equalitycare
WYOMING MEDICAID

EqualityCare Pharmacy News

Dear Providers: May 7, 2010

A. PANCREATIC INSUFFICIENCY MEDICATIONS:

Effective May 19, 2010, the Wyoming EqualityCare **Pharmacy** Program will **DISCONTINUE** covering the products below.
The Food and Drug Administration (FDA) has determined that these are unapproved new drugs within the meaning of Section 201(p) of the Federal Food, Drug, and Cosmetic Act, subject to enforcement action, and cannot be marketed without appropriate FDA approval. According to the FDA, these products do not have approved applications; therefore, the Center for Medicare and Medicaid Services (CMS) has determined that certain National Drug Codes (NDC) do not meet the definition of a covered outpatient drug as defined in Section 1972(k) of the Social Security Act and are subsequently no longer eligible for inclusion in the rebate program.

PRODUCT NAME/STRENGTH	NDC
Creon 5mg	00032-1205
Creon 10mg	00032-1210
Creon 20mg	00032-1220
Kutrase	00091-4175
Pancrelipase 8,000	10267-2737
Pancrelipase 4,500	39822-9045
Pancrelipase 10,000	39822-9100
Pancrelipase 16,000	39822-9160
Pancrelipase 20,000	39822-9200
Pangestyme MT 16	58177-0028
Pangestyme CN 10 (Pancrelipase) Delayed Release	58177-0029
Pangestyme CN 20 (Pancrelipase) Delayed Release	58177-0030
Pangestyme EC	58177-0031
Pangestyme UL 12	58177-0048
Pangestyme UL 18	58177-0049
Pangestyme UL 20	58177-0050
Plaretase	58177-0416
Ultrase MT 12	58914-0002
Ultrase MT 20	58914-0004
Ultrase MT 18	58914-0018
Ultrase MS 4	58914-0045
Viokase	58914-0111
Viokase 8oz Powder	58914-0115
Viokase 16000	58914-0116
Pancrecarb MS-8	59767-0001
Pancrecarb MS-4	59767-0002
Pancrecarb MS-16	59767-0003

Currently, the FDA is working through the approval process for pancreatic enzyme products. The Exocrine Pancreatic Insufficiency medications listed below are still **COVERED** through the Wyoming EqualityCare Pharmacy Program at this time. This may change pending further FDA review of this drug class.

PRODUCT NAME/STRENGTH
Creon 6000
Creon 12000
Creon 24000
Pancrease MT 4
Pancrease MT 10
Pancrease MT 16
Pancrease MT 20
Pancrelipase 5000
Zenpep 5000
Zenpep 10000
Zenpep 15000
Zenpep 20000

B. ORALYTE AND OTHER ELECTROLYTE REPLACEMENT PRODUCTS:

Effective May 19, 2010, the Wyoming EqualityCare **Pharmacy** Program will **DISCONTINUE** covering the products listed below. The Center for Medicare and Medicaid Services (CMS) has determined that these are not to be considered as outpatient covered drugs for the purposes of Medicaid or rebate.

PRODUCT NAME/STRENGTH	NDC
Oralyte Sol	00536-0004
Oralyte Sol	00536-0935
Oralyte Sol	00536-0936
Oralyte Sol	00536-1385
Oralyte Sol	00536-1395
GNP Pediatric Electrolyte Sol	24385-0096
GNP Pediatric Electrolyte Sol	24385-0100
GNP Pediatric Electrolyte Sol	24385-0101
GNP Pediatric Electrolyte Sol	24385-0103
Pediatric Electrolyte Sol Unflavored	24385-0100
Pediatric Electrolyte Sol Unflavored	37205-0222
Pediatric Electrolyte Sol Fruit	37205-0220
Pediatric Electrolyte Sol Fruit	37205-0220
Pediatric Electrolyte Sol Grape	37205-0221
Pediatric Electrolyte Sol Freezer	37205-0963
Pediatric Electrolyte Sol Fruit	49348-0570
Pediatric Electrolyte Sol Unflavored	49348-0571

Pediatric Electrolyte Sol Bubble Gum	49348-0880
Pediatric Electrolyte Sol Fruit	49614-0222
Pediatric Electrolyte Sol Grape	49614-0223
Pediatric Electrolyte Sol	63868-0007
Pediatric Electrolyte Sol	63868-0261
Pediatric Electrolyte Sol	63868-0606

C. PREFERRED BRAND NAME AGENTS:

Recently, generics have become available for **ALDARA, COZAAR** and **HYZAAR.** However, the **BRAND NAME** will remain the preferred agent.

D. MISCELLANEOUS INFORMATION (EFFECTIVE MAY 19, 2010):

1. **FLUOXETINE 20mg TABLETS:** will require prior authorization. The CAPSULES and other tablet strengths will remain a STEP 1 preferred agent and not require prior authorization.

2. **FLUOXETINE WEEKLY:** will require prior authorization.

3. **IMPLANON:** will no longer be covered through the pharmacy program.

4. **MINOCYCLINE 100mg TABLETS:** will require prior authorization. The CAPSULES and other tablet strengths will not require prior authorization.

5. **PERINDOPRIL:** will become a **PREFERRED** ACE inhibitor.