

TENNCARE PRESCRIPTION COVERAGE FOR PEDIATRICS

WRITE FOR GENERIC !!! Most generics (if available) should be covered or at least are more likely to be covered. Occasionally though the preferred drug will be a brand name.

CO-PAYS: The only children's prescriptions that require a co-pay are for those few children who are on TENNCARE STANDARD and whose family incomes are at or above the federal poverty level. Most children are on TennCare Medicaid, so it does not apply.

PRESCRIPTION LIMITS: The 5 prescription per month limit applies **ONLY TO ADULTS** and those **FEW CHILDREN** who are on TennCare Standard and whose family incomes are at or above the federal poverty level (most kids are on TennCare Medicaid).

There are 2 kinds of drugs now—preferred drug list (PDL) and prior approval (PA). Even if a drug is preferred you may have to do step therapy before using it or your patient may have to meet clinical criteria.

If you need prior approval on a drug: Give prescription to patient, but tell them that you will have to get prior approval before they can fill it. You can give the info to Barbara, and she will call for approval. Barbara will need the Rx info, but also any pertinent clinical info and in many cases what treatment they have already failed.

Write monthly prescriptions for **31-day** supply.

On **ALLSCRIPTS**: The formulary "should be" up to date. Inform us of discrepancies. We are working on getting it in line with the new guidelines.

- * **Yellow face** (neutral face) means that the drug is **preferred** (may be generic or brand name)
- * **Green face** (smiling face) means a **generic drug that is not on preferred drug list**, but most generics should be paid for....
- * **PA**= prior approval

Some drug classes have not been addressed yet i.e., OCPs, etc.

TennCare **DOES PAY** for certain **OTC** drugs **NOW**:

Some of the ones we use most commonly are: (See sheet in clinic for full list)

Tylenol and Ibuprofen

Clotrimazole (Lotrimin)

Hydrocortisone 1%

Permethrin 1%

Triple abx ointment/bacitracin

Miconazole vaginal cream

Diphenhydramine

Multivitamins

Iron

Docusate

Prilosec OTC

Spacers

NaCl for nebulizer

Insulin supplies

8/30/2006

H2 BLOCKERS: All are covered as long as written generically i.e., **Ranitidine** vs. Zantac. **Zantac syrup** approved if under 12 yrs old.

PPIs: Must have failed 4 week trial of H2 blocker. Prior approval required for omeprazole and prevacid granules which we use most in infants. **Nexium, Prevacid, and Prilosec OTC** are preferred. Can only be given qday

CONSTIPATION: **Polyethylene glycol** (generic for Miralax) and **lactulose** are preferred.

ADHD MEDS: Adderall XR, Methylphenidate, amphetamine combo salts (gen Adderall), Metadate CD or ER, and Ritalin LA are preferred. Prior approval needed for Adderall, Concerta, Ritalin, Strattera,

ASTHMA: Spacers are covered.

ADVAIR is prior approval only. To qualify your patient must be using optimal doses of inhaled steroids and have breakthrough sx that require frequent use of inhaled short-acting bronchodilators.

INHALED CORTICOSTEROIDS: Pulmicort Respules: No PA needed unless > 6yrs old. Can only be given BID. Pulmicort turbuhaler is PA.

For inhalers: **FLOVENT HFA**, Asmanex, QVAR, and Azmacort are preferred.

ALBUTEROL MDI/SOLUTION: Preferred.

SINGULAIR: Preferred (if using for allergic rhinitis only—must have failed trial of non-sedating antihistamines and nasal steroid before trying)

NON-SEDATING ANTIHISTAMINES: No PA needed for kids under 2 years (for syrup) otherwise **SYRUPS are prior approval.** Combo meds only covered in kids >12 yrs. **Write for Loratadine.**

NASAL STEROIDS: Use **Nasonex** , **Nasacort AQ**, or **Flunisolide.**

ANTIHIAMINE EYE DROPS: **Elestat** and **Patanol** preferred

ANTIFUNGALS: **Griseofulvin** (all formulations) is preferred. Lamisil po is only for those with HIV, DM, immunocompromised—not for cosmetic purpose.

ANTIBIOTICS:

PCN: The generic PCN family of drugs are covered. There is a generic Augmentin ES 600/5ml!

CEPHALOSPORINS: Write for generic and you should be safe: cephalexin, cefadroxil, cefuroxime, etc. However, Suprax & Omnicef are preferred 3rd gen. and cefprozil & Ceftin suspensions are preferred 2nd gen.

MACROLIDES: Generic erythromycin, azyithromycin, clarithromycin, and Zithromax are preferred.

CLINDAMYCIN: Generic preferred. Cleocin (only liquid formulation) is covered per pharmacy.

QUINOLONES: Rarely used by us, but ciprofloxacin, ofloxacin, & Avelox are preferred.

ANTIBIOTIC EYE DROPS: Ciprofloxacin and Vigamox preferred. Any generic erythromycin, bacitracin, neomycin, polymyxin B combo is preferred. Sulfacetamide, Tobra, & Gent also preferred.

OTIC ANTIBIOTICS: **CiproDex** and **Floxin Otic** are preferred.

MIGRAINE: Maxalt and Zomig are preferred. Imitrex injectable is the only Imitrex formulation preferred.

TOPICAL IMMUNOMODULATORS: Elidel and Protopic preferred for atopic dermatitis. BUT pt must have failed a medium-high potency steroid cream (except for face/groin). Elidel is for mild to moderate eczema in kids >2yrs. Protopic 0.03% for mod-severe in ages >2 yrs. Protopic 0.1% for >18 yrs. REMEMBER BLACK BOX WARNING.