

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>ADD/ADHD/ NARCOLEPSY AGENTS</p> <p><i>Use ADD/ADHD/Narcolepsy Agents PA form</i></p>	<p>Prior authorization (PA) is required for ADD/ADHD/Narcolepsy agents for patients 21 years of age or older under the following conditions:</p> <ol style="list-style-type: none"> 1. Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-IV criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV). Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more environments (social, academic, or occupational). 2. Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG). 3. Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist. <p>Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. *If a non-preferred long-acting medication is requested, a trial of the preferred immediate release and extended release product of the same chemical entity is required.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Alpha₂ Agonists, Extended-Release</p> <p><i>Intuniv™ Kapvay™</i></p> <p><i>Use Alpha₂ Agonists, Extended-Release PA form</i></p>	<p>Prior authorization is required for extended-release alpha₂ agonists. Payment will be considered for patients when the following is met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of ADHD and is between 6 and 17 years of age; and 2. Previous trial with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and 3. Previous trial and therapy failure at a therapeutic dose with one preferred amphetamine and one preferred non-amphetamine stimulant; and 4. Previous trial and therapy failure at a therapeutic dose with atomoxetine (Strattera®). <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Alpha₁-Proteinase Inhibitor Enzymes</p> <p><i>Use Miscellaneous PA form</i></p>	<p>Prior authorization is required for Alpha₁-Proteinase Inhibitor enzymes. Payment will be authorized only for cases in which there is a diagnosis of congenital alpha₁-proteinase inhibitor (alpha₁-PI; alpha1-antitrypsin) deficiency with clinically demonstrable panacinar emphysema. Payment for a non-preferred Alpha₁-Proteinase Inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.</p>
<p>Amylino Mimetic (Symlin®)</p> <p><i>Use Amylino Mimetic (Symlin®) form</i></p>	<p>Prior authorization is required for amylin mimetics (Symlin®). Payment will be considered under the following conditions: 1) Diagnosis of Type 1 or Type 2 diabetes mellitus, 2) Concurrent use of insulin therapy, 3) Documentation of blood glucose monitoring three or more times daily, 4) Inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin dosing regimens. Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period.</p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Angiotensin Receptor Blocker Before ACE Inhibitor</p> <p><i>Use Angiotensin Receptor Blocker Before ACE Inhibitor PA form</i></p>	<p>Payment for Angiotensin Receptor Blockers (ARB) and Angiotensin Receptor Blocker Combinations will only be considered for cases in which there is a contraindication or therapy failure with at least one ACE-I or ACE-I Combination. A completed prior authorization form will need to be submitted if a trial with an ACE-I or ACE-I Combination of at least 30 days in length is not found in the point-of-sale system and/or unless evidence is provided that use of an ACE-I or ACE-I Combination would be medically contraindicated. Prior authorization is required for all non-preferred ARBs and ARB Combinations the first day of therapy. Payment for a non-preferred ARB or ARB Combination will be considered following documentation of recent trials and therapy failures with a preferred ACE-I or ACE-I Combination AND a preferred ARB or ARB Combination.</p>
<p>Anti-Acne</p> <p><i>Use Anti-Acne PA form</i></p>	<p>Prior authorization is required for all prescription topical acne products. Payment for the treatment of mild to moderate acne vulgaris will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Previous trial and therapy failure with a preferred over-the-counter benzoyl peroxide product, which is covered by the program without prior authorization. 2. Payment for non-preferred topical acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical agents of a different chemical entity. 3. If the patient presents with a preponderance of comedonal acne, topical retinoid products may be utilized as first line agents with prior authorization (use Topical Retinoids PA form). 4. Requests for non-preferred combination products may only be considered after documented separate trials and therapy failures with the individual ingredients. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents</p> <p><i>Use Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents form</i></p>	<p>Prior authorization is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the following dosage limits per month. Payment for Antiemetic-5HT3 Receptor Agonists/ Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation.</p> <p>Prior authorization will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent in this class. Note: Aprepitant (Emend®) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>Aprepitant (N)/Emend® (N):</p> <ul style="list-style-type: none"> 4 – 125mg capsules 8 – 80mg capsules <p>Dolasetron (N)/Anzemet® (N):</p> <ul style="list-style-type: none"> 5 – 50mg/100mg tablets 4 vials (100mg/5mL) 8 ampules (12.5mg/0.625mL) <p>Granisetron (N)/Kytril®/Granisol™ (N):</p> <ul style="list-style-type: none"> 8 – 1mg tablets 30mL – oral solution (1mg/5mL) 8 vials (1mg/mL) 2 vials (4mg/mL) </td> <td style="width: 50%; vertical-align: top;"> <p>Ondansetron (P)/Zofran® (N):</p> <ul style="list-style-type: none"> 12 – 4mg tablets 12 – 8mg tablets 4 – 24mg tablets 4 – 20mL vials (2mg/mL) 8 – 2mL vials (2mg/mL) <p>Ondansetron ODT (P)/Zofran® ODT (N):</p> <ul style="list-style-type: none"> 12 – 4mg tablets 12 – 8mg tablets <p>Ondansetron Oral Solution (N)/ Zofran® Oral Solution (N)</p> <ul style="list-style-type: none"> 50mL/month – oral solution (4mg/5mL) <p>Palonosetron (N)/ Aloxi® (N):</p> <ul style="list-style-type: none"> 4 vials (0.25mg/5mL) </td> </tr> </table>	<p>Aprepitant (N)/Emend® (N):</p> <ul style="list-style-type: none"> 4 – 125mg capsules 8 – 80mg capsules <p>Dolasetron (N)/Anzemet® (N):</p> <ul style="list-style-type: none"> 5 – 50mg/100mg tablets 4 vials (100mg/5mL) 8 ampules (12.5mg/0.625mL) <p>Granisetron (N)/Kytril®/Granisol™ (N):</p> <ul style="list-style-type: none"> 8 – 1mg tablets 30mL – oral solution (1mg/5mL) 8 vials (1mg/mL) 2 vials (4mg/mL) 	<p>Ondansetron (P)/Zofran® (N):</p> <ul style="list-style-type: none"> 12 – 4mg tablets 12 – 8mg tablets 4 – 24mg tablets 4 – 20mL vials (2mg/mL) 8 – 2mL vials (2mg/mL) <p>Ondansetron ODT (P)/Zofran® ODT (N):</p> <ul style="list-style-type: none"> 12 – 4mg tablets 12 – 8mg tablets <p>Ondansetron Oral Solution (N)/ Zofran® Oral Solution (N)</p> <ul style="list-style-type: none"> 50mL/month – oral solution (4mg/5mL) <p>Palonosetron (N)/ Aloxi® (N):</p> <ul style="list-style-type: none"> 4 vials (0.25mg/5mL)
<p>Aprepitant (N)/Emend® (N):</p> <ul style="list-style-type: none"> 4 – 125mg capsules 8 – 80mg capsules <p>Dolasetron (N)/Anzemet® (N):</p> <ul style="list-style-type: none"> 5 – 50mg/100mg tablets 4 vials (100mg/5mL) 8 ampules (12.5mg/0.625mL) <p>Granisetron (N)/Kytril®/Granisol™ (N):</p> <ul style="list-style-type: none"> 8 – 1mg tablets 30mL – oral solution (1mg/5mL) 8 vials (1mg/mL) 2 vials (4mg/mL) 	<p>Ondansetron (P)/Zofran® (N):</p> <ul style="list-style-type: none"> 12 – 4mg tablets 12 – 8mg tablets 4 – 24mg tablets 4 – 20mL vials (2mg/mL) 8 – 2mL vials (2mg/mL) <p>Ondansetron ODT (P)/Zofran® ODT (N):</p> <ul style="list-style-type: none"> 12 – 4mg tablets 12 – 8mg tablets <p>Ondansetron Oral Solution (N)/ Zofran® Oral Solution (N)</p> <ul style="list-style-type: none"> 50mL/month – oral solution (4mg/5mL) <p>Palonosetron (N)/ Aloxi® (N):</p> <ul style="list-style-type: none"> 4 vials (0.25mg/5mL) 		
<p>Anti-Fungal</p> <p><i>Use Anti-Fungal PA form</i></p>	<p>Prior authorization is not required for preferred oral antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. Prior authorization will be required for all non-preferred oral antifungal therapy beginning the first day of therapy. Payment for a non-preferred oral antifungal will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment for any oral antifungal therapy beyond a cumulative 90 days of therapy per 12-month period per patient will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This prior authorization requirement does not apply to nystatin.</p>		

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Antihistamines</p> <p><i>Use Antihistamine PA form</i></p>	<p>Prior authorization is required for all non-preferred oral antihistamines.</p> <p>Patients 21 years of age and older must have three unsuccessful trials with antihistamines that do not require prior authorization, prior to the approval of a non-preferred oral antihistamine. Two of the trials must be with cetirizine and loratadine.</p> <p>Patients 20 years of age and younger must have unsuccessful trials with cetirizine and loratadine prior to the approval of a non-preferred oral antihistamine.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Anti-Thrombotics, Injectable</p> <p><i>Use Anti-Thrombotic Injectable PA form</i></p>	<p>Prior authorization is required for use of any preferred injectable anti-thrombotic agent longer than 10 consecutive days. Prior authorization will be required for all non-preferred injectable anti-thrombotic agents beginning the first day of therapy. Payment for non-preferred anti-thrombotic injectable agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment for usage of injectable anti-thrombotic agents beyond this limit will be authorized for cases in which there is a clinical diagnosis of:</p> <ol style="list-style-type: none"> 1. Pregnancy or planned pregnancy 2. Cancer-associated thromboembolic disease 3. Anti-thrombin III deficiency 4. Warfarin allergy 5. History of thrombotic event while on therapeutic anticoagulant therapy. 6. Total hip arthroplasty.
<p>Becaplermin (Regranex®)</p> <p><i>Use Regranex® PA form</i></p>	<p>Prior authorization is required for Regranex®. Payment for new prescriptions will be authorized for ten weeks for patients who meet the following criteria:</p> <ol style="list-style-type: none"> 1. Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond 2. Inadequate response to 2 weeks of wound debridement and topical moist wound dressing <p>Longer than 10 weeks will be authorized for patients who meet the following criteria: Wound has decreased in size by 30% after 10 weeks</p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Biologicals for Arthritis <i>Abatacept (Orencia®)</i> <i>Adalimumab (Humira®)</i> <i>Anakinra (Kineret®)</i> <i>Certolizumab Pegol (Cimzia®)</i> <i>Etanercept (Enbrel®)</i> <i>Infliximab (Remicade®)</i> <i>Golimumab (Simponi™)</i></p> <p><i>Use Biologicals for Arthritis PA form</i></p>	<p>Prior authorization is required for biologicals used for arthritis. Patients initiating therapy with a biological agent must:</p> <ol style="list-style-type: none"> 1. Be screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; 2. Have not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; 3. Not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less; and 4. Be screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment. <p>Payment will be considered under the following conditions:</p> <p>A diagnosis of rheumatoid arthritis (RA):</p> <ol style="list-style-type: none"> 1. A trial and inadequate response to two preferred disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline). 2. Upon an unsuccessful methotrexate trial in patients with established RA, the combination trial with a second DMARD may be overridden if there is evidence of severe disease documented by radiographic erosions. <p>A diagnosis of moderate to severe psoriatic arthritis: A trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).</p> <p>A diagnosis of moderate to severe juvenile idiopathic arthritis: A trial and inadequate response to intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated</p> <p>Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of a previous trials and therapy failures with two preferred biological agents.</p>
---	--

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Biologicals for Inflammatory Bowel Disease</p> <p><i>Adalimumab (Humira®)</i> <i>Certolizumab Pegol (Cimzia®)</i> <i>Infliximab (Remicade®)</i></p> <p><i>Use Biologicals for Inflammatory Bowel Disease PA form</i></p>	<p>Prior authorization is required for biologicals used for inflammatory bowel disease. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.</p> <ul style="list-style-type: none"> • Crohn’s Disease – Payment will be considered following an inadequate response to two preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate. • Ulcerative colitis (moderate to severe) – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine.
<p>Biologicals for Plaque Psoriasis</p> <p><i>Alefacept (Amevive®)</i> <i>Adalimumab (Humira®)</i> <i>Etanercept (Enbrel®)</i> <i>Infliximab (Remicade®)</i></p> <p><i>Use Biologicals for Plaque Psoriasis PA form</i></p>	<p>Prior authorization is required for biologicals used for plaque psoriasis. Payment will be considered following an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine. Payment for non-preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents.</p>
<p>Buprenorphine (Butrans™) Transdermal System</p> <p><i>Use Buprenorphine (Butrans™) Transdermal System PA form</i></p>	<p>Prior authorization is required for Butrans™. Payment will be considered when the following conditions are met:</p> <ol style="list-style-type: none"> 1. Previous trials and therapy failures at a therapeutic dose with two long acting opioids. The preferred trials must allow for adequate dose titration and show use of a short acting narcotic for breakthrough pain. 2. A trial and therapy failure with fentanyl patch at maximum tolerated dose. <p>The required trials may be overridden when documented evidence it provided that use of these agents would be medically contraindicated.</p>

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Colchicine (Colcrys®)</p> <p><i>Use Colchicine (Colcrys®) PA form</i></p>	<p>Prior authorization is not required for colchicine (Colcrys®) for the treatment of acute gout for three (3) tablets per 60-day period. Prior authorization is required for colchicine (Colcrys®) for the treatment of chronic hyperuricemia/gout prophylaxis or Familial Mediterranean fever. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Chronic hyperuricemia/gout prophylaxis following a trial and therapy failure at a therapeutic dose with allopurinol or probenecid. A quantity limit of sixty (60) tablets per thirty (30) days will be applied, when criteria for coverage are met. 2. Familial Mediterranean fever. A maximum quantity of 120 tablets per thirty (30) days will be applied for this diagnosis. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Concurrent IM/PO Antipsychotic Use</p> <p><i>Use Concurrent IM/PO Antipsychotic Utilization PA form</i></p>	<p>A prior authorization is required for concurrent long acting injectable and oral antipsychotic medications after 12 weeks (84 days) of concomitant treatment. Consideration of concomitant therapy beyond 12 weeks (84 days) will require documentation of medical necessity. Prior authorization is required for all non-preferred antipsychotics as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred antipsychotics will be considered only for cases in which there is documentation of previous trials and therapy failures with a preferred agent.</p>
<p>Crizotinib (Xalkori®)</p> <p><i>Use Xalkori® PA form</i></p>	<p>Prior authorization is required for Xalkori® (crizotinib). Payment will be considered for patients when the following is met:</p> <ol style="list-style-type: none"> 1. Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test (attach copy of results); and 2. Is prescribed by an oncologist.
<p>DPP-4 Inhibitors</p> <p><i>Use DPP-4 Inhibitor PA form</i></p>	<p>Prior authorization is required for dipeptidyl peptidase-4 (DPP-4) inhibitors and DPP-4 Inhibitor Combinations. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. A diagnosis of Type 2 Diabetes Mellitus 2. Patient is 18 years of age or older 3. The patient has not achieved HbgA1C goals using a combination of two or more antidiabetic medications (metformin, sulfonylurea, thiazolidinedione, or insulin) at maximum tolerated doses unless otherwise contraindicated. <p>Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated.</p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Dabigatran (Pradaxa®)</p> <p><i>Use Dabigatran (Pradaxa®) PA form</i></p>	<p>Prior authorization is required for dabigatran (Pradaxa®). Payment will be considered for patients under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of non-valvular atrial fibrillation; and 2. Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial); and 3. Presence of at least one additional risk factor for stroke, with a CHADS₂ score ≥ 1; and 4. Patient does not have a mechanical prosthetic heart valve; and 5. Patient does not have active pathological bleeding; and 6. Patient does not have severe renal impairment (CrCl < 15mL/min) or is not on dialysis. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Dalfampridine (Ampyra™)</p> <p><i>Use Dalfampridine (Ampyra™) PA form</i></p>	<p>Prior authorization is required for dalfampridine (Ampyra™). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. For patients that have a gait disorder associated with MS. 2. Initial authorizations will be approved for 12 weeks with a baseline Timed 25-foot Walk (T25FW) assessment. 3. Additional prior authorizations will be considered at 6 month intervals after assessing the benefit to the patient as measured by a 20% improvement in the T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained. <p>Prior authorizations will not be considered for patients with a seizure diagnosis or in patients with moderate to severe renal impairment.</p>
<p>Dextromethorphan and Quinidine (Nuedexta™)</p> <p><i>Use Dextromethorphan and Quinidine (Nuedexta™) PA form</i></p>	<p>Prior authorization is required for Nuedexta™. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS). 2. A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI. 3. Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire. 4. Subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire.
<p>Dornase Alfa (Pulmozyme®)</p> <p><i>Use Miscellaneous PA form</i></p>	<p>Prior authorization is required for Pulmozyme®. Payment will be authorized only for cases in which there is a diagnosis of cystic fibrosis.</p>
<p>Duloxetine (Cymbalta®)</p> <p><i>Use Chronic Pain Syndromes PA form</i></p>	<p><i>See Chronic Pain Syndromes Prior Authorization Criteria.</i></p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Fentanyl, Short Acting Oral Products</p> <p><i>Use Short Acting Oral Fentanyl Products PA form</i></p>	<p>Prior authorization is required for short acting oral fentanyl products. Payment will be considered only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. These products carry a Black Box Warning. Actiq[®], Fentora[®], & Onsolis[™]:</p> <ul style="list-style-type: none"> • Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain. • Are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.
<p>Fifteen Day Initial Prescription Supply Limit</p> <p><i>Use Fifteen Day Initial Prescription Supply Limit PA form</i></p>	<p>Designated drugs are limited to a fifteen day initial supply. These drugs are identified on the Fifteen Day Initial Prescription Supply Limit list located on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab. Providers must submit a prior authorization request for override consideration. Documentation of medical necessity, excluding patient convenience, is required for consideration of the fifteen day initial supply override.</p>
<p>Granulocyte Colony Stimulating Factor Agents</p> <p><i>Use Granulocyte Colony Stimulating Factor PA form</i></p>	<p>Prior authorization is required for therapy with granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Laboratory values for complete blood and platelet count must be obtained as directed by the manufacturer's instructions. Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines. Payment shall be authorized for one of the following uses:</p> <ol style="list-style-type: none"> 1. Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy. 2. Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant. 3. Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy. 4. Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Incretin Mimetic</p> <p><i>Byetta[®]</i> <i>Victoza[®]</i> <i>Bydureon[™]</i></p> <p><i>Use Incretin Mimetic form</i></p>	<p>Prior authorization is required for incretin mimetics. Payment will be considered under the following conditions: 1) Diagnosis of Type 2 diabetes mellitus, 2) Unless otherwise contraindicated, the member has not achieved HbgA1C goals using a combination of two or more antidiabetic medications (metformin, sulfonylurea, or thiazolidinedione) at maximum therapeutic doses. Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period. Payment for a non-preferred medication will be authorized only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent, unless evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Insulin, Pre-Filled Pens</p> <p><i>Use Pre-filled Insulin Pen PA form</i></p>	<p>Prior authorization is required for pre-filled insulin pens. Prior authorization is granted when documentation indicates:</p> <ul style="list-style-type: none"> • The patient’s visual or motor skills are impaired to such that they cannot accurately draw up their own insulin, and • There is no caregiver available to provide assistance. <p>Prior authorization for non-preferred insulin pens will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.</p>
<p>Isotretinoin (Oral)</p> <p><i>Use Oral Isotretinoin PA form</i></p>	<p>Prior authorization is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne under the following conditions:</p> <ol style="list-style-type: none"> 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata. 2. Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (www.ipledgeprogram.com) risk management program. <p>Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent</p>
<p>Ivacaftor (Kalydeco[™])</p> <p><i>Use Kalydeco[™] PA form</i></p>	<p>Prior authorization is required for Kalydeco[™] (ivacaftor). Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient is 6 years of age or older; and 2. Has a diagnosis of cystic fibrosis with a G551D mutation in the CFTR gene as detected by a FDA-cleared CF mutation test; and 3. Prescriber is a CF specialist or pulmonologist; and 4. Patient does not have one of the following infections: <i>Burkholderia cenocepacia, dolosa, or Mycobacterium abscessus</i>.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Janus Kinase Inhibitors</p> <p><i>Use Janus Kinase Inhibitor PA form</i></p>	<p>Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered when the following conditions are met:</p> <ol style="list-style-type: none"> 1. The patient is 18 years of age or older; and 2. Has a diagnosis of moderate to severe rheumatoid arthritis; and 3. Has a documented trial and inadequate response to two preferred oral disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline); and 4. Has a documented trial and inadequate response to two preferred biological DMARDs; and 5. The patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and 6. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and 7. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and 8. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and 9. Patient is not at an increased risk of gastrointestinal perforation. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Ketorolac</p> <p><i>Use Ketorolac PA form</i></p>	<p>Prior authorization is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions. This product carries a Black Box Warning. Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given. 2. Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40mg/day. Maximum IV/IM dose is 120mg/day. Maximum intranasal dose is 126mg/day. Maximum combined duration of therapy is 5 days per month. 3. Diagnosis indicating moderately severe, acute pain. <p>Requests for IV/IM and intranasal ketorolac must document previous trials and therapy failures with at least two preferred non-steroidal anti-inflammatory drugs at therapeutic doses.</p>
<p>Lidocaine Patch (Lidoderm®)</p> <p><i>Use Lidocaine Patch (Lidoderm®) PA form</i></p>	<p>Prior authorization is required for topical lidocaine patches (Lidoderm®). Payment will be considered for a diagnosis of pain associated with post-herpetic neuralgia following a previous treatment failure with a preferred agent at therapeutic dose from two of the following: tricyclic antidepressant, opioid, gabapentin, carbamazepine, or valproic acid. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.</p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Linezolid (Zyvox®)</p> <p><i>Use Zyvox® PA form</i></p>	<p>Prior authorization is required for Zyvox®. Payment for Zyvox® will be authorized when there is documentation that:</p> <ol style="list-style-type: none"> 1. Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable). 2. Patient has an active infection and meets one of the following diagnostic criteria: <ul style="list-style-type: none"> • Vancomycin-resistant Enterococcus (VRE) and no alternate regimens with documented efficacy are available and VRE is not in lower urinary tract**. • Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin* • Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin* <p>*Severe intolerance to vancomycin is defined as:</p> <ul style="list-style-type: none"> – Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration – Red-man’s syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine) <p>**VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.</p>
<p>Long-Acting Narcotics</p> <p><i>Use Long-Acting Narcotics PA form</i></p>	<p>Prior authorization is required for all non-preferred long-acting narcotics. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. There is documentation of previous trials and therapy failures with two (2) chemically distinct preferred long-acting narcotics (such as extended-release morphine sulfate, Opana ER and methadone) at therapeutic doses, and 2. A trial and therapy failure with fentanyl patch at maximum tolerated doses, and 3. A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization, and 4. The prescriber must review the patient’s use of controlled substances on the Iowa Prescription Monitoring Program website at https://pmp.iowa.gov/IAPMPWebCenter/ prior to requesting prior authorization. 5. Requests for long-acting narcotics will only be considered for FDA approved dosing. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Mifepristone (Korlym®)</p> <p><i>Use Mifepristone (Korlym) PA form</i></p>	<p>Prior authorization is required for mifepristone (Korlym®). Payment will be considered for patients when the following is met:</p> <ol style="list-style-type: none"> 1. The patient is 18 years of age or older: and 2. Has a diagnosis of endogenous Cushing’s Syndrome with hyperglycemia secondary to hypercortisolism in patients with Type 2 Diabetes or glucose intolerance: and 3. Patient must have failed surgery or is not a candidate for surgery: and 4. Prescriber is an endocrinologist: and 5. Female patients of reproductive age must have a negative pregnancy test confirmed within the last 7 days and must use a non-hormonal method of contraception during treatment and for one month after stopping treatment.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

17
PDL IMPLEMENTATION DATE 01-15-05

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Multiple Sclerosis Agents-Oral</p> <p><i>Use Multiple Sclerosis Agents-Oral PA form</i></p>	<p>Prior authorization is required for fingolimod (Gilenya™), teriflunomide (Aubagio®), or dimethyl fumarate (Tecfidera™). Payment will be considered for patients 18 years of age and older under the following conditions:</p> <ol style="list-style-type: none"> 1. A diagnosis of relapsing forms of multiple sclerosis; and 2. A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p> <p>For patients initiating therapy with fingolimod (Gilenya™), documentation of the following must be provided:</p> <ul style="list-style-type: none"> • Patient does not have a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization or Class III/IV heart failure. • Patient does not have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless the patient has a pacemaker. • Patient does not have a baseline QTc interval \geq 500ms. • Patient is not being treated with Class Ia or Class III anti-arrhythmic drugs. <p>For patients initiating therapy with teriflunomide (Aubagio®), documentation of the following must be provided:</p> <ul style="list-style-type: none"> • Patient does not have severe hepatic impairment. • A negative pregnancy test for females of childbearing age. • Use of a reliable form of contraception for females of childbearing age. • Patient is not taking leflunomide. <p>For patients initiating therapy with dimethyl fumarate (Tecfidera™), documentation of the following must be provided:</p> <ul style="list-style-type: none"> • Patient does not have a low lymphocyte count as documented by a recent (within 6 months) CBC prior to initiating therapy. • Upon renewal, documentation of an updated CBC.
<p>Muscle Relaxants</p> <p><i>Use Muscle Relaxant PA form</i></p>	<p>Prior authorization is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. * If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.</p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Narcotic Agonist-Antagonist Nasal Sprays</p> <p><i>Use Narcotic Agonist/Antagonist Nasal Spray PA form</i></p>	<p>Prior authorization is required for narcotic agonist-antagonist nasal sprays. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines. For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration.</p> <p>Payment for non-preferred narcotic agonist-antagonist nasal sprays will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.</p> <p>Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.</p>
<p>Nebivolol (Bystolic®)</p> <p><i>Use Nebivolol (Bystolic®) PA form</i></p>	<p>Prior authorization is required for Bystolic®. Payment will be considered in cases where there are documented trials and therapy failures with two preferred cardio-selective beta-blockers of a different chemical entity at a therapeutic dose. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Nicotine Replacement Therapy</p> <p><i>Use Nicotine Replacement Therapy PA form</i></p>	<p>Prior Authorization is required for over-the-counter nicotine replacement patches, gum, or lozenges, and prescription nicotine nasal spray or inhaler. Requests for authorization must include:</p> <ol style="list-style-type: none"> 1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling. 2) Confirmation of enrollment in the Quitline Iowa counseling program is required for approval. Continuation therapy is available only with documentation of ongoing participation in the Quitline Iowa program. 3) Approvals will only be granted for patients eighteen years of age and older. 4) The maximum allowed duration of therapy is twelve weeks total combined therapy within a twelve-month period. 5) Patients may receive nicotine replacement patches in combination with one of the oral nicotine replacement products (gum or lozenges). A maximum quantity of 14 nicotine replacement patches and 110 pieces of nicotine gum or 144 nicotine lozenges may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a 4 week supply at one unit per day of nicotine replacement patches and 330 pieces of nicotine gum or 288 nicotine lozenges. 6) Requests for non-preferred nicotine replacement products will be considered after documentation of previous trials and intolerance with a preferred oral and preferred topical nicotine replacement product. A maximum quantity of 168 nicotine inhalers or 40ml nicotine nasal spray may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a 4 week supply at 336 nicotine inhalers or 80ml of nicotine nasal spray. 7) The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products</p> <p><i>Use Non-Parenteral Vasopressin Deriv. of Posterior Pituitary Hormone Products PA form</i></p>	<p>Prior authorization is required for non-parenteral vasopressin derivatives of posterior pituitary hormone products. Payment for preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses:</p> <ol style="list-style-type: none"> 1. Diabetes Insipidus. 2. Hemophilia A. 3. Von Willebrand's disease. <p>Payment for oral vasopressin derivatives of posterior pituitary hormone products used in the treatment of primary nocturnal enuresis will be authorized for patients who are six years of age or older for periods of six months. Approvals will be granted for subsequent six-month periods only after a drug-free interval to assess the need for continued therapy. Payment for non-preferred non-parenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial and therapy failure with the preferred agent.</p>
<p>Non-Preferred Drug</p> <p><i>Use Non-Preferred Drug PA form</i></p>	<p>Prior authorization is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-preferred medication will be authorized only for cases in which there is documentation of previous trial and therapy failure with the preferred agent, unless evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Nonsteroidal Anti-inflammatory Drugs</p> <p><i>Use Non-Steroidal Anti-inflammatory Drug PA form</i></p>	<p>Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs (nsaids) and COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs or COX-2 inhibitors.</p> <ol style="list-style-type: none"> 1. Requests for a non-preferred nsaid must document previous trials and therapy failures with at least three preferred nsaids. 2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with three preferred nsaids, two of which must be a preferred COX-2 preferentially selective nsaid. 3. Requests for a non-preferred topical nsaid must document previous trials and therapy failures with three preferred nsaids. The trials must include two preferred COX-2 preferentially selective nsaids and the oral drug of the same chemical entity. In addition, the use of a topical delivery system must be deemed medically necessary. 4. Requests for a non-preferred extended release nsaid must document previous trials and therapy failures with three preferred nsaids, one of which must be the preferred immediate release nsaid of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Omalizumab (Xolair®)</p> <p><i>Use Xolair® PA form</i></p>	<p>Prior authorization is required for Xolair®. Payment for Xolair® will be authorized when the following criteria are met:</p> <ol style="list-style-type: none">1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and2. Patient is 12 years of age or older; and3. Pretreatment IgE level is between 30 IU/mL and 700 IU/mL; and4. Patient's weight is between 30 kg and 150 kg; and5. History of positive skin or RAST test to a perennial aeroallergen; and6. Prescriber is an allergist, immunologist, or pulmonologist; and7. Patient is currently using a high dose inhaled corticosteroid AND long-acting beta-agonist, is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy.8. Patient must have access to an EpiPen to treat allergic reactions that may occur after administration of Xolair®. <p>If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to Xolair® therapy and for patients who do not continue concurrent use with a high dose corticosteroid and long-acting beta-agonist.</p> <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
--	---

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

Oral Constipation Agents	<p>Prior authorization is required for lubiprostone (Amitiza[®]) and linaclotide (Linzess[™]). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none">1. Patient is 18 years of age or older; and2. Patient must have documentation of adequate trials and therapy failures with at least one medication from each of the following categories:<ol style="list-style-type: none">a. Saline laxative (milk of magnesia); andb. Osmotic laxative (polyethylene glycol or lactulose); andc. Stimulant laxative (senna); and3. Patient does not have a known or suspected mechanical gastrointestinal obstruction; and4. Patient has one of the following diagnoses:<ol style="list-style-type: none">a. A diagnosis of chronic idiopathic constipation (Amitiza[®] or Linzess[™])<ol style="list-style-type: none">i. Patient has less than 3 spontaneous bowel movements (SBMs) per week; andii. Patient has two or more of the following symptoms within the last 3 months:<ol style="list-style-type: none">1. Straining during at least 25% of bowel movements;2. Lumpy or hard stools for at least 25% of bowel movements; and3. Sensation of incomplete evacuation for at least 25% of bowel movements; andiii. Documentation the patient is not currently taking constipation causing therapiesb. A diagnosis of irritable bowel syndrome with constipation (Amitiza[®] or Linzess[™])<ol style="list-style-type: none">i. Patient is female (Amitiza[®] only); andii. Patient has abdominal pain or discomfort at least 3 days per month in the last 3 months associated with two (2) or more of the following:<ol style="list-style-type: none">1. Improvement with defecation;2. Onset associated with a change in stool frequency; and/or3. Onset associated with a change in stool formc. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza[®])<ol style="list-style-type: none">i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; andii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:<ol style="list-style-type: none">1. hard to very hard stool consistency;2. Moderate to very severe straining; and/or3. Having a sensation of incomplete evacuation <p>If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation of therapy may be provided if prescriber documents adequate response to treatment.</p>
---------------------------------	--

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Repository Corticotropin Injection (H.P. Acthar Gel)</p> <p><i>Use Repository Corticotropin Injection (H.P. Acthar Gel) PA form</i></p>	<p>Prior authorization is required for repository corticotropin injection. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient is under two years of age and 2. Patient has a diagnosis of infantile spasms. <p>Treatment of compendia indicated steroid-responsive conditions will only be considered upon documented contraindications or intolerance to corticosteroids not expected to occur with the use of repository corticotropin injection.</p> <p>If criteria for coverage are met, authorization will be provided for up to 30 days of treatment for all indications.</p>
<p>Roflumilast (Daliresp™)</p> <p><i>Use Roflumilast (Daliresp™) PA form</i></p>	<p>Prior authorization is required for roflumilast (Daliresp™). Payment will be considered for patients 18 years of age or older when the following is met:</p> <ol style="list-style-type: none"> 1. A diagnosis of severe COPD with chronic bronchitis as documented by spirometry results, and 2. A smoking history of ≥ 20 pack-years, and 3. Currently on a long-acting bronchodilator in combination with an inhaled corticosteroid with documentation of inadequate control of symptoms, and 4. A history of at least one exacerbation in the past year requiring treatment with oral glucocorticosteroids. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Sedative/Hypnotics-Non-Benzodiazepine</p> <p><i>Use Sedative/Hypnotics-Non-Benzodiazepine PA form</i></p>	<p>Preferred agents are available without prior authorization (PA). Although intermittent therapy is recommended, quantity limits will allow for 30 tablets per 30 days supply without PA for preferred medications.</p> <p>Prior authorization is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent(s). Payment for non-preferred non-benzodiazepine sedative/hypnotics will be considered when there is:</p> <ol style="list-style-type: none"> 1) A diagnosis of insomnia, 2) Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued, 3) Enforcement of good sleep hygiene is documented. 4) All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses. 5) Patient has a documented trial and therapy failure with zaleplon.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Selected Brand Name Drugs</p> <p><i>Use Selected Brand Name PA forms</i></p>	<p>Prior authorization is required for selected brand-name drugs, as determined by the Department, for which there is available an “A” rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For prior authorization to be considered, the prescriber must submit a completed Selected Brand Name PA form and Iowa Medicaid MedWatch form with:</p> <ol style="list-style-type: none"> 1. Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available. 2. Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval. <p>Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.</p>
<p>Serotonin 5-HT1-receptor Agonists</p> <p><i>Use Serotonin 5-HT1-receptor Agonists PA form</i></p>	<p>Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for quantities exceeding 12 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for non-preferred combination products may only be considered after documented separate trials and therapy failures with the individual ingredients. For consideration, the following information must be supplied:</p> <ol style="list-style-type: none"> 1. The diagnosis requiring therapy. 2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.
<p>Short Acting Narcotics</p> <p><i>Use Short Acting Narcotics PA form</i></p>	<p>Prior authorization is required for all non-preferred short acting narcotics. Payment will be considered for cases in which there is documentation of previous trials and therapy failures with three (3) chemically distinct preferred short acting narcotics (based on narcotic ingredient only) at therapeutic doses, unless evidence is provided that use of these products would be medically contraindicated.</p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Smoking Cessation Therapy-Oral</p> <p><i>Chantix® Bupropion SR</i></p> <p><i>Use Smoking Cessation Therapy-Oral PA form</i></p>	<p>Prior Authorization is required for varenicline (Chantix®) or bupropion SR that is FDA approved for smoking cessation. Requests for authorization must include:</p> <ol style="list-style-type: none"> 1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling. 2) Confirmation of enrollment and ongoing participation in the Quitline Iowa counseling program is required for approval and continued coverage. 3) Approvals will only be granted for patients eighteen years of age and older. 4) The duration of therapy is initially limited to twelve weeks within a twelve-month period. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment will be considered with a prior authorization request. The maximum duration of approvable therapy is 24 weeks within a twelve-month period. 5) Requests for varenicline to be used in combination with bupropion SR that is FDA indicated for smoking cessation or nicotine replacement therapy will not be approved. 6) The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation
<p>Sodium Oxybate (Xyrem®)</p> <p><i>Use Sodium Oxybate (Xyrem®) PA form</i></p>	<p>Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered for patients 16 years of age or older under the following conditions:</p> <ol style="list-style-type: none"> 1. A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including PSG, MSLT, and ESS) and previous trial and therapy failure with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline. 2. Patient is enrolled in the Xyrem® Success Program. 3. A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant. 4. Patient has been instructed to not drink alcohol when using Xyrem®. 5. Requests for patients with a prior history of substance abuse, concurrent use with a sedative hypnotic, or a semialdehyde dehydrogenase deficiency will not be considered. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Step Therapy Requirements</p> <p><i>Use Non-Preferred Drug PA form</i></p>	<p>Designated therapeutic drug classes are subject to step therapy edits. For these therapeutic drug classes, drugs are assigned to numbered steps and appropriate trials must be made of the drugs assigned to each step before payment will be made for drugs assigned to a subsequent step. These therapeutic classes, as well as the specific step edit requirements, are identified on the Iowa Medicaid Preferred Drug List posted on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab. Providers should submit a Prior Authorization request for override consideration.</p> <p>Therapeutic Classes Included: Antipsychotics-Atypicals</p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Thrombopoietin Receptor Agonists</p> <p><i>Use Thrombopoietin Receptor Agonists PA form</i></p>	<p>Payment for a preferred thrombopoietin receptor agonist will only be considered for cases in which there is a diagnosis of chronic immune thrombocytopenic purpura (ITP) including documentation of an insufficient response to a corticosteroid, an immunoglobulin, or the patient has undergone a splenectomy.</p> <p>Payment for eltromobopag (Promacta[®]) for the treatment of chronic hepatitis C associated thrombocytopenia will only be considered to allow for initiation and/or maintenance of interferon-based therapy with ribavirin when the patient has a baseline platelet count less than 75×10^9 L. Requests will not be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient taking direct acting antiviral agents for the treatment of chronic hepatitis C genotype 1 infection in addition to interferon-based therapy with ribavirin. 2. Patients with decompensated liver disease with a Child-Pugh score > 6 (Class B & C). 3. Patients with a history of ascites. 4. Patients with hepatic encephalopathy. <p>Payment for a non-preferred thrombopoietin receptor agonist will be considered following documentation of a recent trial and therapy failure with a preferred thrombopoietin receptor agonist unless such a trial would be medically contraindicated.</p>
<p>Topical Retinoids for Acne</p> <p><i>Use Topical Retinoids for Acne PA form</i></p>	<p>Prior authorization is required for all prescription topical retinoid products. Payment for prescription topical retinoid products will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Previous trial and therapy failure with a preferred over-the-counter benzoyl peroxide product, and 2. Previous trials and therapy failures with two preferred topical and/or oral antibiotics for the treatment of mild to moderate acne (non-inflammatory and inflammatory), and drug-induced acne. 3. Payment for non-preferred topical retinoid products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. 4. Trials and therapy failure will not be required for those patients presenting with a preponderance of comedonal acne. 5. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of topical retinoid products. 6. Requests for non-preferred combination products may only be considered after documentation of separate trials and therapy failures with the individual ingredients. 7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>

Iowa Medicaid Drug Prior Authorization Criteria

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity. All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

Updated 10/1/2013

<p>Vemurafenib (Zelboraf™)</p> <p><i>Use Zelboraf™ (vemurafenib) PA form</i></p>	<p>Prior authorization is required for Zelboraf™. Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient is 18 years of age or older; and 2. Has a diagnosis of unresectable or metastatic melanoma with BRAF^{V600E} mutation as detected by an FDA-approved test; and 3. Prescriber is an oncologist. <p>If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.</p>
<p>Vilazodone (Viibryd™)</p> <p><i>Use Vilazodone (Viibryd™) PA form</i></p>	<p>Prior authorization is required for Viibryd™. Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of Major Depressive Disorder (MDD) and is 18 years of age or older; and 2. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SSRI; and 3. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and 4. Documentation of a previous trial and therapy failure at a therapeutic dose with an additional generic antidepressant from any class. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Vitamins, Minerals and Multiple Vitamins</p> <p><i>Use Vitamin/Mineral PA form</i></p>	<p>Payment for vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease or for patients under 21 years of age if there is a diagnosed disease which inhibits the nutrition absorption process as a secondary effect of the disease. (Prior approval is not required for prescribed multi-vitamins with or without iron or vitamin D supplements for patients under 12 months of age or a prescription product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)</p>
<p>Vusion™ Ointment</p> <p><i>Use Vusion™ Ointment PA form</i></p>	<p>Prior Authorization is required for Vusion™ Ointment. Payment will only be considered for cases in which there is documentation of previous trials and therapy failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated.</p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.