



NorthSTAR

Pharmacy Manual

Revised October, 2008

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I. Introduction:

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ValueOptions is contracted with a Pharmacy Benefit Manager (PBM). The PBM, in turn, is contracted with an extensive number of pharmacies across the NorthSTAR Service Delivery Area to provide easy pharmacy access for our consumer population.

When filling a prescription for a NorthSTAR consumer, the NorthSTAR prescription pad must be utilized and all information completed. These prescription pads will be given to each *ValueOptions* Network Provider eligible to prescribe medication.

Please note that thirty days is the maximum time for which any prescription may be written. Please do not use the NorthStar prescription pads for Medicaid clients, as this may result in a delay in getting the member's prescription filled.

The NorthSTAR formulary that applies to Indigent Consumers is included as Section IV in this Manual. Medicaid recipients are not restricted to this formulary. The formulary is a contractual requirement between the State and *ValueOptions*. Please note that, when available, generic medications are the only formulary option. Please read the formulary to familiarize yourself with the available medications.

If a client has Medicaid, and they lose their Medicaid coverage, *ValueOptions* NorthSTAR will authorize the medications for 3 months to allow for reinstatement of Medicaid.

For Indigent consumers, pre-authorization will be required for certain medications. These include, but are not limited to, the following medications:

1. Clozapine, Zyprexa, Seroquel, Geodon, and Abilify
2. Lithobid, Eskalith CR, Lamotrigine, and Trileptal.
3. The Hypnotic agent Sonata.
4. Non-generic antidepressants (i.e. generic fluoxetine, paroxetine, bupropion SR, Sertraline, mirtazapine, Fluvoxamine and nefazadone are available without prior authorization).
5. Other agents such as generic Adderall, Cylert, Biperiden (Akineton).
6. Certain agents are not formulary. Please see the subsections for specific details.

Please refer to the Preauthorization Section of this Manual for further clarification.

To maximize resources available to the NorthSTAR population, it is critical to efficiently and effectively administer pharmacy benefits. Collaboration among *ValueOptions*, the PBM, and providers is very important. Through the PBM, *ValueOptions* will be able to review prescribing patterns and practices and share this information with providers. Through this information and educational process, there

is an opportunity to maximize our consumers' resources. Where possible, we will be evaluating prescribing patterns in accordance with the Texas Implementation of Medication Algorithms. Among the issues to be reviewed will be the following:

1. Polypharmacy.
2. Over and under utilization of prescriptions.
3. Dosing concerns (both high and low).
4. Therapeutic duplication.
5. Drug-drug interactions.

Our hope is providing this information contained in this Pharmacy Manual is that our providers will find it to be valuable and in that it in some way may enhance patient care.

Agents not listed are considered non-formulary. The NorthSTAR formulary will be reviewed periodically as new medications are released and new information is available.

II. Antidepressants:

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ValueOptions NorthSTAR employs a preferred-agent formulary. This means that certain agents are available without a prior authorization or copay, and that other agents are available with a \$20.00 copay. Also, there is a dose limit. Doses above the dose limit require a dose override.

Agents available without prior authorization or copay (generic versions of the following);

1. Fluoxetine - the 10 or 20mg capsules-(weekly & 40mg tabs are nonformulary)
2. Citalopram
3. Mirtazapine
4. Paroxetine
5. Bupropion and Bupropion SR
6. Sertraline
7. Fluvoxamine
8. Nefazadone
9. Trazodone (not the 300mg tablet)
10. Tricyclic antidepressants
11. MAO-I's

Agents that require a prior authorization and a \$20.00 copay:

1. Lexapro.
2. Effexor and Effexor XR.

The agents listed above may be available for a member without a copay if:

1. The member has failed adequate trials of the preferred agents.
2. Or if there is a medical contraindication for the preferred agent not yet tried.
3. The member transfers to the NorthSTAR service area and they had received care from a community mental health center, and they have been stable on the non-preferred agent for more than 12 months.

These agents are non-formulary:

1. Paxil CR.
2. Wellbutrin (Brand), in the SR and XL formulations.
3. Prozac Weekly.
4. Any brand name medication for which there is a generic alternative
5. Certain dose strengths of formulary medications: Doxepin 150mg, Fluoxetine 40mg, trazodone 300mg.
6. Duloxetine (Cymbalta).

Maximum daily dose without override

- | | |
|-----------------------|-------|
| 1. Fluoxetine | 60mg |
| 2. Citalopram | 60mg |
| 3. Mirtazapine | 45mg |
| 4. Paroxetine | 60mg |
| 5. Bupropion and SR | 450mg |
| 6. Lexapro | 20mg |
| 7. Luvox | 200mg |
| 8. Serzone | 400mg |
| 9. Sertraline | 200mg |
| 10. Venlafaxine or XR | 300mg |

Requests for dual antidepressant therapy will be reviewed in accordance with the Texas Medication Algorithm Project (TMAP) Guidelines. Dual therapy is Stage 5. Trazodone will not be considered as a second antidepressant, given that it is commonly used to improve sleep. The combination of a SSRI and Bupropion (Wellbutrin) will be considered dual antidepressant therapy, not augmentation, and would therefore require prior authorization.

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III. New Generation Antipsychotic Medications [● Contents](#) **(Including Clozapine, Risperdal, Zyprexa, Seroquel, Geodon, and Abilify)**

The Texas State Legislature has allocated a fixed amount of funding for New Generation Antipsychotic Medications. The amount allocated for new generation antipsychotics has not been appreciably changed in the last several years, despite ever increasing enrollment into the NorthSTAR program. Patients who qualify for Indigent Mental Health Care under the NorthSTAR Program will be eligible to access this New Generation Fund.

Clozapine continues to be available with pre-authorization.

NorthSTAR does not cover the usage of Atypicals in the maintenance treatment of Bipolar Disorder. There are many agents available on the formulary for this. Atypicals may be authorized for acute stabilization in Bipolar Disorder, but these authorizations will be time limited.

Please note that routine EKGs are not required prior to starting **Geodon**, and therefore cannot be obtained through NorthSTAR funding. If the patient has known or suspected cardiovascular disease then referral to a medical clinic for medical clearance may be appropriate.

Risperdone is the preferred New Generation antipsychotic agent. It is available in generic formulation to eligible NS clients with appropriate diagnoses. As tracking of utilization of Second Generation Antipsychotics (SGA's) remains important, please submit PA forms for registration in the event there are funding limitations in the future. As the preferred SGA, this means that a patient must have been tried on this medication prior to having another atypical agent authorized, unless contraindicated medically. This also means that those who may be on an atypical agent prior, who are switching to another atypical agent, who have not been tried on Risperdone, must be then switched to Risperdone prior to having another atypical agent authorized.

For patients currently authorized for one of the atypical medications, switching to a different atypical medication will be authorized on a case-by-case basis. Please make this request by completing a pre-authorization form and providing clinical documentation supporting the request. When switching from one atypical medication to another dual therapy for the purpose of transition will be authorized for up to three weeks. If additional transition time is needed utilizing dual therapy then the authorization request will need to be completed and sent to Value Options utilizing the pre-authorization form. Please note that dual therapy with atypical antipsychotics is not typically authorized on an ongoing basis.

Patients placed on an atypical in a State Hospital will be continued as is clinically appropriate after discharge (i.e. for several months in a patient with Bipolar Disorder or Major Depression with psychotic features, or long-term for a patient with Schizophrenia).

Patients transferring into the NorthSTAR service from a community mental health center, who have been on an atypical for a year or longer, will have the atypical authorized upon reviewing for appropriateness of medication usage for that individual and their diagnosis.

Patients with Tardive Dyskinesia as documented by AIMS are eligible to bypass the waitlist (if in effect). Please attach a copy of the AIMS with the request for an atypical agent.

Patients who have been off new generation medications for over 90 days will be considered as new starts and will require preauthorization if their authorization has expired (if wait list conditions exist).

This policy does not apply to those with Medicaid pharmacy benefits, as their pharmacy benefit is directly from Medicaid.

Please note that starting a patient on the atypical antipsychotic medication without pre-authorization places the patient at risk of being stabilized on medication they may not be able to continue. This is most likely to occur when pharmaceutical samples (other than risperidone) are utilized prior to pre-authorization or during inpatient hospitalization.

Haldol-D and Prolixin-D are available without prior authorization or copay.

Risperdal Consta is non-formulary.

Maximum Dose of New Generation Antipsychotics Without Dose Override:

1. Risperidone 6mg
2. Geodon 80mg bid (160mg)
3. Abilify 30mg
4. Zyprexa 20mg
5. Seroquel 800mg

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IV. Mood Stabilizers:

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The NorthSTAR formulary contains several mood stabilizers. As with the antidepressants, there are some that are available without the need for a copay or for prior authorization.

Agents available without prior authorization or copay:

1. Lithium (may have Lithobid or Eskalith with prior authorization if the patient has a documented history of gastrointestinal side effects to lithium).
2. Valproic Acid (May have Depakote with prior authorization if the patient has a documented history of gastrointestinal side effects to Valproic Acid).
3. Carbamazepine.
4. Divalproex/generic Depakote (Brand Depakote and Depakote ER are non-formulary)
5. Gabapentin (Brand Neurontin is now non-formulary)

Agents that require a prior authorization and a \$20.00 copay:

1. Brand name Lithobid or Eskalith (see above for note about obtaining these medications without a copay).
2. Trileptal.
3. lamotrigine (Brand Lamictal is now non-formulary)

To obtain a copay waiver on Trileptal or Lamotrigine, a NorthSTAR client must:

1. Have a diagnosis of Bipolar Disorder or Schizoaffective Disorder.
2. Adequate therapeutic trials of Lithium, Valproic acid, Divalproex or Carbamazepine, unless contraindicated.
3. Have transferred into the NorthSTAR service area from an outside community mental health center already taking Trileptal or Lamotrigine for more than one year.

These agents are not formulary:

1. Topamax.
2. Brand name Neurontin (as of December 1, 2004).
3. Brand Depakote (as of September 2008)
4. Brand Lamictal (as of September 2008)
5. Depakote ER.
6. Other agents not explicitly stated to be on the formulary are considered not formulary.

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V. ADHD medications:

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Some stimulants and clonidine are available for the treatment of ADHD in members below the age of 18, or who are still enrolled in high school (for example, a member who turns 18 in March of the 12th grade would be covered until the end of the academic year with prior authorization). There is no NorthSTAR benefit for the treatment of ADHD in adults.

Agents available without prior authorization or copay:

1. Methylphenidate.
2. Dextroamphetamine.
3. Clonidine.
4. Antidepressants as noted in [Section II](#)

Agents that require a prior authorization and a \$20.00 copay:

1. Generic Adderall
2. Cylert

These agents are non-formulary:

1. Adderall XR
2. Strattera
3. Focalin
4. Other agents unless specifically noted as being formulary.

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VI. Anxiolytics and Sedative-Hypnotics:

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Benzodiazepines are available for anxiety and sleep. Generic benzodiazepines do not require prior authorization or copayment. Generic buspirone is available for use without copayment or prior authorizations as well, and is limited to a dose of 60mg/d or less without a dose override. In addition, generic Ambien/zolpidem is available without prior authorization or copay.

1. Generic benzodiazepines are available for anxiety treatment without prior authorization or copay.
2. Generic zolpidem is available without prior authorization or copay.
3. Generic buspirone (not the 30mg tablet) is available for anxiety without prior authorization or copay up to a dose of 60mg/d.
4. The 30mg buspirone tablet is not formulary.

Many agents are available on the NorthSTAR formulary for anxiety and sleep. However, due to the high cost of Sonata, preauthorization will be required for all patients prescribed Sonata. Furthermore, the benefit for Sonata is limited to a short-time frame. A copay waiver is therefore generally limited to 2 months duration. The use of Sonata beyond this time frame will usually require a copayment. To qualify for Sonata, a patient must have

1. For new starts trials of at least 2 other hypnotic or hypnotic like agents (i.e. trazodone) will be required prior to considering approval of Sonata.
2. For continuation of Sonata beyond 60 days an authorization request must be submitted stating the clinical need for continuation. If an alternative hypnotic agent is substituted then no authorization request is required.
3. Generally speaking, copay waivers for these medications will only be granted for up to 60 days. Following this, a copay of \$20 will be required.

Hydroxyzine Pamoate (Vistaril) is formulary, but Hydroxyzine HCl (Atarax) is not.

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VII. Other Agents:

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Biperiden (Akineton) requires prior authorization.

Suboxone/Subutex are available on a limited basis:

1. An individual must have failed other types of rehabilitation.
2. There is a \$20 copay for this medication. Copay waivers are not granted for this medication.
3. The duration of the authorization will be for 3-6 months. After that, the patient will either need to taper off of the medication, or they may elect to pay out of pocket for the medication.
4. The prescribing clinician must have the appropriate certification for prescribing this medication.

Campral (acamprosate) is non-formulary at this time. The data available on this medication do not appear to justify its usage at this time.

Naltrexone is nonformulary at this time.

Vagus Nerve Stimulation is not a covered benefit under NorthSTAR.

VIII. Formulary Summary:

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A. Antidepressants:

i. Agents that do not require prior auth or copay:

<u>Name:</u>	<u>Max Dose w/o override:</u>
Fluoxetine (not 40mg tab)	60mg/d
Bupropion & Bupropion SR (not XL)	450mg/d
Paroxetine (not CR)	60mg/d
Mirtazapine	45mg
Citalopram	60mg
Sertraline	200 mg/day
Fluvoxamine	200 mg/day
Nefazodone	400 mg/day

ii. Agents that require prior auth and \$20 copay:

<u>Name:</u>	<u>Max Dose w/o override:</u>
Lexapro	20mg
Effexor	300mg
Effexor XR	300mg

B. New Generation Antipsychotics: (clozapine requires prior auth, but is not subject to wait list if in effect. Other agents may be subject to a wait list depending on available funding. See [Section III](#) for details.)

i. Preferred agents (must be tried first).

<u>Name:</u>	<u>Max Dose w/o override:</u>
Risperidone	6mg/d

ii. Non-preferred agents (may be used after preferred agents):

Geodon	80mg bid (160mg/d)
Abilify	30mg/d
Zyprexa	20mg/d
Seroquel	800mg/d

C. Mood Stabilizers: (Agents not listed are not formulary, see [Section IV](#) for details.) No dose override necessary.

- i. Agents that do not require prior auth or copay:

Name:

Lithium.

Valproic Acid.

Carbamazepine

Divalproex (generic Depakote)

- ii. Agents that require prior auth and \$20 copay: (may be eligible for copay waiver under certain circumstances, see [Section IV](#) for details).

Lithobid or Eskalith

Lamotrigine

Trileptal.

For other medications, please refer to the specific section.

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VI. The NorthSTAR Formulary:

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A. Open Formulary (No prior authorization or copay needed for Generics, although maximum dose without override may apply.):

Alprazolam	Imipramine
Amantadine	Levothyroxine
Amitriptyline	Lithium Carbonate
Amoxapine	Lithium Citrate
Atenolol	Lorazepam
Benzotropine	Loxapine
Bupropion and SR	Maprotiline
Buspirone (not 30mg)	Mesoridazine
Carbamazepine	Methylphenidate
Chlorodiazepoxide	Mirtazapine
Chlorpromazine	Molindone
Citalopram	Nortriptyline
Clomipramine	Nefazadone
Clonazepam	Oxazepam
Clonidine	Paroxetine (generic, not CR)
Clorazepate	Perphenazine
Depo-Provera	Phenelzine
Desipramine	Phenytoin
Dextroamphetamine	Propranolol
Diazepam	Sertraline
Diphenhydramine	Temazepam
Divalproex	Thioridazine
Doxepin	Thiothixene
Fluoxetine (generic, not 40mg tabs)	Tranylcypromine
Fluvoxamine	Trazodone
Fluphenazine	Trifluoperazine
Flurazepam	Trihexphenidyl
Gabapentin	Valproic Acid (not Depakote)
Haloperidol	Vitamin E
Hydroxyzine Pamoate (Vistaril) (Atarax-Hydroxyzine HCl is not formulary)	Zolpidem

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