Medicaid Services Manual
Transmittal Letter

September 8, 2025

To: Custodians of Medicaid Services Manual

From: Casey Angres
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 1200 – Prescribed Drugs

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 1200 – Prescribed Drugs are being proposed to update the age requirement in Appendix A, Section BBBB. Anticonvulsants, Subsection 3. Valtoco® from six to two years or older. Moved the following sections from Appendix B to Appendix A: Appendix B, Section 2 – Medications with Gender/Age Edits – Prenatal Vitamins to Appendix A, Section 2.; Appendix B, Section 2 – Medications with Gender/Age Edits – Oral/Topical Contraceptives to Appendix A, Section 2.; Appendix B, Section 2 – Medications with Gender/Age Edits – Gender Edits to Appendix A, Section 2.; Appendix B, Section 2 – Medications with Gender/Age Edits – Vitamins with Fluoride to Appendix A, Section 2.; Appendix B, Section 3. – Antiretrovirals to Appendix A, Section 3.; and Appendix B, Section 4. – Diabetic Supply Program to Appendix A, Section 4.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective September 8, 2025.

Material Transmitted	Material Superseded
MTL N/A Chapter 1200– Prescribed Drugs	MTL N/A Chapter 1200– Prescribed Drugs

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section BBBB. Subsection 3	**Anticonvulsants**	Valtoco® - Updated age requirement from six to two years or older.
Appendix A Section 2	**Medications with Gender/Age Edits**	Moved from Appendix B.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section 2	**Oral/Topical Contraceptive**	Moved from Appendix B.
Appendix A Section 2	**Gender Edits**	Moved from Appendix B.
Appendix A Section 2	**Vitamins with Fluoride**	Moved from Appendix B.
Appendix A Section 3.	**Antiretrovirals**	Moved from Appendix B.
Appendix A Section 4.	**Diabetic Supply Program**	Moved from Appendix B.

BBBB. Anticonvulsants

Therapeutic Class: Anticonvulsants
Last Reviewed by the DUR Board: April 22, 2021

Anticonvulsants are subject to PA and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Cannabinoid

   a. Epidiolex® (cannabidiol)

      1. Approval will be given if the following criteria are met and documented:

         a. The recipient has a diagnosis of Lennox-Gastaut syndrome, Dravet Syndrome or Tuberous Sclerosis Complex (TSC); and

         b. The recipient is one years of age or older; and

         c. A recent serum transaminase (ALT and AST) and total bilirubin level has been obtained and is within normal limits; and

         d. The drug is prescribed by or in consultation with a neurologist; and

         e. The total dose does not exceed 20 mg/kg/day (10 mg/kg twice daily) for LGS/DS or 25 mg/kg/day (12.5 mg/kg twice daily)

         f. The medication will be used as adjunctive therapy in recipients with uncontrolled seizure management (the recipient has taken one or more antiepileptic drugs and has chart notes confirming persistent seizure events after titration of current anti-seizure regiment to highest tolerated doses).

      2. Recertification Requests

         a. Documentation of a positive clinical response to Epidiolex® therapy; and

         b. Serum transaminase (ALT and AST) and total bilirubin level has been re-checked per package insert.

      3. PA Guidelines

         a. Initial PA will be for three months.

         b. Recertification approval will be for 12 months.

4. For anticonvulsant criteria for children and adolescents, refer to Section N, titled Psychotropic Medications for Children and Adolescents.

2. Nayzilam® (midazolam)

a. Approval will be given if the following criteria are met and documented:

1. The recipient has a diagnosis of acute intermittent seizures; and

2. The recipient is at least 12 years of age; and

3. The medication is prescribed by or in consultation with a neurologist; and

4. The dose must not exceed two sprays per seizure cluster, no more than one episode every three days and treat no more than five episodes per month.

b. Recertification Requests

1. Documentation of positive clinical response to Nayzilam® therapy.

c. PA Guidelines

1. Initial PA will be for six months.

2. Recertification approval will be for 12 months.

3. Valtoco® (diazepam)

a. Approval will be given if all the following criteria are met and documented:

1. The recipient has a diagnosis of epilepsy; and

2. The recipient is ~~six~~ two years or older; and

3. The medication is prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern; and

4. The medication is prescribed by or in consultation with a neurologist; and

5. The quantity must not exceed five episodes per month.

b. PA Guidelines:

1. Documentation of positive clinical response to Valtoco® therapy.

c. PA Guidelines:

1. Initial authorization will be approved for six months.

2. Recertification approval will be approved for 12 months.

4. Fintepla® (fenfluramine)

   a. Approval will be given if all the following criteria are met and documented:

      1. The recipient has a documented diagnosis of seizures associated with Dravet Syndrome; and

      2. The recipient is two years of age or older; and

      3. The medication is prescribed by or in consultation with a neurologist.

   b. Recertification Requests:

      1. The recipient has documentation of positive clinical response to Fintepla® therapy.

   c. PA Guidelines:

      1. Initial authorization will be for 12 months.

      2. Recertification approval will be for 12 months.

5. Ztalmy® (ganaxolone)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is ≥2 years of age; and

2. Recipient has a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) confirmed with genetic testing; and

3. Recipient has tried and/or is concomitantly receiving ≥2 other anticonvulsant medications; and

4. Ganaxolone is prescribed by or in consultation with a neurologist.

b. Dosage Limits

1. Max Daily Dose is 1,800 mg

c. Recertification Requests:

1. Recipient must continue to meet the above criteria; and

2. Prescriber attests to stabilization of disease or reduction in seizure frequency from baseline; and

3. Recipient has not experienced any treatment-restricting adverse effects (e.g., somnolence, pyrexia, suicidal thoughts, or behavior).

d. PA Guidelines:

1. Initial approval will be given for six months.

2. Recertification will be given for 12 months.

2. MEDICATIONS WITH GENDER/AGE EDITS

A Prenatal Vitamins

1. Payable only for female recipients.

2. Exemption to the above gender edits:

   A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriated ICD code is documented on the prescription and transmitted on the claim.

B Oral/Topical Contraceptives

1. Payable only for female recipients.

2. Exemption to the above gender edits:

A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriate ICD code is documented on the prescription and transmitted on the claim.

C Gender Edits

1. Hormones

a. Estrogen – payable only for female recipients.

b. Progestins – payable only for female recipients.

c. Estrogen and Androgen Combinations – payable only for female recipients.

d. Estrogen and Progestin Combinations – payable only for female recipients.

e. Contraceptive Hormones – payable only for female recipients.

f. Testosterone – payable only for male recipients.

g. Androgen Hormone Inhibitor – payable only for male recipients.

2. Exception to the above gender edits:

A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriated ICD code is documented on the prescription and transmitted on the claim.

D Vitamins with Fluoride

1. Payable only for recipients up to age 21 years.

3. ANTIRETROVIRALS

Antiretrovirals for the treatment of HIV/AIDS are a covered benefit for Nevada Medicaid recipients. The FDA approved antiretrovirals whose manufacturers participate in the federal Drug Rebate Program and are not Drug Efficacy Study and Implementation (DESI) drugs, are covered.

4. DIABETIC SUPPLY PROGRAM

Diabetic Supplies are subject to PA and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

PA is required for preferred and non-preferred diabetic products (including insulin delivery system and Continuous Glucose Monitor [CGM] receivers and readers).

Preferred (including sensors and transmitters) and non-preferred (including tubing, reservoirs for pumps and transmitters and sensors for CGMs) diabetic supplies do not require a PA. These items require a documented diagnosis of Diabetes Mellitus Type I (DM1), Diabetes Mellitus Type II (DM2) (if applicable), or gestational diabetes, and recipients must meet all age restrictions stated on the manufacturer's label.

Pharmacy benefit allows a 100-day supply for insulin system and CGM supplies.

A. Preferred Insulin Delivery System

1. Approval will be given if the following criteria are met and documented:

   a. Recipient must have a documented diagnosis of DM1 or Gestational Diabetes; and

   b. The product must be prescribed by, or in consultation with, an endocrinologist; and

   c. The recipient must meet all age restrictions stated in the manufacturer's label; and

   d. The recipient must have been compliant on their current antidiabetic regimen for at least the last six months and this regimen must include multiple day injections of insulin (requiring at least three injections per day); and

   e. One of the following:

      1. Documented history of recurring hypoglycemia; or

      2. Wide fluctuations in pre-meal blood glucose, history of sever glycemic excursions or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200 mg/dL; or

      3. Prior use of an insulin pump with documented frequency of glucose self-testing of at least four times per day in the month immediately prior to the request.

2. PA Guidelines
   a. Initial PA approval will be for one year.

3. Recertification Request

a. Recertification of PA approval will be given if the recipient has documented positive clinical response to the product (including current HbA1C).

b. Recertification PA approval will be for one year.

B. Non-Preferred Insulin Delivery System

1. Approval will be given if the following criteria are met and documented:

a. In addition to meeting the "Preferred Insulin Delivery System" criteria, the recipient must also meet the following:

1. The recipient must have been trained to use the non-preferred product; and

2. The recipient must have benefited from use of the non-preferred product; and

3. The recipient must have one of the following reasons/special circumstances:

4. Recipient has had an allergic reaction to a preferred product or related supply; or

5. Recipient has a visual impairment which requires the use of a non-preferred product; or

6. Recipient has medical necessity justification (e.g., mental or physical limitation) which requires them to stay on their current product.

C. Preferred CGMs

1. Approval will be given if the following criteria are met and documented:

a. Recipient must have a documented diagnosis of DM1, DM2, or Gestational Diabetes; and

b. Recipient must meet all age restrictions stated in the manufacturer's label; and

c. Recipient must have been compliant on their current antidiabetic regimen for at least the last six months and this regimen must include multiple daily injections of insulin (requiring at least three injections per day); and

d. One of the following:

1. Documented history of recurring hypoglycemia; or

2. Wide fluctuations in pre-meal blood glucose, history of sever glycemic excursions, or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200 mg/dL; or

3. Recipient is currently using insulin pump therapy while continuing to need frequent dosage adjustments or experiencing recurring episodes of severe hypoglycemia (50 mg/dL).

2. PA Guidelines

a. Initial PA approval will be for one year.

D. Non-Preferred CGM

1. Approval will be given if the following criteria are met and documented:

a. In addition to meeting the Preferred CGM criteria, the recipient must also meet the following:

1. Recipient has had an allergic reaction to a preferred product or related supply; or

2. Recipient has a visual impairment which requires the use of a non-preferred product; or

3. Recipient has medical necessity justification (e.g., mental or physical limitation) which requires them to stay on their current product; or

4. The recipient must have been trained to use the non-preferred product; and

5. The recipient must have benefited from use of the non-preferred product.

E. Test Strips and Lancets

Blood Glucose monitors with special features (e.g., voice synthesizers) require a PA. For special blood glucose monitors, a diagnosis and a statement from the physician documenting the impairment is required with a PA.

~~2. MEDICATIONS WITH GENDER/AGE EDITS~~

~~A. Prenatal Vitamins~~

~~1. Payable only for female recipients.~~

~~2. Exemption to the above gender edits:~~

~~A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriate International Classification of Diseases (ICD) code is documented on the prescription and transmitted on the claim.~~

~~B. Oral/Topical Contraceptives~~

~~1. Payable only for female recipients.~~

~~2. Exemption to the above gender edits:~~

~~A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriate ICD code is documented on the prescription and transmitted on the claim.~~

~~C. Gender Edits~~

~~1. Hormones~~

~~a. Estrogen – payable only for female recipients.~~

~~b. Progestins – payable only for female recipients.~~

~~c. Estrogen and Androgen Combinations – payable only for female recipients.~~

~~d. Estrogen and Progestin Combinations – payable only for female recipients.~~

~~e. Contraceptive Hormones – payable only for female recipients.~~

~~f. Testosterone – payable only for male recipients.~~

~~g. Androgen Hormone Inhibitor – payable only for male recipients.~~

~~2. Exception to the above gender edits:~~

~~A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriate ICD code is documented on the prescription and transmitted on the claim.~~

~~D. Vitamins with Fluoride~~

~~1. Payable only for recipients up to age 21 years.~~

~~3. ANTIRETROVIRALS~~

~~Antiretrovirals for the treatment of Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) are a covered benefit for Nevada Medicaid recipients. The Food and Drug Administration (FDA) approved antiretrovirals whose manufacturers participate in the federal Drug Rebate Program and are not Drug Efficacy Study and Implementation (DESI) drugs, are covered.~~

4. DIABETIC SUPPLY PROGRAM

Diabetic Supplies are subject to prior authorization (PA) and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the Drug Use Review (DUR) Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

PA is required for preferred and non-preferred diabetic products (including insulin delivery system and Continuous Glucose Monitor [CGM] receivers and readers).

Preferred (including sensors and transmitters) and nonpreferred (including tubing, reservoirs for pumps and transmitters and sensors for CGM's) diabetic supplies do not require a prior authorization. These items require a documented diagnosis of Diabetes Mellitus Type I (DM1), Diabetes Mellitus Type II (DM2) (if applicable), or gestational diabetes and recipients must meet all age restrictions stated on the manufacturer's label.

Pharmacy benefit allows a 100-day supply for insulin system and CGM supplies.

A. Preferred Insulin Delivery System

1. Approval will be given if the following criteria are met and documented:

a. Recipient must have a documented diagnosis of DM1 or Gestational Diabetes; and

b. The product must be prescribed by or in consultation with an endocrinologist; and

c. The recipient must meet all age restrictions stated in the manufacturer's label; and

d. The recipient must have been compliant on their current antidiabetic regimen for at least the last six months and this regimen must include multiple day injections of insulin (requiring at least three injections per day); and

e. One of the following:

1. Documented history of recurring hypoglycemia; or

2. Wide fluctuations in pre-meal blood glucose, history of severe glycemic excursions or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200 milligram (mg)/deciliter (dL), or

3. Prior use of an insulin pump with documented frequency of glucose self-testing of at least four times per day in the month immediately prior to the request.

2. PA Guidelines

a. Initial PA approval will be for one year.

3. Recertification Request

a. Recertification of PA approval will be given if the recipient has documented positive clinical response to the product (including current HbA1C).

b. Recertification PA approval will be for one year.

B. Non-Preferred Insulin Delivery System

1. Approval will be given if the following criteria are met and documented:

a. In addition to meeting the "Preferred Insulin Delivery System" criteria, the recipient must also meet the following:

1. The recipient must have been trained to use the non-preferred product; and

2. The recipient must have benefited from use of the non-preferred product; and

3. The recipient must have one of the following reasons/special circumstances:

4. Recipient has had an allergic reaction to a preferred product or related supply; or

5. Recipient has a visual impairment which requires the use of a non-preferred product; or

6. Recipient has medical necessity justification (e.g., mental or physical limitation) which requires them to stay on their current product.

C. Preferred CGMs

1. Approval will be given if the following criteria are met and documented:

a. Recipient must have a documented diagnosis of DM1, DM2, or Gestational Diabetes; and

b. Recipient must meet all age restrictions stated in the manufacturer's label; and

c. Recipient must have been compliant on their current antidiabetic regimen for at least the last six months and this regimen must include multiple daily injections of insulin (requiring at least three injections per day); and

d. One of the following:

1. Documented history of recurring hypoglycemia; or

2. Wide fluctuations in pre-meal blood glucose, history of severe glycemic excursions or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200 mg/dL; or

3. Recipient is currently using insulin pump therapy while continuing to need frequent dosage adjustments or experiencing recurring episodes of severe hypoglycemia (50 mg/dL).

2. PA Guidelines

a. Initial PA approval will be for one year.

D. Non-Preferred CGM

1. Approval will be given if the following criteria are met and documented:

a. In addition to meeting the Preferred CGM criteria, the recipient must also meet the following:

1. Recipient has had an allergic reaction to a preferred product or related supply; or

2. Recipient has a visual impairment which requires the use of a non-preferred product; or

3. Recipient has medical necessity justification (e.g., mental or physical limitation) which requires them to stay on their current product; or

4. The recipient must have been trained to use the non-preferred product; and

5. The recipient must have benefited from use of the non-preferred product.

E. Test Strips and Lancets

Blood Glucose monitors with special features (e.g., voice synthesizers) require a PA. For special blood glucose monitors, a diagnosis and a statement from the physician documenting the impairment is required with a PA.