North Dakota Medicaid Academic Detailing

Quarter 1 2025

Russell Moore (Medicaid Pharmacy Specialist - Acentra Health)
russell.moore@acentra.com

Agenda

- General Updates
- Coverage Updates: GLP-1 Agonists, Erzofri, Bendamustine, Biosimilars, and Diabetic Supplies
- Prior Authorization (PA) Updates: Dual Coverage with Medicare, ADHD Stimulants, Insulin Vials
- Brand Name Requirements
- Core Measures: Antipsychotics in Nursing Homes and Controller Medication Use in Asthma
- Medicaid Newsletters and Emails

General Updates

- ND Medicaid PA website: https://ndmedicaid.acentra.com/
- Preferred Drug List (PDL) Changes
  - Monitor for PDL changes often throughout the year.
  - Save this URL to see the most current version: https://ndmedicaid.acentra.com/ndpdl/
- NDC Drug Lookup Tool
  - Instructions for how to use can be found in North Dakota Medicaid's Winter 2024 Newsletter
- Please see the academic detailing page for information previously presented
- Medicaid Expansion eligibility can now be viewed in the MMIS portal. Under the Eligibility Confirmation header in the Eligibility Inquiry screen, a red banner will display stating "Eligibility is under ND Medicaid Expansion" if the member has eligibility through Medicaid Expansion. Previously, no eligibility results would display for members eligible under Medicaid Expansion.
  - Please visit Member Eligibility Instructions for detailed information on how to check member eligibility in the MMIS portal.

Criteria Updates

- Rezdiffra requires a step trial.
  - Concurrent Type 2 DM diagnosis: semaglutide with pioglitazone
  - NO concurrent Type 2 DM diagnosis: semaglutide

- GLP-1 receptor agonists were added for MASH.
  - Victoza is the preferred initial GLP-1 RA.
  - Mitigation efforts are expected when there is GLP-1 GI intolerance.
    - GI effects are common across all GLP-1 agonist agents and typically transient in nature.
    - Mitigation efforts should be trialed for at least 2 months:
      - Reduction in meal size
      - Eating slower
      - Decreased intake of greasy, high-fat or spicy food
      - Refrain from laying down after eating

Metabolic Dysfunction-Associated Steatohepatitis (MASH)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
pioglitazone	REZDIFFRA (resmetirom)
VICTOZA (liraglutide)	OZEMPIC (semaglutide)
	SAXENDA (liraglutide)
	WEGOVY (semaglutide)

Prior Authorization Criteria

Initial Criteria - Approval Duration: 12 months

- The requested medication must be prescribed by, or in consult with, an endocrinologist, gastroenterologist or hepatologist.
- The member has moderate to severe fibrosis (F2 or F3) as determined by one of the following (1-5):
  1. Biopsy
  2. Vibration-controlled transient elastography (VCTE; e.g. Fibroscan)
  3. Enhanced Liver Fibrosis (ELF)
  4. Magnetic Resonance Imaging Proton Density Fat Fraction (MRI-PDFF).
  5. Magnetic resonance elastography (MRE)
- If the member has a history of alcohol use within the past 5 years, one of the following must be met:
  1. The member has a phosphatidylethanol (PEth) level < 20 ng/mL.
  2. The member has submitted two negative alcohol tests with the most recent alcohol test within the past 3 months.
- The member must not have a concomitant terminal diagnosis where life expectancy is less than 1 year.
- Rezdiffra Only:
  - If concurrent Type 2 DM diagnosis, the member has failed a 6-month trial of semaglutide combined with pioglitazone as evidenced by paid claims or pharmacy printouts
  - If no concurrent Type 2 DM diagnosis, the member has failed a 6-month trial of semaglutide as evidenced by paid claims or pharmacy printouts.
- Saxenda Only:
  - If the member qualifies for Saxenda, the most cost effective liraglutide product will be authorized.
- Wegovy Only:
  - If the member qualifies for Wegovy, a dose escalation to 2mg weekly of Ozempic (semaglutide) must be tolerated before Wegovy will be authorized.

Renewal Criteria – Approval Duration: 12 months

- The member must have experienced one of the following (1-3):
  1. Resolution of steatohepatitis AND no worsening of liver fibrosis
  2. Improvement of liver fibrosis greater than or equal to one stage AND no worsening of steatohepatitis
  3. Both resolution of steatohepatitis AND improvement in fibrosis.
- Fibrosis and steatosis are measured by one of the following (1-5):
  1. Biopsy
  2. Vibration-controlled transient elastography (VCTE; e.g. Fibroscan)
  3. Enhanced Liver Fibrosis (ELF)
  4. Magnetic Resonance Imaging Proton Density Fat Fraction (MRI-PDFF)
  5. Magnetic resonance elastography (MRE)

Criteria Updates

- Erzofri (paliperidone): LAI Antipsychotic
  - Alternative for Invega Sustenna
  - Initiation dosing is different from Invega Sustenna
    - Erzofri requires one initial dose prior to maintenance
    - Invega Sustenna requires two initiation doses prior to maintenance

Long Acting Injectable (LAI)

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
ABILIFY ASIMTUFII (aripiprazole)	risperidone ER (risperidone microspheres)
ABILIFY MAINTENA (aripiprazole)	
ARISTADA (aripiprazole lauroxil)	
ARISTADA INITIO (aripiprazole lauroxil)	
ERZOFRI (paliperidone)	
INVEGA HAFYERA (paliperidone)	

- Bendamustine coverage changes, effective February 1, 2025, are reflected in the **2025 Preferred Drug List**
  - Preferred products do NOT require PA:
    - Bendeka 100 mg/4 mL vials J9034
    - Generic bendamustine 25 mg and 100 mg vials J9033
  - Non-preferred products require PA:
    - Belrapzo J9036
    - Vivimusta J9056

Bendamustine

PREFERRED AGENTS (NO PA REQUIRED)	NON-PREFERRED AGENTS (PA REQUIRED)
bendamustine 25 mg and 100 mg vials	BELRAPZO (bendamustine) 100 MG/4 ML VIALS
BENDEKA (bendamustine) 100 MG/4 ML VIALS	bendamustine 100 mg/4 mL vials
	VIVIMUSTA (bendamustine) 100 MG/4 ML VIALS

Criteria Updates

- Preferred biosimilars are listed in a new section of the PDL, Biosimilar Agents.

- Please refer to the PDL for preferred biosimilars for the following (list is not all inclusive):
  - Adalimumab
  - Bevacizumab
  - Filgrastim
  - Pegfilgrastim
  - Infliximab
  - Rituximab
  - Tocilizumab
  - Trastuzumab

Criteria Updates

- Test strips:
  - Accu-Chek Guide test strips are the only test strips covered.
  - Contour and OneTouch test strips are NO LONGER covered.

- Insulin Syringes:
  - BD/embecta and Ulticare insulin syringes are the only insulin syringes covered.

- Pen Needles:
  - BD/embecta (Ultra-Fine) and Owen Mumford (Unifine) pen needles are covered.
  - All other brands are NOT covered.

Prior Authorization Updates

Drug	PA Status	Class
Adzenys XR - ODT	PA	ADHD Stimulants
Alhemo	PA	Hemophilia
Alomide	PA	Ophthalmic Antihistamines
Alyftrek	PA	Cystic Fibrosis
Aptensio XR (and its generic)	PA	ADHD Stimulants
Aqneursa	PA	Medications that cost over $3000
Attruby	PA	Amyloidosis
Azstarys	PA	ADHD Stimulants
Crenessity	PA	Medications that cost over $3000
Dyanavel XR suspension	PA	ADHD Stimulants
Eohilia	PA	Non-preferred Dosage Forms
Hympavzi	PA	Hemophilia
Ilevro	PA	Non-preferred Dosage Forms
Jornay PM	PA	ADHD Stimulants
ketorolac 0.4%	PA	Non-preferred Dosage Forms
Miplyffa	PA	Medications that cost over $3000
Mydayis (and its generic)	PA	ADHD Stimulants
Natacyn	PA	Ophthalmic Antiinfectives
Opipza	PA	Non-preferred Dosage Forms
Selarsdi	PA	Stelara Biosimilar
Steqeyma	PA	Stelara Biosimilar
Ustekinumab-ttwe	PA	Stelara Biosimilar
Vyvanse chew (and its generic)	PA	ADHD Stimulants
Xelstrym	PA	ADHD Stimulants
Yesintek	PA	Stelara Biosimilar
Betimol	Remove PA	Glaucoma
Durezol	Remove PA	Ophthalmic Corticosteroids

Prior Authorization Updates

- Some ADHD stimulants now require prior authorization. Grandfathering will be allowed for members who are stable (evidenced by pharmacy claims history) on ADHD stimulants that are now non-preferred.

- Medical claims for members who have Medicare as primary insurance do not require prior authorization for compendia-supported indications.

- Effective immediately, insulin lispro vials require use of an insulin pump.
  - If the member is not using an insulin pump, insulin lispro pens are preferred.
  - Insulin lispro vials
    - PA Not Required Criteria: A 28-day supply of Omnipod has been paid within 90 days prior to insulin lispro vial claim date of service.
    - PA Required Criteria: The member has an insulin pump.

- There has been an increase in PA requests for albuterol HFA.
  - Ventolin HFA brand is preferred and does NOT require PA.
    - The quantity limit for Ventolin HFA is set to 2 canisters per 6 months (2 puffs/day).
    - If more is needed, the member must switch to ProAir Respiclick HFA and be on a steroid inhaler to control asthma.
  - ProAir Respiclick does NOT require PA if the member is using a steroid inhaler.

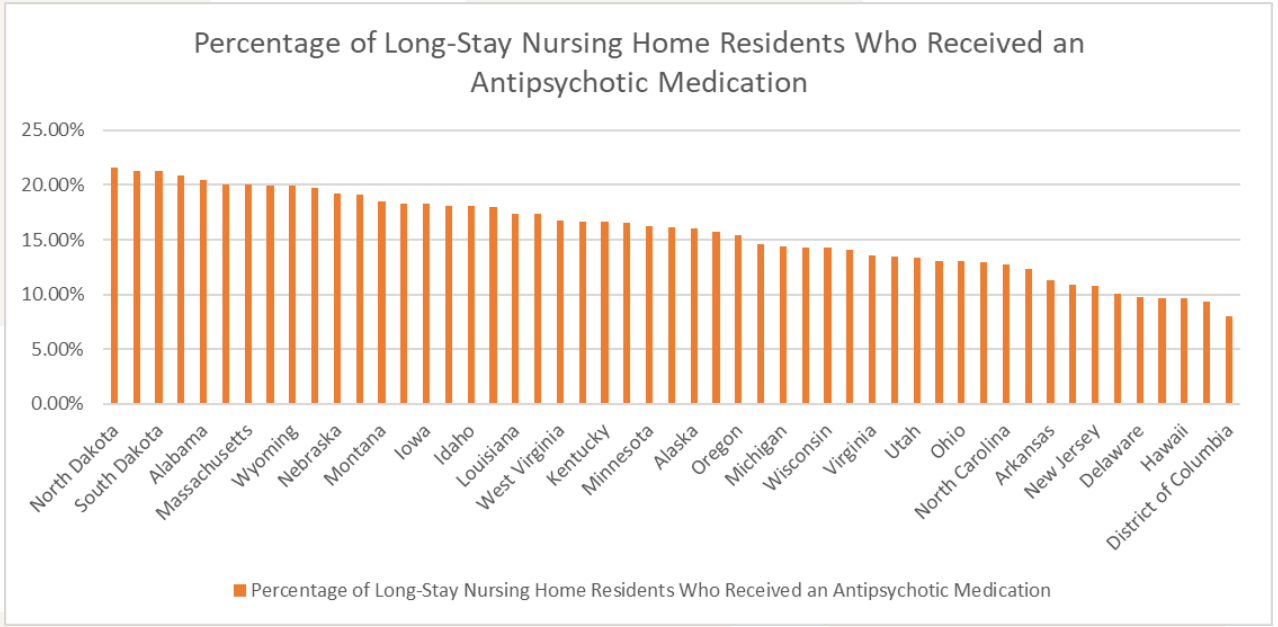
Brand Name Required: Effective Immediately

- Generic Required - No longer brand name required: Generic can be billed effective immediately
  - Adderall XR
  - Concerta
  - Mydayis (generic requires PA)
  - Viibryd

- Brand Name Required
  - Prescribers should not submit a DAW request based on ND Medicaid brand preference. Pharmacies can automatically substitute and bill brand name without prescriber intervention when the payer requires brand.
  - If a member requires brand name (brand medically necessary), a Dispense as Written (DAW1) prior authorization (PA) must be submitted.
    - DAW criteria must be met, which require a trial of all available generics along with an FDA MedWatch form submitted for each generic trial. The FDA needs to be made aware when a marketed product is not producing expected results.
    - If products have authorized generics, prescriber-requested DAW will not be approved.

Core Measures

- Antipsychotics in Nursing Homes
  - H.R. 4366 – Consolidated Appropriations Act, 2024 Sec. 203 – Monitoring Prescribing of Antipsychotic Medication
- ND has ranked highest (higher is not better)
  - Only Medicaid members included
  - Dual eligible with Medicare primary not included
- Continue to assess use of antipsychotics for your patients residing in nursing homes
  - Ongoing medical necessity
  - Possible dose reduction



References:

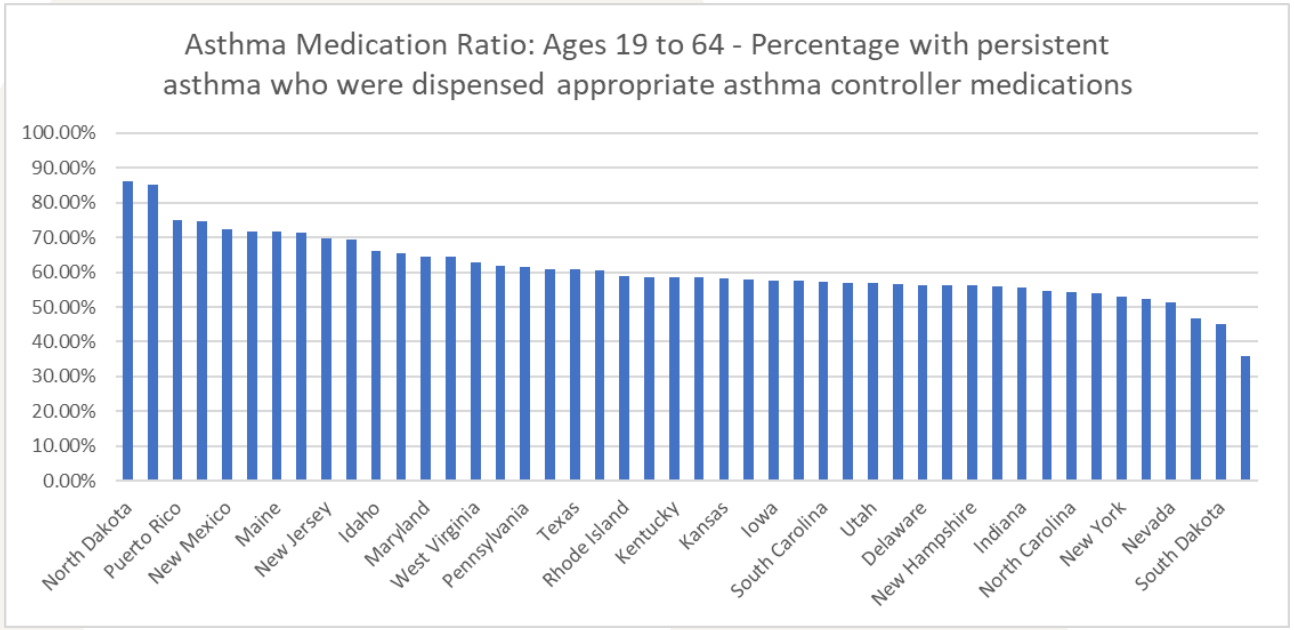
1. Reddel, H, et al. 2024 Summary Guide for Asthma Management and Prevention for Adults, Adolescents, and Children 6-11 years. Updated 2024. GINA-Summary-Guide-2024-WEB-WMS.pdf
2. Medicaid and CHIP 2024 Scorecard. Medicaid and CHIP Scorecard - Explore data

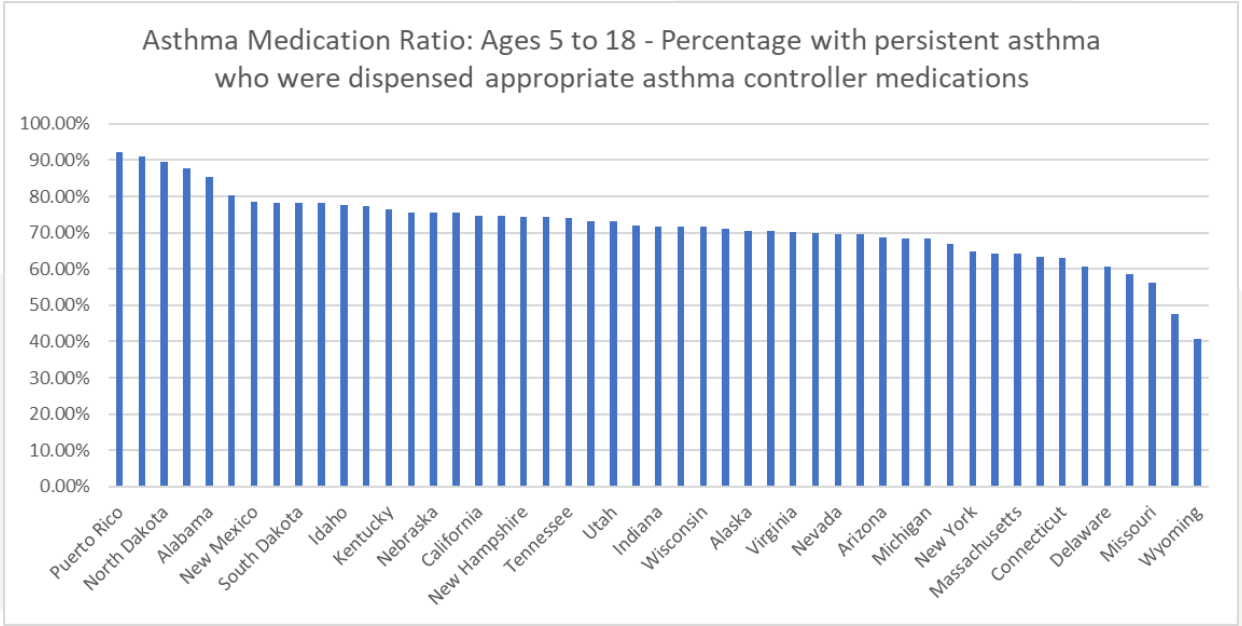
Core Measures

- Controller Medication Use in Asthma
  - Asthma Medication Ratio: Ages 19 to 64 – 86.3%
  - Asthma Medication Ratio: Ages 5 to 18 – 89.5%

- ND has ranked at or near the top (higher is better)

- Continue to follow guideline-based recommendations
  - Evaluate adherence and symptom control
  - ND Medicaid quantity limit for Dulera (which contains ICS-formoterol) allows:
    - Up to 2 inhalers per 30 days (not to exceed a total of 9 inhalers per 182 days)
    - MART (maintenance and reliever therapy) as recommended by the GINA (Global Initiative for Asthma) guidelines





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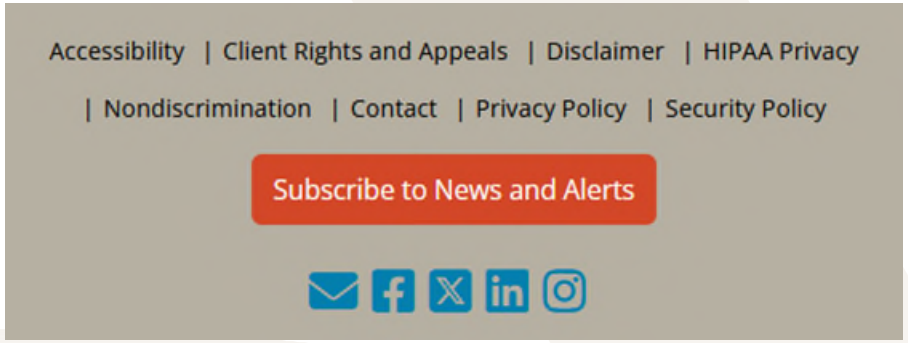
Medicaid Newsletters and Emails

- Signing up to receive ND Medicaid provider communications, including updates, news releases, and newsletters is easy.
  - **Step 1:** Go to the Provider webpage.
  - **Step 2:** Click on the Subscribe to News and Alerts button at the bottom of the screen.
  - **Step 3:** Enter your email address and click submit.
  - **Step 4:** Follow directions to set up and choose your subscription options. Select Medicaid Provider Newsletter.



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