who are treating a patient for any form of cancer or sickle cell disease and document the International Statistical Classification of Diseases and Related Health Problems (ICD-10) diagnosis code on the opioid prescription order, will be excluded from the PA requirement:

- 207RH0000X – Allopathic & Osteopathic Physicians/Internal Medicine, Hematology
- 207RH0003X – Allopathic & Osteopathic Physicians/Internal Medicine, Hematology & Oncology
- 207RX0202X – Allopathic & Osteopathic Physicians/Internal Medicine, Medical Oncology

- 2080P0207X – Allopathic & Osteopathic Physicians/Pediatrics, Pediatric Hematology&Oncology

Approvals will be given a duration of 6 months.

Cystic Fibrosis Medically Necessary Prior Authorization

New prescriptions for the Cystic Fibrosis drugs Kalydeco, Orkambi, Symdeko and Trikafta will require prior authorization.

Prescribers should complete the Cystic Fibrosis Prior Authorization form and fax to Gainwell Technologies for processing.

Cystic Fibrosis Prior Authorization requests should be submitted on the Cystic Fibrosis PA Form, and will be granted in cases where provider documentation indicates the following:

- Kalydeco:
  - Patient is 1 month of age or older; and,
  - Patient has a diagnosis of cystic fibrosis with one mutation in the CFTR gene confirmed by an FDA-cleared CF mutation test or if the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use

- Orkambi:
  - Patient is 1 year of age or older; and,
  - Patient has a diagnosis of cystic fibrosis homozygous for the F508del mutation in the CFTR gene confirmed by an FDA-cleared CF mutation test

- Symdeko:
  - Patient is 6 years of age or older; and,
  - Patient has a diagnosis of cystic fibrosis homozygous for the F508del mutation in the CFTR gene confirmed by an FDA-cleared CF mutation test or have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence or if the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use

- Trikafta:
  - Patient is 2 years of age or older; and,
  - Patient has a diagnosis of cystic fibrosis with at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by a FDA-cleared CF mutation test or if the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of at least one F508del mutation or a mutation that is responsive based on in vitro data

In instances where the individual does not meet criteria, the prescriber may write a letter of medical necessity and submit along with the Cystic Fibrosis PA form to the Department's Medical Director for consideration via email at rx.lmn@CT.gov or to DSS fax at (860) 424-4822.

Proprotein Convertase Subtilisin Kexin type 9 (PCSK9) inhibitors Medically Necessary Prior Authorization

PCSK9 inhibitors are approved for use in addition to diet and maximally tolerated statin therapy in adult patients with Heterozygous Familial Hypercholesterolemia (HeFH), or Homozygous Familial Hypercholesterolemia (HoFH), or clinical Atherosclerotic Cardiovascular Disease (ASCVD), such as heart attacks or strokes, who require additional lowering of LDL cholesterol.

New prescriptions for PCSK9 inhibitors will require prior authorization. The PCSK9i Prior Authorization (PA) Form must be filled out by the prescriber and faxed to Gainwell Technologies for processing. Prior Authorization will be granted in situations where the prescriber indicates:

- Repatha ONLY: Patients aged 10 – 17 years:

- Diagnosis of homozygous familial hypercholesterolemia (HoFH) or heterozygous familial hypercholesterolemia (HeFH) and requires additional lowering of low-density lipoprotein cholesterol (LDL-C) as an adjunct to diet and other LDL-C lowering therapies of homozygous familial hypercholesterolemia (HoFH)

- Repatha and Praluent: Patients 18 years of age or older:
  - Diagnosis of homozygous familial hypercholesterolemia (HoFH), heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD) and requires additional lowering of low-density lipoprotein cholesterol (LDL-C) as an adjunct to diet and other LDL-C lowering therapies

- Leqvio: Patients 18 years of age or older:
  - Diagnosis of heterozygous familial hypercholesterolemia (HeFH) or clinical atherosclerotic cardiovascular disease (ASCVD) and requires additional lowering of low-density lipoprotein cholesterol (LDL-C) as an adjunct to diet and maximally tolerated statin therapy

In instances where the individual does not meet criteria, the prescriber may write a letter of medical necessity and submit with the PCSK9i PA form to the Department's Medical Director for consideration via email at rx.lmn@CT.gov or to DSS fax at (860) 424-4822.

Step Therapy Non – PDL Prior Authorization

New prescriptions for non-Preferred drugs in the following classes: Proton Pump Inhibitors (PPIs), Antimigraine Triptans, Acne Agents - Topical, Statins (HMG CoA-Reductase inhibitors), and Cytokine and CAM Antagonists will require Step Therapy Prior Authorization.

Prescribers may switch the recipient to a preferred agent to avoid point of sale (POS) issues at the pharmacy or must submit a Step Therapy Prior Authorization request.

The Step Therapy PA form requires prescribers to explain why the client cannot be treated with one of the currently preferred agents. The prescriber must indicate a contraindication to the preferred agents, or list which preferred product has been utilized in the past, select a reason for the failure, and supply a specific written clinical explanation of the failure.

- Prior Authorization for drugs subject to Step Therapy will be granted in cases where documentation indicates the following:
  - Use of the formulary alternative is contraindicated (e.g., due to hypersensitivity)
  - The patient has experienced significant adverse effects from the formulary alternative, FDA 3500 MedWatch form filed
  - Use of the formulary alternative has resulted in therapeutic failure after the course of treatment
  - Pediatric patient (the patient is younger than 12 years of age)

Medically Necessary Dupixent Prior Authorization

Prior Authorization (PA) requirement for prescription benefit coverage of dupilumab injection, marketed as Dupixent

New prescriptions for Dupixent will require prior authorization. The Dupixent PA Form must be filled out by the prescriber and faxed to Gainwell Technologies for processing. Prior Authorization will be granted in situations where the prescriber indicates:

- Eosinophilic Esophagitis:
  - The patient must be 1 year of age or older
  - The patient must weigh at least 15 kg and have a diagnosis of eosinophilic esophagitis

- Uncontrolled Moderate-to-Severe Atopic Dermatitis:
  - The patient must be 6 months of age or older
  - The patient must have a diagnosis of moderate to severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapy or when those therapies are not advisable

- Moderate-to-Severe Asthma:
  - The patient must be 6 years of age or older
  - The patient must have a diagnosis of eosinophilic phenotype asthma (e.g., peripheral blood eosinophils ≥150/microL) and is oral corticosteroid dependent and not controlled on maximum inhaled GC/LAMA/LABA therapy

- Inadequately Controlled Chronic Rhinosinusitis with Nasal Polyposis:
  - The patient must be 18 years of age or older
  - The patient must have a diagnosis of chronic rhinosinusitis with nasal polyposis and has failed to be controlled by a course of systemic corticosteroids or history of sinus surgery followed by topical corticosteroid treatment

- Prurigo Nodularis:
  - The patient must be 18 years of age or older
  - The patient must have a diagnosis of Prurigo Nodularis

In instances where the individual does not meet criteria, the prescriber may write a letter of medical necessity and submit with Dupixent PA form to the Department's Medical Director for consideration via email at rx.lmn@CT.gov or to DSS fax at (860) 424-4822.

Medically Necessary Evrysdi Prior Authorization

Spinal Muscular Atrophy (SMA) is a hereditary disease that causes weakness and muscle wasting due to the loss of lower motor neurons responsible for controlling movement. Risdiplam is the first oral agent indicated for SMA.

New prescriptions for Evrysdi will require prior authorization. The Evrysdi PA Form must be filled out by the prescriber and faxed to Gainwell Technologies for processing. Prior Authorization will be granted in situations where the prescriber indicates:

- Clinical criteria for PA approval for Evrysdi (Risdiplam) are as follows:
  - The patient must have a diagnosis of spinal muscular atrophy (SMA);
  - The patient is NOT receiving concomitant chronic survival motor neuron (SMN) modifying therapy, i.e., Spinraza ™ (nusinersen);
  - The patient has previously received gene replacement therapy with ZOLGENSMA® (onasemnogene abeparvovci-xioi), and has there been a decline in clinical status (i.e., loss of motor milestone(s))

In instances where the individual does not meet criteria, the prescriber may write a letter of medical necessity and submit with Evrysdi PA form to the Department's Medical Director for consideration via email at rx.lmn@CT.gov or to DSS fax at (860) 424-4822.

Medically Necessary Spravato Prior Authorization

Prior Authorization (PA) requirement for prescription benefit coverage of esketamine nasal spray, marketed as Spravato

New prescriptions for Spravato will require prior authorization. The Spravato Prior Authorization Form must be filled out by the ADMINISTERING prescriber and faxed to Gainwell Technologies for processing. Prior Authorization will be granted in situations where the prescriber indicates:

- Clinical criteria for PA approval for esketamine nasal spray is as follows:
  - The patient must be 18 years of age or older;
  - The patient has experienced treatment-resistant depression;
  - The patient has experienced treatment failure (at least a 4-week trial) or adverse effects from the use of a SSRI and one other antidepressant (non-SSRI);
  - The patient has experienced an inadequate response (defined as at least four weeks of therapy for antidepressants) or adverse reaction to one of the below mentioned antidepressant augmentation strategies or does the patient have a contraindication to all the below mentioned augmentation strategies:
    - Second-generation antipsychotic
    - Lithium

- A second antidepressant from a different class
- Thyroid hormone

For a PA approval from Gainwell Technologies, either all the top 4 clinical criteria must be met, or the request will also be approved if it is for a continuation of Spravato that was started in an inpatient unit for treatment of acute suicidal ideation.

In instances where the individual does not meet criteria, the prescriber may write a letter of medical necessity and submit with Spravato PA form to CT BHP for consideration. Submit request to CT BHP via fax, to 866-434-7681.

Medically Necessary Insulin Pump Prior Authorization

Specific insulin pump devices will be payable through pharmacy Point of Sale (POS) with an approved Prior Authorization meeting medical necessity.

These insulin delivery products, when processed as a pharmacy POS claim, will be subject to the Diabetic Preferred Product List. Preferred insulin delivery products are recommended and should be prescribed unless the prescribing provider's clinical judgement is in opposition. The full list of preferred products is published on the Connecticut Medical Assistance Program (CMAP) Web site www.ctdssmap.com under the Pharmacy section. From the Home page, go to Pharmacy Information → Preferred Drug List Information → Diabetic Supplies Preferred Product List.

New prescriptions for an Insulin Pump will require prior authorization. The Insulin Pump PA Form must be filled out by the prescriber and faxed to Gainwell Technologies for processing. Prior Authorization will be granted in situations where the prescriber indicates:

- Clinical criteria for PA approval for Insulin Pump Therapy is as follows:
  - For patients currently established on insulin pump therapy: Are the following statements true:
    - Physician monitoring is planned
    - Proper use and continued benefit have been established by diabetes care team
  - For patients not currently established on insulin pump therapy: ALL relevant below statements true:
    - Patient has a diagnosis of Diabetes Mellitus Type 1 or 2
    - Patient has been testing ≥ 4 times per day for ≥ 8 weeks or is using a continuous glucose monitor (CGM)
    - Patient or caregiver motivated to assume responsibility for self-care and insulin management
    - Patient or caregiver demonstrates knowledge of importance of nutrition including carbohydrate counting and meal planning
    - Patients with Type 2 Diabetes: Has completed a Diabetes Management Program
    - Patients with Type 2 Diabetes: Has self-administered injections ≥ 3 times per day and have performed self-adjusted dose changes for ≥ 6 months (adults) or ≥ 3 months (pediatric)
    - Patient with Type 2 Diabetes: Has experienced 3 ≥ of the following conditions:
      - Unexplained, nocturnal, or severe hypoglycemia
      - Hypoglycemia unawareness
      - Dawn Phenomenon blood glucose > 200 mg/dl
      - Wide and unpredictable (erratic) swings in blood glucose levels
      - Glycemic targets within individualized range but lifestyle requires increased flexibility of insulin pump use
      - Glycosylated hemoglobin (HbA1C) > 7% or outside of individualized targets

In instances where the individual does not meet criteria, the prescriber may write a letter of medical necessity and submit with Insulin Pump PA form to the Department's Medical Director for consideration via email at rx.lmn@CT.gov or to DSS fax at (860) 424-4822.

Medically Necessary Continuous Glucose Monitoring Prior Authorization

Specific Continuous Glucose Monitors will be payable through pharmacy Point of Sale (POS) with an approved Prior Authorization meeting medical necessity.

CGM devices, when processed as a pharmacy POS claim, will be subject to the Preferred Diabetic Supply Product List (PDSPL). Only CGM devices listed on the PDSPL are covered under the pharmacy benefit. The full list of preferred products will be published on the Connecticut Medical Assistance Program (CMAP) Web

site www.ctdssmap.com under the Pharmacy section. From the Home page, go to Pharmacy Information → Preferred Drug List Information → Diabetic Supplies Preferred Product List.

New prescriptions for a Continuous Glucose Monitor will require prior authorization. The Continuous Glucose Monitoring PA Form must be filled out by the prescriber and faxed to Gainwell Technologies for processing. Prior Authorization will be granted in situations where the prescriber indicates:

- Clinical criteria for PA approval for CGM Therapy is as follows:
  - For patients currently established on CGM therapy: Are the following statements true:
    - There is assessment by the treating provider at least every 12 months and
    - There is documented evidence of compliance with the device (e.g. data download, documentation of review of data download) to which proper use and continued benefit has been established by diabetes care team
  - For patients not currently established on CGM therapy: ALL relevant below statements true:
    - Patient is managed by an endocrinologist or clinician with expertise treating individuals with diabetes
    - Patient satisfies one or more of the criteria listed below:
      - Patient is diagnosed with Type 1 Diabetes
      - Patient is diagnosed with Type 2 Diabetes AND is treated with insulin AND has patterns of hypoglycemia or hyperglycemia
      - Patient is using insulin pump for insulin delivery
      - Patient has gestational diabetes or is pregnant and a CGM is recommended by the treating provider

In instances where the individual does not meet criteria, the prescriber may write a letter of medical necessity and submit with Continuous Glucose Monitoring PA Form to the Department's Medical Director for consideration via email at rx.lmn@CT.gov or to DSS fax at (860) 424-4822.

Useful information and Bulletin Links pertaining to Pharmacy Prior Authorization Requirements and the Preferred Drug Listing

1. **One-Time, 14-day Prior Authorization - Provider Bulletin 2013-49**
   - Pharmacies have the option to utilize a one-time 14-day supply of a prescription medication when;
     - The prescribing provider is not actively enrolled with Connecticut Medicaid
       - To dispense a one-time, 14 day supply of a medication when it has been determined that the prescribing provider is not actively enrolled, pharmacies can enter a Prescribing Provider Exception (PPE) override by entering all 7's in the Prior Authorization Number Submitted field, NCPDP 462-EV, and a numeric value of "1" in the Prior Authorization Type field
     - When Prior Authorization (PA) is required
       - PA is required when any new or refill prescription is filled for the first time for a non-preferred product or a brand-name medication when a chemically equivalent generic is available.
         - To dispense a one-time, 14 day supply of a non-preferred or brand-name medication pharmacies should continue to enter all 9's in the Prior Authorization Number Submitted field, 462-EV, and a numeric value of "1" in the Prior Authorization Type field
   - Pharmacies should indicate the reason for dispensing a 14-day supply on the updated flier and notify the client prior to dispensing the medication.
2. **Pharmacy Web Prior Authorization - Provider Bulletin 2019-70**
   - Actively enrolled prescribing providers can utilize the Pharmacy Web PA feature to:
     - Submit requests for Brand Medically Necessary, Early Refill, Preferred Drug List, Optimal Dosage, Step Therapy and Opioid PA requests
     - Verify approval status of PA requests
     - Upload additional supporting clinical documentation for previous Web PA requests
     - Receive a PA number
     - Search and view previously submitted PA requests
3. **5-day Emergency Supply**
   - In addition to the one-time 14-day temporary supply, DSS also allows for a 5-day emergency supply of a medication that requires PA for non-PDL or Brand Medically Necessary (BMN). If the pharmacist or prescriber is unable to obtain a PA and the client

requires the medication after the one-time 14- day override has been used and outside of regular business hours, the pharmacist may call the 24 hour Pharmacy Prior Authorization Assistance Call Center.

4. **Billing Clarification for Brand Name Medications on the Preferred Drug List (PDL)**
   - If the brand name medication for a multi-source product (a medication that is available as both the brand name and the generic) is identified as the preferred drug on the PDL, and the brand medication is dispensed, the claim does not need to be submitted with a Dispense As Written (DAW) code of '1' for the pharmacy to receive brand reimbursement. If the prescriber has not indicated the brand product is medically necessary, the pharmacy may submit the claim with a DAW code of '5' to signify that the pharmacy dispensed the brand as the generic, or '9' to signify that although substitution is allowed by the prescriber, the Connecticut Medical Assistance Program requests the brand and will receive brand reimbursement as long as the brand name product remains preferred on the PDL.
   - Any pharmacy claim submitted with a DAW of '1' to signify the prescriber specified the brand product is medically necessary is subject to audit. Unless a prescription is transmitted electronically, such as through SureScripts, the pharmacy must have a prescription with the words 'Brand Medically Necessary' written in the prescriber's handwriting on file; failure to provide written documentation in the event of an audit will result in the recoupment of the claim. A verbal prescription would need to be followed up by a hard copy prescription sent to the pharmacy with the appropriate documentation.
   - Should the pharmacy choose to dispense the generic equivalent when the brand is the preferred product, a non-preferred PA would be required for the claim to process.
5. **Biannual Changes to the Connecticut Medicaid Preferred Drug List (PDL)**
   - The Pharmaceutical & Therapeutics (P&T) Committee has modified the list of preferred prescription products. The Committee has determined these preferred products as efficacious, safe, and cost-effective choices when prescribing for HUSKY A, HUSKY C, HUSKY D, Tuberculosis (TB), Emergency Medicaid Dialysis Service (EMDS), and Family Planning (FAMPL) clients.
   - Biannual changes go into effect on either July 1st or January 1st. each therapeutic class is reviewed annually, half in the spring and half in the fall. The therapeutic class review schedule is available on the www.ctdssmap.com Web site. From the Home page, go to Pharmacy Information → Preferred Drug List Information → TOP$ Therapeutic Class Review Schedule. The full list of PDL changes is available on the www.ctdssmap.com Web site. From the Home page, go to Pharmacy Information → Preferred Drug List Information → Preferred Drug List Changes. A new brand or generic entry into an existing PDL class will only appear if it is preferred. Preferred brand name products with a non-preferred generic equivalent will be designated in **bold** print.