Louisiana Medicaid
Point-of-Sale (POS) Requirements for Agents
That are Not Subject to Prior Authorization

Acetaminophen and Aspirin Adult Maximum Daily Dose Limit

The adult maximum daily dose of acetaminophen is 4000mg, from all submitted prescription claims for acetaminophen-containing products. The adult maximum daily dose of aspirin is 6000mg, from all submitted prescription claims for aspirin-containing products.

Beyaz® (Drospirenone/Ethynyl Estradiol/Levomefolate Calcium) Excluded Diagnosis Codes

The following acne-related ICD-10 diagnosis codes for Beyaz® (drospirenone/ethynyl estradiol/levomefolate calcium) are **not** payable: L70* and L73.0.

Caplyta™ (Lumateperone) Diagnosis Code Required, Maximum Dose/Age Limit, Therapeutic Duplication

Pharmacy claims for Caplyta™ (lumateperone) require a diagnosis code for schizophrenia at POS (F20* - where the * can be any number or letter or combination of **UP TO FOUR** numbers or letters of an assigned ICD-10 diagnosis code).

Caplyta™ is limited to a maximum dose of 0mg/day for recipients who are younger than 18 years of age, and a maximum dose of 42mg/day for adults who are 18 years of age or older. Requests for Caplyta™ that exceed 0mg/day for recipients who are younger than 18 years of age are addressed in the Behavioral Health Medications for Children Under 6 Years of Age document and in the Antipsychotics Criteria document (see Approval Criteria for All Ages to Override Maximum Daily Dose and/or Quantity Limits).

Caplyta™ is monitored at the pharmacy POS for therapeutic duplication with other oral antipsychotics.

Carafate® (Sucralfate) Duration of Therapy Limit

Carafate® (sucralfate) is subject to a duration of therapy limit. This limit is 90 days in a calendar year. For use beyond 90 days duration, an appropriate diagnosis code is required at POS. The ICD-10 diagnosis codes listed in Table 1 are exempt from the Carafate® duration of therapy limit.

~~**Table 1. Diagnosis Codes that are Exempt from Sucralfate (Carafate®) Duration of Therapy Limits**~~

Table 1. Diagnosis Codes that are Exempt from Sucralfate (Carafate®) Duration of Therapy Limits	
Abscess of Esophagus	K20.8
Barrett's Esophagus	K22.7*
Crohn's Disease	K50.*
Chronic Pancreatitis	K86.0, K86.1
Duodenal Ulcer	K26.*
Esophagitis, Unspecified	K20.9
Gastric Hyperacidity	K30
Gastric Ulcer	K25.*
Gastritis/Duodenitis	K29.*
Gastroesophageal Reflux Disease (GERD)	K21.9
Gastrointestinal Hemorrhage	K92.2
Malignant Mast Cell Tumors	C96.2*
Multiple Endocrine Adenomas	D44.0, D44.2, D44.9
Peptic Ulcer	K27.*
Reflux Esophagitis	K21.0

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Ulcer of Esophagus with OR without Bleeding	K22.1*
Zollinger-Ellison Syndrome	E16.4

* Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

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Cuprimine®, Depen® (Penicillamine) Quantity Limit

Cuprimine® capsules and Depen® tablets (penicillamine) are limited to a quantity of 240 capsules/tablets per 30 days.

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Fycompa® Age Limit

Fycompa® (perampanel) is indicated for adult and pediatric patients 4 years of age and older. The age limit may be overridden at the pharmacy POS after the dispensing pharmacist consults with the prescriber to verify necessity of prescribing perampanel for a child younger than 4 years of age.

Isotretinoin Capsule Prescription Requirement

Only original handwritten prescriptions signed by the prescribing practitioner, with no provision for refill, are covered.

Keveyis® (Dichlorphenamide) Quantity Limit

Keveyis® (dichlorphenamide) is limited to a quantity of 120 tablets per 30 days.

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Nexplanon® (Etonogestrel) Quantity Limit

The quantity limit for Nexplanon® (etonogestrel) is one implant every two years. The quantity limit may be overridden by the pharmacy POS after the dispensing pharmacist consults with the prescriber to verify the necessity of exceeding the quantity limit.

Oralair® (Mixed Grass Allergen Extract) Reimbursement Requirements

The following is required for reimbursement related to the above-referenced allergen extract(s):

- Pharmacy: A pharmacy claim for an auto-injectable epinephrine product within the previous 12 months.
- Prescriber: One of the following specialties:
  - Allergy
  - Otology/Laryngology/Rhinology
  - Ophthalmology/Otology/Laryngology/Rhinology

Prudoxin®, Zonalon® (Doxepin) Age Limit, Diagnosis Required, Therapeutic Duplication, Quantity Limit

Prudoxin® and Zonalon® (doxepin) are limited to use in adults 18 years of age or older. These agents require a diagnosis code at POS for either atopic dermatitis (L20* - where the * can be any number or letter or combination of **UP TO FOUR** numbers or letters of an assigned ICD-10 diagnosis code) or lichen simplex chronicus (L28.0) ~~at the pharmacy POS (See Table 2)~~. These agents are monitored at the pharmacy POS for therapeutic duplication with each other. These agents are limited to a quantity of 45 grams per 30 days.

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Qualaquin®/Quinine Sulfate 324mg Day Supply Limit, Diagnosis Code Required, Quantity Limit

Qualaquin®/quinine sulfate 324mg is limited to a maximum quantity of 42 capsules and a 7-day supply.

Pharmacy claims for Qualaquin®/quinine sulfate 324mg require a diagnosis code for *Plasmodium falciparum* malaria (B50.9) at POS. ~~Qualaquin®/quinine sulfate 324mg is limited to a maximum quantity of 42 capsules.~~

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~~**Rybelsus® (Semaglutide) Prior Use of Metformin is Required**~~

~~The pharmacy POS system verifies that there has been at least a 90-day supply of metformin in the previous 180-day period **OR** that there has been at least a 60-day supply of Rybelsus® or any other incretin mimetic/enhancer in the previous 90-day period.~~

Samsca® (Tolvaptan) Quantity Limit

Samsca® (tolvaptan) 30mg tablet is limited to a quantity of 60 tablets per fill. Samsca® (tolvaptan) 15mg tablet is limited to a quantity of 30 tablets per fill.

Sunosi® (Solriamfetol) Age Limit, Concurrent Use Restriction, Therapeutic Duplication, Diagnosis Required

Sunosi® (solriamfetol) is limited to use in adults 18 years of age or older. Sunosi® is monitored at the pharmacy POS for concurrent use with sedative-hypnotics.

Sunosi® is monitored at the pharmacy POS for therapeutic duplication with any other stimulant or related agent.

Sunosi® requires a diagnosis code at POS for either narcolepsy (G47.4* - where the * can be any number or letter or combination of **UP TO FOUR** numbers or letters of an assigned ICD-10 diagnosis code) or obstructive sleep apnea (G47.33). ~~(See Table 2)~~

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~~**Tosymra® (Sumatriptan) Quantity Limit and Diagnosis Required if Younger than 18 Years Old**~~

~~The quantity limit for Tosymra® is 6 units per 30 days. The quantity limit may be overridden at the pharmacy POS after the dispensing pharmacist consults with the prescriber to verify the necessity of exceeding the quantity limit. Tosymra®, like all other triptans that are listed on the PDL/NPDL, requires a diagnosis code at POS for recipients who are younger than 18 years old. (See Table 2)~~**Ultomiris® (Ravulizumab-cwvz) Diagnosis Code Required**

Ultomiris® (ravulizumab-cwvz) requires a diagnosis code at POS for either paroxysmal nocturnal hemoglobinuria (D59.5) or hemolytic uremic syndrome (D59.3).

Table 2. Additional Agents ~~that have diagnosis code requirements~~That Require a Diagnosis Code at POS (but are not subject to prior authorization)

Medication	Diagnosis Code	Diagnosis Description
Actimmune® (Interferon gamma-1b)	D71	Chronic Granulomatous Disease
	Q78.2	Malignant Osteopetrosis
Alferon N® (Interferon alfa-N3)	A63.0	External Genital and Perianal Warts (Condylomata Acuminata)
~~Egrifta®; Egrifta SV™ (Tesamorelin)~~	~~B20~~	~~Human Immunodeficiency Virus [HIV] Disease~~
Exjade®, Jadenu® (Deferasirox) [2-9 years old]	E83.111	Chronic Iron Overload Due to Blood Transfusions
Exjade®, Jadenu® (Deferasirox) [10 years and older]	E83.111	Chronic Iron Overload Due to Blood Transfusions
	D56.8	Hemoglobin C/β-Thalassemia
	D56.5	Hemoglobin E/β -Thalassemia
	D57.4*	Hemoglobin S/β-Thalassemia
	D56.0	α-Thalassemia Intermedia [Hemoglobin H Disease]
	D56.1	β-Thalassemia Intermedia
Fabrazyme® (Agalsidase beta)	E75.21	Fabry (-Anderson) Disease
Flolan®, Veletri® (Epoprostenol Sodium); Remodulin® (Treprostinil Sodium) Injection	I27.0, I27.2, I27.89, P29.3	Pulmonary Arterial Hypertension (PAH)
HIV Agents	B16.1, B16.2, B16.9	Acute Hepatitis B
	B18.0, B18.1	Chronic Viral Hepatitis B
	B19.1, B19.10, B19.11	Unspecified Viral Hepatitis B
	B20	HIV
	B97.35	HIV, type 2
	W46.0XXA, W46.0XXD	Contact with Hypodermic Needle
	W46.1XXA, W46.1XXD	Contact with Contaminated Hypodermic Needle
	Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmitted
	Z20.6	Contact with and (suspected) exposure to HIV
	Z20.828, Z20.89, Z20.9	Contact with and (suspected) exposure to other or unspecified communicable diseases
	Z22.51	Carrier of Viral Hepatitis B
	Z72.5, Z72.51, Z72.52, Z72.53	High Risk Sexual Behavior
	Z77.21	Contact with and (suspected) exposure to potentially hazardous body fluid
	Z77.9	Other Contact with and (suspected) exposures hazardous to health
Intron-A® (Interferon alfa-2B Recombinant)	C46.*	AIDS-Related Kaposi's Sarcoma
	B18.0, B18.1	Chronic Hepatitis B
	B18.2	Chronic Hepatitis C
	C82.*	Follicular Lymphoma
	C91.4*	Hairy Cell Leukemia
	C43.*	Melanoma

~~**Table 2. Agents that have diagnosis code requirements (but are not subject to prior authorization)** *continued*~~

~~Medication~~	~~Diagnosis Code~~	~~Diagnosis Description~~
Lumizyme® (Alglucosidase alfa)	E74.02	Pompe Disease
Onpattro® (Patisiran); Tegsedi™ (Inotersen)	E85.1	Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis
Proleukin® (Aldesleukin)	C43.*	Melanoma
	C64.*	Renal Cell Carcinoma
~~Prudoxin®, Zonalon® (Doxepin)~~	~~L20*~~	~~Atopic Dermatitis~~
	~~L28.0~~	~~Lichen Simplex Chronicus~~
Pulmozyme® (Dornase alfa)	E84.*	Cystic Fibrosis
Radicava® (Edaravone); Rilutek®, Tiglutik® (Riluzole)	G12.21	Amyotrophic Lateral Sclerosis

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Soliris® (Eculizumab)	D59.3	Hemolytic-Uremic Syndrome
	D59.5	Paroxysmal Nocturnal Hemoglobinuria [Marchiafava-Micheli]
	G36.0	Neuromyelitis optica spectrum disorder (NMOSD)
	G70.0	Myasthenia Gravis
~~Sunosi® (Solriamfetol)~~	~~G47.4*~~	~~Narcolepsy~~
	~~G47.33~~	~~Obstructive Sleep Apnea~~
Sylatron ® (Peginterferon alfa-2b)	C43.*	Melanoma
~~Tosymra® (Sumatriptan) diagnosis required for <18 Years Old~~	~~G43.0*, G43.1*, G43.7*~~	~~Migraine With or Without Aura, Chronic Migraine Without Aura~~

*Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

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Revision	Date
Modified Fycompa age, added sucralfate bypass diagnosis chart, modified wording in entire document for clarity	August 2019
Added diagnoses for Fabrazyme, Lumizyme, HIV Agents, expanded diagnosis code for malignant mast cell tumors, and added a new diagnosis for Soliris, removed allergen extracts Grastek® and Ragwitek®	November 2019
Removed First-Progesterone VGS®, added Tosymra® diagnosis requirement, quantity limit and reference, added some generics, made trademark and capitalization corrections	December 2019
Added POS information for Egrifta®/Egrifta SV™, Onpattro®, Radicava®, Rilutek®, Rybelsus®, Sunosi®, Tegsedi™, Tiglutik™, Wakix™; added references for Accutane®, Beyaz®, Fabrazyme®, Lumizyme®, Pulmozyme®, and Soliris®	March 2020
Added POS information for Cuprimine®, Depen®, Prudoxin®, Samsca®, Secuado® and Zonalon®	May 2020
Removed POS information for Cialis®, Secuado® and Wakix™	July 2020
Added POS information for Caplyta™, Keveyis®, Qualaquin®, Quinine Sulfate, and Ultomiris®; removed POS information for Egrifta®/Egrifta SV®, Rybelsus®, Tosymra®; formatting changes	Implementation Date TBD

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