

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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<p>ADD/ADHD/ NARCOLEPSY AGENTS</p> <p><i>Use CNS Stimulants and Atomoxetine PA form</i></p>	<p><i>See CNS Stimulants and Atomoxetine Prior Authorization Criteria.</i></p>
<p>Age Edit Override – Codeine or Tramadol</p> <p><i>Use Age Edit Override- Codeine or Tramadol PA form</i></p>	<p>An age edit override for codeine or tramadol is required for patients under 18 years of age. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Member is 12 years of age or older; and 2. Medication is not being prescribed to treat pain after surgery following tonsil and/or adenoid procedure for members 12 to 18 years of age; and 3. If member is between 12 and 18 years of age, member is not obese (BMI greater than 30kg/m²), does not have obstructive sleep apnea, or severe lung disease.
<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 <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>

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Updated 6/1/2018

<p>Antidepressants</p> <p><i>Aplenzin</i> <i>Fetzima</i> <i>Khedezla</i> <i>Viibryd</i></p> <p><i>Use Antidepressants PA form</i></p>	<p>Prior authorization is required for non-preferred antidepressants subject to clinical criteria. 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 two preferred generic SSRIs; 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 one non-SSRI/SNRI generic antidepressant 5. If the request is for an isomer, prodrug or metabolite of a medication indicated for MDD, one of the trials must be with the preferred parent drug of the same chemical entity that resulted in a partial response with a documented intolerance. <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-Diabetics, Non-Insulin Agents</p> <p><i>Use Anti-Diabetics, Non-Insulin PA form</i></p>	<p>Prior authorization is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. A diagnosis of Type 2 Diabetes Mellitus, and 2. Patient is 18 years of age or older, and 3. The patient has not achieved HgbA1C goals after a minimum three month trial with metformin at maximally tolerated dose. <p>Payment for a non-preferred anti-diabetic, non-insulin agent subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor Combination, a preferred Incretin Mimetic, and a preferred SGLT2 Inhibitor at maximally tolerated doses.</p> <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p> <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 continued improvement in HgbA1C.</p>

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<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%;">Aprepitant (N)/Emend (P):</td> <td style="width: 50%;">Ondansetron (P)/Zofran (N):</td> </tr> <tr> <td style="padding-left: 20px;">4 – 125mg capsules</td> <td style="padding-left: 20px;">60 – 4mg tablets</td> </tr> <tr> <td style="padding-left: 20px;">8 – 80mg capsules</td> <td style="padding-left: 20px;">60 – 8mg tablets</td> </tr> <tr> <td>Dolasetron (N)/Anzemet (N):</td> <td style="padding-left: 20px;">4 – 24mg tablets</td> </tr> <tr> <td style="padding-left: 20px;">5 – 50mg/100mg tablets</td> <td style="padding-left: 20px;">4 – 20mL vials (2mg/mL)</td> </tr> <tr> <td style="padding-left: 20px;">4 vials (100mg/5mL)</td> <td style="padding-left: 20px;">8 – 2mL vials (2mg/mL)</td> </tr> <tr> <td style="padding-left: 20px;">8 ampules (12.5mg/0.625mL)</td> <td>Ondansetron ODT (P)/Zofran ODT (N):</td> </tr> <tr> <td>Granisetron (N):</td> <td style="padding-left: 20px;">60 – 4mg tablets</td> </tr> <tr> <td style="padding-left: 20px;">8 – 1mg tablets</td> <td style="padding-left: 20px;">60 – 8mg tablets</td> </tr> <tr> <td style="padding-left: 20px;">8 vials (1 mg/mL)</td> <td>Ondansetron Oral Solution (N)/ Zofran Oral Solution (N)</td> </tr> <tr> <td style="padding-left: 20px;">2 vials (4mg/mL)</td> <td style="padding-left: 20px;">50mL/month – oral solution (4mg/5mL)</td> </tr> <tr> <td>Akynzeo (N):</td> <td>Palonosetron (N)/ Aloxi (N):</td> </tr> <tr> <td style="padding-left: 20px;">2 – 300/0.5mg capsules</td> <td style="padding-left: 20px;">4 vials (0.25mg/5mL)</td> </tr> </table>	Aprepitant (N)/Emend (P):	Ondansetron (P)/Zofran (N):	4 – 125mg capsules	60 – 4mg tablets	8 – 80mg capsules	60 – 8mg tablets	Dolasetron (N)/Anzemet (N):	4 – 24mg tablets	5 – 50mg/100mg tablets	4 – 20mL vials (2mg/mL)	4 vials (100mg/5mL)	8 – 2mL vials (2mg/mL)	8 ampules (12.5mg/0.625mL)	Ondansetron ODT (P)/Zofran ODT (N):	Granisetron (N):	60 – 4mg tablets	8 – 1mg tablets	60 – 8mg tablets	8 vials (1 mg/mL)	Ondansetron Oral Solution (N)/ Zofran Oral Solution (N)	2 vials (4mg/mL)	50mL/month – oral solution (4mg/5mL)	Akynzeo (N):	Palonosetron (N)/ Aloxi (N):	2 – 300/0.5mg capsules	4 vials (0.25mg/5mL)
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<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>																										
<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>																										

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Updated 6/1/2018

Apremilast (Otezla®)	<p>Prior authorization is required for apremilast (Otezla®). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient is 18 years of age or older; and 2. Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints); or 3. Patient has a diagnosis of moderate to severe plaque psoriasis; and 4. Prescribed by a rheumatologist or a dermatologist; and 5. Patient does not have severe renal impairment (CrCl < 30 mL/min). <p><u>Psoriatic Arthritis</u></p> <ul style="list-style-type: none"> • Patient has documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and • Patient has documentation of trials and therapy failures with two preferred biological agents used for psoriatic arthritis. <p><u>Plaque Psoriasis</u></p> <ul style="list-style-type: none"> • Patient has documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; and • Patient has documentation of trials and therapy failures with two preferred biological agents. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
Becaplermin (Regranex®) <i>Use Regranex® PA form</i>	<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>
Benzodiazepines <i>Use Benzodiazepine PA form</i>	<p>Prior authorization is required for non-preferred benzodiazepines. Payment for non-preferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. Requests for clobazam (ONFI) will be considered for a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) in patients 2 years of age and older when used as an adjunctive treatment. Prior authorization will be approved for up to 12 months for documented:</p> <ol style="list-style-type: none"> 1. Generalized anxiety disorder. 2. Panic attack with or without agoraphobia. 3. Seizure. 4. Non-progressive motor disorder. 5. Dystonia. <p>If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine. Prior authorization requests will be approved for up to a three-month period for all other diagnoses related to the use of benzodiazepines. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>

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Updated 6/1/2018

<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> <i>Tocilizumab (Actemra)</i> <i>Ustekinumab (Stelara)</i> <i>Canakinumab (Ilaris)</i> <i>Sarilumab (Kevzara)</i> <i>Secukinumab (Cosentyx)</i></p> <p><i>Use Biologicals for Arthritis PA form</i></p>	<p>Prior authorization is required for biologicals used for arthritis. Request must adhere to all FDA approved labeling. 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. Payment will be considered under the following conditions:</p> <ul style="list-style-type: none"> • Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and • Patient has been 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; and • Patient has a diagnosis of rheumatoid arthritis (RA): 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). 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; or • Patient has 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); or • Patient has 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); and <p>In addition to the above: Requests for TNF Inhibitors:</p> <ul style="list-style-type: none"> • Patient has 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; and • Patient does 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. <p>Requests for Interleukins:</p> <ul style="list-style-type: none"> • Medication will not be given concurrently with live vaccines. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
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Updated 6/1/2018

<p>Biologicals for Hidradenitis Suppurativa</p>	<p>Prior authorization is required for biologicals FDA approved for the treatment of Hidradenitis Suppurativa (HS). 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; and 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 biologic agent; and 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> <ol style="list-style-type: none"> 1. Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease; and 2. Patient is 18 years of age or older; and 3. Patient has at least three (3) abscesses or inflammatory nodules; and 4. Patient has documentation of adequate trials and therapy failures with the following: <ol style="list-style-type: none"> a. Daily treatment with topical clindamycin; b. Oral clindamycin plus rifampin; c. Maintenance therapy with tetracyclines (doxycycline or minocycline). <p>If criteria for coverage are met, initial requests will be given for 3 months. Additional authorizations will be considered upon documentation of clinical response to therapy. Clinical response is defined as at least a 50% reduction in total abscess and inflammatory nodule count with no increase in abscess count and no increase in draining fistula count from initiation of therapy.</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><i>Adalimumab (Humira)</i></p>	
<p><i>Use Biologicals for Hidradenitis Suppurativa PA form</i></p>	

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<p>Biologicals for Plaque Psoriasis <i>Alefacept (Amevive)</i> <i>Adalimumab (Humira)</i> <i>Etanercept (Enbrel)</i> <i>Infliximab (Remicade)</i> <i>Secukinumab (Cosentyx)</i> <i>Ustekinumab (Stelara)</i> <i>Brodalumab (Siliq)</i> <i>Ixekizumab (Taltz)</i> <i>Guselkumab (Tremfya)</i></p> <p><i>Use Biologicals for Plaque Psoriasis PA form</i></p>	<p>Prior authorization is required for biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling. 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. Payment will be considered under the following conditions:</p> <ul style="list-style-type: none"> • Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and • Patient has been 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; and • Patient has documentation of an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine; and <p>In addition to the above: Requests for TNF Inhibitors</p> <ul style="list-style-type: none"> • Patient has 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; and • Patient does 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. <p>Requests for Interleukins:</p> <ul style="list-style-type: none"> • Medication will not be given concurrently with live vaccines. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
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Updated 6/1/2018

<p>Chronic Pain Syndromes</p> <p><i>Duloxetine (Cymbalta®)</i> <i>Pregabalin (Lyrica®)</i> <i>Milnacipran (Savella™)</i></p> <p><i>Use Chronic Pain Syndromes PA form</i></p>	<p>A prior authorization is required for pregabalin (Lyrica®) and milnacipran (Savella™). These drugs will be considered for their FDA indications(s) and other conditions as listed in the compendia. Requests for doses above the manufacturer recommended dose will not be considered. For patients with a chronic pain diagnosis who are currently taking opioids, as seen in pharmacy claims, a plan to decrease and/or discontinue the opioid(s) must be provided with the initial request. Initial authorization will be given for three (3) months. There must be a significant decrease in opioid use or discontinuation of opioid(s) after the initial three (3) month authorization for further approval consideration. Additional prior authorizations will be considered with documentation of a continued decrease in opioid utilization. Requests for non-preferred brand name drugs, when there is a preferred A-rated bioequivalent generic product available, are also subject to the Selected Brand Name prior authorization criteria and must be included with this request. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. A diagnosis of fibromyalgia (Lyrica® and Savella™) <ol style="list-style-type: none"> a. a trial and therapy failure at a therapeutic dose with gabapentin plus one of the following preferred generic agents: tricyclic antidepressant or SNRI WITH b. documented non-pharmacologic therapies (cognitive behavior therapies, exercise, etc.) 2. A diagnosis of post-herpetic neuralgia (Lyrica®) A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant, topical lidocaine, or valproate. 3. A diagnosis of diabetic peripheral neuropathy (duloxetine and Lyrica®) A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant, duloxetine or topical lidocaine. 4. A diagnosis of partial onset seizures, as adjunct therapy (Lyrica®)
<p>CNS Stimulants and Atomoxetine</p>	<p>Prior authorization (PA) is required for CNS stimulants and atomoxetine for patients 21 years of age or older. Prior to requesting prior authorization for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at https://pmp.iowa.gov/IAPMPWebCenter/. Payment for CNS stimulants and atomoxetine will be considered 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-5 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 current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms the patient continues to require medication to treat the symptoms of ADD/ADHD will be required for renewals or patients newly eligible that are established on medication to treat ADD/ADHD. 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. 4. Binge Eating Disorder (Vyvanse only) <ul style="list-style-type: none"> • Patient is 18 to 55 years of age; and • Patient meets DSM-5 criteria for Binge Eating Disorder (BED); and

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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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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<p><i>Use CNS Stimulants and Atomoxetine or Binge Eating Disorder Agents PA form</i></p>	<ul style="list-style-type: none"> • Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number of episodes must be reported); and • Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent 3 month period, that did not significantly reduce the number of binge eating episodes; and • Prescription is written by a psychiatrist or psychiatric nurse practitioner; and • Patient has a BMI of 25 to 45; and • Patient does not have a history of cardiovascular disease; and • Patient has no history of substance abuse; and • Is not being prescribed for the treatment of obesity or weight loss; and • Doses above 70mg per day will not be considered. • Initial requests will be approved for 12 weeks. • Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week. <p><u>DSM-5 Criteria</u></p> <ul style="list-style-type: none"> i. <i>Recurrent episodes of binge eating, including eating an abnormally large amount of food in a discrete period of time and has a feeling of lack of control over eating; and</i> ii. <i>The binge eating episodes are marked by at least three of the following:</i> <ul style="list-style-type: none"> 1. <i>Eating more rapidly than normal</i> 2. <i>Eating until feeling uncomfortably full</i> 3. <i>Eating large amounts of food when not feeling physically hungry</i> 4. <i>Eating alone because of embarrassment by the amount of food consumed</i> 5. <i>Feeling disgusted with oneself, depressed, or guilty after overeating; and</i> iii. <i>Episodes occur at least 1 day a week for at least 3 months; and</i> iv. <i>No regular use of inappropriate compensatory behaviors (e.g. purging, fasting, or excessive exercise) as are seen in bulimia nervosa; and</i> v. <i>Does not occur solely during the course of bulimia nervosa or anorexia nervosa.</i> <p><u>Moderate to Severe BED</u></p> <p><i>Based on the number of binge eating episodes per week:</i></p> <p><i>Moderate - 4 to 7</i></p> <p><i>Severe – 8 to 13</i></p> <p><i>Extreme – 14 or more</i></p> <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 with the preferred immediate release and extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) 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>
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Iowa Medicaid Drug Prior Authorization Criteria

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<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 for members 18 years of age and older. 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>Crisaborole (Eucrisa)</p> <p><i>Use Crisaborole (Eucrisa) PA form</i></p>	<p>Prior authorization is required for Eucrisa (crisaborole). Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of mild to moderate atopic dermatitis; and 2. Patient is within the FDA labeled age; and 3. Patient has failed to respond to good skin care and regular use of emollients; and 4. Patient has documentation of an adequate trial and therapy failure with two preferred medium to high potency topical corticosteroids for a minimum of 2 consecutive weeks; and 5. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and 6. Patient will continue with skin care regimen and regular use of emollients. 7. Quantities will be limited to 60 grams for use on the face, neck, and groin and 100 grams for all other areas, per 30 days. <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>

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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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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<p>Deflazacort (Emflaza) <i>Use Deflazacort (Emflaza™) PA form</i></p>	<p>Prior authorization is required for Emflaza (deflazacort). Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene; and 2. Patient is within the FDA labeled age; and 3. Patient experienced onset of weakness before 5 years of age; and 4. Is prescribed by or in consultation with a physician who specializes in treatment of Duchenne muscular dystrophy; and 5. Patient has documentation of an adequate trial and therapy failure, intolerance, or significant weight gain (significant weight gain defined as 1 standard deviation above baseline percentile rank weight for height) while on prednisone at a therapeutic dose; and 6. Is dosed based on 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>Dextromethorphan and Quinidine (Nuedexta™) <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 a neurological condition. 2. A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI; and 3. Patient has documentation of a current EKG (within the past 3 months) without QT prolongation. 4. Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire. 5. Subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Dornase Alfa (Pulmozyme®) <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®) <i>Use Chronic Pain Syndromes PA form</i></p>	<p><i>See Chronic Pain Syndromes Prior Authorization Criteria.</i></p>

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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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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<p>Dupilumab (Dupixent)</p> <p><i>Use Dupilumab (Dupixent) PA form</i></p>	<p>Prior authorization is required for Dupixent (dupilumab). Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and 2. Patient is within the FDA labeled age; and 3. Is prescribed by or in consultation with a dermatologist; and 4. Patient has failed to respond to good skin care and regular use of emollients; and 5. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and 6. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and 7. Patient has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and 8. Patient will continue with skin care regimen and regular use of emollients; and 9. Dose does not exceed an initial one-time dose of 600mg and maintenance dose of 300mg thereafter given every other week. <p>If criteria for coverage are met, initial authorization will be given for 16 weeks to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy.</p> <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Duplicate Therapy Edits</p> <p>Antipsychotics NSAIDs</p> <p><i>Use Duplicate Therapy Edit Override PA form</i></p>	<p>Designated therapeutic classes are subject to duplicate therapy edits. Providers should submit a Prior Authorization request for override consideration.</p>

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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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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<p>Eluxadoline (Viberzi™)</p> <p><i>Use Eluxadoline (Viberzi™) PA form</i></p>	<p>Prior authorization is required for eluxadoline. Only FDA approved dosing will be considered. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient is 18 years of age or older. 2. Patient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D). 3. Patient does not have any of the following contraindications to therapy: <ol style="list-style-type: none"> a. Patient is without a gallbladder. b. Known or suspected biliary duct obstruction, or sphincter of Oddi disease/dysfunction. c. Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than 3 alcoholic beverages per day. d. A history of pancreatitis or structural diseases of the pancreas (including known or suspected pancreatic duct obstruction). e. Severe hepatic impairment (Child-Pugh Class C). f. Severe constipation or sequelae from constipation. g. Known or suspected mechanical gastrointestinal obstruction. 4. Patient has documentation of a previous trial and therapy failure at a therapeutic dose with both of the following: <ol style="list-style-type: none"> a. A preferred antispasmodic agent (dicyclomine or hyoscyamine). b. A preferred antidiarrheal agent (loperamide). <p>If criteria for coverage are met, initial authorization will be given for 3 months to assess the response to treatment. Requests for continuation of therapy will require the following:</p> <ol style="list-style-type: none"> 1. Patient has not developed any contraindications to therapy (defined above). 2. Patient has experienced a positive clinical response to therapy as demonstrated by at least one of the following: <ol style="list-style-type: none"> a. Improvement in abdominal cramping or pain. b. Improvement in stool frequency and consistency. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Eplerenone (Inspra®)</p> <p><i>Use Miscellaneous PA form</i></p>	<p>Prior authorization is required for Inspra®. Payment will be authorized only in cases where there is documented trial and therapy failure on Aldactone® or documented cases of gynecomastia from Aldactone® therapy.</p>

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Iowa Medicaid Drug Prior Authorization Criteria

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<p>Erythropoiesis Stimulating Agents</p> <p><i>Use Erythropoiesis Stimulating Agent PA form</i></p>	<p>Prior authorization is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for non-preferred erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.</p> <p>Patients who meet all of the following criteria may receive prior authorization for the use of erythropoiesis stimulating agents:</p> <ol style="list-style-type: none"> 1. Hemoglobin less than 10g/dL. If renewal of prior authorization is being requested, a hemoglobin less than 11g/dL (or less than 10g/dL for patients with Chronic Kidney Disease (CKD) not on dialysis) will be required for continued treatment. Hemoglobin laboratory values must be dated within four weeks of the prior authorization request. 2. Transferrin saturation greater than or equal to 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron binding capacity), ferritin levels greater than or equal to 100 mg/ml, or on concurrent therapeutic iron therapy. Transferrin saturation or ferritin levels must be dated within three months of the prior authorization request. 3. For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy. 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
<p>Eteplirsen (Exondys 51)</p> <p><i>Use Eteplirsen (Exondys 51) PA form</i></p>	<p>Prior authorization is required for Exondys 51 (eteplirsen). Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with mutation amendable to exon 51 skipping confirmed by genetic testing (attach results of genetic testing); and 2. Is prescribed by or in consultation with a physician who specializes in treatment of Duchenne muscular dystrophy; and 3. Patient is currently ambulatory; and 4. A baseline 6-Minute Walk Distance (6MWD) is provided and patient is able to achieve a distance of at least 180 meters while walking independently; and 5. Patient is currently stable on an oral corticosteroid regimen for at least 6 months; and 6. Is dosed based on FDA approved dosing: 30 mg/kg once weekly; and 7. Medication is to be administered by a healthcare professional in member's home by home health or in a long-term care facility. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p> <p>When criteria for coverage are met, an initial authorization will be given for 6 months. Requests for continuation of therapy will be considered at 6 month intervals when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient has demonstrated a response to therapy as evidenced by remaining ambulatory (able to walk with or without assistance, not wheelchair dependent); and 2. An updated 6MWD is provided documenting patient is able to achieve a distance of at least 180 meters.

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Iowa Medicaid Drug Prior Authorization Criteria

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<p>Extended Release Formulations</p> <p><i>Use Extended Release Formulations PA form</i></p>	<p>Payment for a non-preferred extended release formulation will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Previous trial and therapy failure 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 2. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p> <p>Prior authorization is required for the following extended release formulation(s): Adoxa, Amoxicillin ER, Astagraf XL, Augmentin XR, Cardura XL, Carvedilol ER, Cipro XR, Coreg CR, Doryx, Envarsus XR, Fortamet, Glumetza, Gralise, Keppra XR, Lamictal XR, Luvox CR, Mirapex ER, Moxatag, Namenda XR, Oleptro, Oxtellar XR, Pramipexole ER, Prozac Weekly, Qudexy XR, Rayos, Requip XL, Rythmol SR, Solodyn ER, Topiramate ER, Trokendi XR, Ximino.</p>
<p>Febuxostat (Uloric®)</p> <p><i>Use Febuxostat (Uloric®) PA form</i></p>	<p>Prior authorization is required for febuxostat (Uloric®). Payment for febuxostat (Uloric®) will only be considered for cases in which symptoms of gout still persist while currently using 300mg per day of a preferred allopurinol product unless documentation is provided that such a trial would be medically contraindicated.</p>
<p>Fentanyl, Short Acting Products</p> <p><i>Use Short Acting Fentanyl Products PA form</i></p>	<p>Prior authorization is required for short acting 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.</p> <p>Short acting fentanyl products:</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>

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<p>GLP-1 Agonist/Basal Insulin Combinations</p> <p><i>Use GLP-1 Agonist/Basal Insulin Combinations PA form</i></p>	<p>Prior authorization is required for GLP-1 agonist receptor/basal insulin combination products. Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> 1. A diagnosis of type 2 diabetes mellitus; and 2. Patient is 18 years of age or older; and 3. The patient has not achieved HgbA1C goals after a minimum three-month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated; and 4. Documentation of an adequate trial and inadequate response with at least one preferred GLP-1 receptor agonist and one preferred long-acting insulin agent concurrently; and 5. Will not be used concurrently with prandial insulin; and 6. Clinical rationale is provided as to why the patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently; and 7. Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of: <ol style="list-style-type: none"> a. Soliqua below 15 units or over 60 units, or b. Xultophy persistently below 16 units or over 50 units.
<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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<p><i>Use Hepatitis C Treatments PA form</i></p>	<ul style="list-style-type: none"> • Patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), proteinuria, nephritic syndrome, or membranoproliferative glomerulonephritis. <ol style="list-style-type: none"> 8. Patient’s prior treatment history is provided (treatment naïve or treatment experienced); and 9. If patient has a history of non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and 10. Patient has abstained from the use of illicit drugs and alcohol for a minimum of three (3) months as evidenced by a negative urine confirmation test; and 11. For regimens containing sofosbuvir, patient does not have severe renal impairment (creatinine clearance < 30ml/min) or end stage renal disease requiring hemodialysis; and 12. HCV treatment is prescribed by a digestive disease, liver disease, or infectious disease provider practice; and. 13. For patients on a regimen containing ribavirin, the following must be documented on the PA form: <ol style="list-style-type: none"> a) Patient is not a pregnant female or male with a pregnant female partner; and b) Women of childbearing potential and their male partners must use two forms of effective contraception during treatment and for at least 6 months after treatment has concluded; and c) Monthly pregnancy tests will be performed during treatment; and 14. Prescriber has reviewed the patient’s current medication list and acknowledged that there are no significant drug interactions with the HCV medication. 15. Documentation is provided for patients who are ineligible to receive ribavirin. 16. Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved. 17. Patient does not have limited life expectancy (less than 12 months) due to non-liver related comorbid conditions. 18. If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on length of therapy for the particular treatment. 19. Lost or stolen medication replacement requests will not be authorized. 20. The 72-hour emergency supply rule does not apply to oral hepatitis C antiviral agents.
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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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 6/1/2018

<p>Insulin, Pre-Filled Pens</p> <p><i>Use Pre-filled Insulin Pen PA form</i></p>	<p>Prior authorization (PA) is required for pre-filled insulin pens as designated on the Preferred Drug List (PDL). For pre-filled insulin pens requiring PA where the requested insulin is available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria:</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 (not applicable for pediatric patients), and • There is no caregiver available to provide assistance, and • Patient does not reside in a long-term care facility, and • For requests for non-preferred pre-filled insulin pens, patient has documentation of a previous trial and therapy failure with a preferred pre-filled insulin pen within the same class (i.e. rapid, regular or basal). <p>For pre-filled insulin pens requiring PA where the requested insulin is not available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria:</p> <ul style="list-style-type: none"> • Preferred pre-filled insulin pens- Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e. rapid, regular or basal) or clinical rationale as to why the patient cannot use a preferred insulin agent, and • Non-preferred pre-filled insulin pens- Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e. rapid, regular or basal). • Requests for Toujeo will require clinical rationale as to why the patient cannot use Lantus and patient must be using a minimum of 100 units of Lantus per day.
<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 authorizations.</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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05 27

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 6/1/2018

<p>Ivabradine (Corlanor®)</p> <p><i>Use Ivabradine (Corlanor®) PA form</i></p>	<p>Prior authorization is required for ivabradine. Only FDA approved dosing will be considered. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient is 18 years of age or older; and 2. Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV); and 3. Patient has documentation of a left ventricular ejection fraction $\leq 35\%$; and 4. Patient is in sinus rhythm with a resting heart rate of ≥ 70 beats per minute; and 5. Patient has documentation of blood pressure $\geq 90/50$ mmHg; and 6. Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g. carvedilol 50mg daily, metoprolol succinate 200mg daily, or bisoprolol 10mg daily), or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and 7. Patient has documentation of a trial and continued use with a preferred ACE inhibitor or preferred ARB at a maximally tolerated dose. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</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 2 years of age or older; and 2. Has a diagnosis of cystic fibrosis; and 3. Patient has one of the CFTR gene mutations as indicated in the FDA approved label as detected by an FDA-cleared CF mutation test; and 4. Prescriber is a CF specialist or pulmonologist; and 5. Baseline liver function tests (AST/ALT) are provided; and <p>If the criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 6 months at a time if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Adherence to ivacaftor therapy is confirmed; and 2. Liver function tests (AST/ALT) are assessed every 3 months during the first year of treatment and annually thereafter.

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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05 28

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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<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>

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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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<p>Lidocaine Patch (Lidoderm®)</p> <p><i>Use Lidocaine Patch (Lidoderm®) PA form</i></p>	<p>Prior authorization is required for topical lidocaine patches. Payment will be considered only for cases in which there is a diagnosis of pain associated with post-herpetic neuralgia. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.</p>
<p>Linezolid (Zyvox®)</p> <p><i>Use linezolid (Zyvox®) PA form</i></p>	<p>Prior authorization is required for linezolid (Zyvox®). Payment for linezolid (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 alternative 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>

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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 6/1/2018

<p>Lumacaftor/Ivacaftor (Orkambi™)</p> <p><i>Use Lumacaftor/Ivacaftor (Orkambi) PA form</i></p>	<p>Prior authorization is required for Orkambi™ (lumacaftor/ivacaftor). Dual therapy with another cystic fibrosis transmembrane conductance regulator (CFTR) potentiator will not be considered. 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; and 3. Patient is homozygous for the <i>F508del</i> mutation in the <i>CFTR</i> gene as confirmed by a FDA-cleared CF mutation test; and 4. Baseline liver function tests (AST/ALT) and bilirubin levels are provided and 5. Prescriber is a CF specialist or pulmonologist. <p>If the criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 6 months at a time if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Adherence to lumacaftor/ivacaftor therapy is confirmed; and 2. Liver function tests (AST/ALT) and bilirubin are assessed every 3 months during the first year of treatment and annually thereafter.
<p>Lupron Depot – Adult</p> <p><i>Use Lupron Depot-Adult PA form</i></p>	<p>Prior authorization is required for Lupron Depot (leuprolide acetate). Payment will be considered for patients under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient is 18 years of age or older; and 2. Medication is to be administered by a healthcare professional in the member’s home by home health or in a long-term care facility; and 3. Patient has a diagnosis of endometriosis for whom therapy with NSAIDs and at least one preferred 3 month course of a continuous hormonal contraceptive has failed; or 4. Patient has a diagnosis of uterine leiomyomata with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively; or 5. Patient has a diagnosis of advanced prostate cancer. <p>Therapy will be limited as follows:</p> <ul style="list-style-type: none"> • Endometriosis – initial 6 month approval. If symptoms of endometriosis recur after the first course of therapy, a second course of therapy with concomitant norethindrone acetate 5 mg daily will be considered. Retreatment is not recommended for longer than one additional 6 month course. • Uterine leiomyomata – 3 month approval. • Advanced prostate cancer – initial 6 month approval. Renewal requests must document suppression of testosterone levels towards a castrate level of < 50 ng/dL (attach lab).

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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 6/1/2018

<p>Lupron Depot – Pediatric</p>	<p>Prior authorization is required for Lupron Depot-Ped. Payment will be considered for patients when the following is met:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of central precocious puberty (CPP); and 2. Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males; and 3. Patient is currently < 11 years of age for females or < 12 years of age for males; and 4. Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test is provided (attach results); and 5. Documentation of advanced bone age (defined as greater than or equal to two standard deviations above the gender/age related mean); and 6. Baseline evaluations including the following have been conducted and/or evaluated: <ol style="list-style-type: none"> a. Height and weight measurements; and b. Sex steroid (testosterone or estradiol) levels have been obtained; and c. Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor; and d. Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors; and e. Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor; and f. Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia; and 7. Medication is to be administered by a healthcare professional in the member’s home by home health or in a long-term care facility.
<p><i>Use Lupron Depot-Pediatric PA form</i></p>	<p>When criteria for coverage are met, an initial authorization will be given for 6 months.</p> <p>Additional approvals will be granted at 6 month intervals until the patient is ≥ 11 years of age for females and ≥ 12 years of age for males. If therapy beyond the aforementioned ages is required, documentation of medical necessity will be required.</p>

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 6/1/2018

Modified Formulations	<p>Payment for a non-preferred isomer, prodrug, or metabolite will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2. Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available. <p>The required trials may be overridden when documented evidence is provided that use of these preferred agent(s) would be medically contraindicated.</p>
<i>Use Modified Formulations PA form</i>	<p>Prior authorization is required for the following modified dosage forms: Abilify Discmelt, Aricept ODT, Binosto, FazaClo, Horizant, Invega, Metoclopramide ODT, Remeron SolTab, Risperdal M-Tab, Sitavig, Spritam, Trilipix, Xopenex, Zyprexa Zydis.</p>

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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 6/1/2018

<p>Narcan (Naloxone) Nasal Spray</p> <p><i>Use Narcan (Naloxone) Nasal Spray PA form</i></p>	<p>Prior authorization is required for a patient requiring more than 2 doses of Narcan (naloxone) nasal spray per 365 days. Requests for quantities greater than 2 doses per 365 days will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Documentation is provided indicating why patient needs additional doses of Narcan (naloxone) nasal spray (accidental overdose, intentional overdose, other reason); and 2. Narcan (naloxone) nasal spray is to be used solely for the patient it is prescribed for; and 3. The patient is receiving an opioid as verified in pharmacy claims; and 4. Patient has been reeducated on opioid overdose prevention; and 5. Documentation is provided on the steps taken to decrease the chance of opioid overdose again; and 6. A treatment plan is included documenting a plan to lower the opioid dose.
<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>

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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 6/1/2018

<p>Palivizumab (Synagis®)</p>	<p>Respiratory Syncytial Virus (RSV) Season is defined by the centers for disease control and prevention of the United States department of health and human services and described in the RSV surveillance reports published annually in the Morbidity and Mortality Weekly Report (MMWR) and available at http://www.cdc.gov/surveillance/nrevss/rsv/reports.html.</p> <ul style="list-style-type: none"> • Medicaid will use virology data provided by the Iowa department of public health (IDPH) to prospectively estimate the start of the RSV season and follow the virology data to the end of the season. • Medicaid will provide coverage of prescription drugs that protect against RSV consistent with the current American Academy of Pediatrics (AAP) Guidelines for Infants and Children at Risk for Severe Illness due to RSV Infection. • The start date will begin two weeks prior to the expected season start date for the state of Iowa. The start date will be adjusted to an earlier date by Medicaid if indicated by the virological data. The expected season start date shall be derived from the median start date of the past 5 seasons using Iowa virological data. <p>Prior authorization is required for therapy with palivizumab. Prior authorizations will be approved for administration during the RSV season for a maximum of five doses per patient. No allowances will be made for a sixth dose. Patients, who experience a breakthrough RSV hospitalization, should have their monthly prophylaxis discontinued, as there is an extremely low likelihood of a second RSV hospitalization in the same season. Payment for palivizumab will be considered for patients who meet one of the following criteria:</p> <p><u>Chronic Lung Disease (CLD) of Prematurity</u></p> <ul style="list-style-type: none"> • Patient is less than 12 months of age at start of therapy and has CLD of prematurity (defined as gestational age less than 32 weeks and required greater than 21% oxygen for at least the first 28 days after birth). • Requests for patients during their second year of life (12 months to < 24 months) will be considered for patients meeting the CLD of prematurity definition above and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season. <p><u>Prematurity (without CLD of Prematurity or Congenital Heart Disease)</u></p> <ul style="list-style-type: none"> • Patient is less than 12 months of age at start of therapy with a gestational age of less than 29 weeks. <p><u>Neuromuscular Disorders or Anatomic Pulmonary Abnormalities</u></p> <ul style="list-style-type: none"> • Patient is 12 months of age or younger at the start of therapy and has either severe neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway due to an ineffective cough. <p><u>Hemodynamically Significant Congenital Heart Disease (CHD)</u></p> <ul style="list-style-type: none"> • Patient is less than 12 months of age at start of therapy and has hemodynamically significant CHD further defined by any of the following: Acyanotic heart disease receiving medication to control congestive heart failure and will require cardiac surgical procedures, moderate to severe pulmonary hypertension, or cyanotic heart defects with documentation of consultation with a pediatric cardiologist that recommends palivizumab prophylaxis. <p><u>Immunocompromised Children</u></p> <ul style="list-style-type: none"> • Patient is less than 24 months of age at start of therapy and is profoundly immunocompromised during the RSV season (e.g., severe combined immunodeficiency, advanced acquired immunodeficiency syndrome, receiving chemotherapy).
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Use Palivizumab PA form

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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<p>PCSK9 Inhibitors</p> <p><i>Praluent</i>[®] <i>Repatha</i>[™]</p>	<p>Prior authorization is required for PCSK9 Inhibitors. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient is 18 years of age or older (or, for Homozygous Familial Hypercholesterolemia patient is 13 years of age or older); AND 2. Current use of a statin and documentation of adherence to prescribed lipid lowering medications for the previous 90 days is provided (further defined below, by diagnosis); AND 3. Is to be prescribed as an adjunct to a low fat diet; AND 4. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; AND 5. Documentation patient has been counseled on importance of abstinence from tobacco and, if a current smoker, be encouraged to enroll in a smoking cessation program; AND 6. Is prescribed by a lipidologist, cardiologist, or endocrinologist. 7. The 72-hour emergency supply rule does not apply to PCSK9 Inhibitors. 8. Prescriber and dispensing pharmacy will educate the patient on proper storage and administration. Improperly stored medications will not be replaced. 9. Lost or stolen medication replacement requests will not be authorized. 10. Goal is defined as a 50% reduction in untreated baseline LDL-C. 11. Is prescribed for one of the following diagnoses: <p style="margin-left: 20px;"><u>Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH)</u></p> <ol style="list-style-type: none"> 1. Total cholesterol > 290mg/dL or LDL-C > 190mg/dL; AND <ol style="list-style-type: none"> a. Presence of tendon xanthomas; OR b. In first or second degree relative, one of the following: <ol style="list-style-type: none"> i. Documented tendon xanthomas; or ii. MI at age ≤60 years; or iii. Total cholesterol > 290mg/dL; OR c. Confirmation of diagnosis by gene or receptor testing (attach results); AND 2. Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), PLUS ezetimibe (Zetia) 10mg daily, PLUS cholestyramine daily. <p style="margin-left: 20px;"><u>Diagnosis of Clinical Atherosclerotic Cardiovascular Disease (ASCVD)</u></p> <ol style="list-style-type: none"> 1. History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; AND 2. Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), PLUS ezetimibe (Zetia) 10mg daily, PLUS cholestyramine daily. <p style="margin-left: 20px;"><u>Diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) – Repatha (evolocumab) only</u></p>
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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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05 46

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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

1. Total cholesterol and LDL-C > 600mg/dL and triglycerides within reference range; OR
2. Confirmation of diagnosis by gene or receptor testing (attach results); AND
3. Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), PLUS ezetimibe (Zetia) 10mg daily, PLUS cholestyramine daily.

The required trials (excluding the statin trial) may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Initial and Renewal Authorizations

HeFH or ASCVD

- Initial
 - Praluent 75mg or Repatha 140mg every 2 weeks for 8 weeks (4 doses).
- Renewal
 - Lipid profile required at week 8, week 24, and every 6 months thereafter; and
 - Patient continues therapy with a maximally tolerated statin dose and remains at goal; and
 - Patient has continued compliance with a low fat diet; and

Praluent

- If LDL-C at goal, continue therapy at 75mg every 2 weeks for 24 weeks.
- If LDL-C not at goal, dose increase to 150mg every 2 weeks for 8 weeks (4 doses) and repeat LDL-C in 8 weeks.
 - If repeat LDL-C not at goal, discontinue Praluent.
 - If repeat LDL-C at goal, continue therapy at 150mg every 2 weeks for 24 weeks; or

Repatha

- If LDL-C at goal, continue therapy at 140mg every 2 weeks for 24 weeks.
- If LDL-C not at goal, discontinue Repatha.

HoFH (Repatha only)

- Initial
 - Repatha 420mg (3x140mg autoinjectors) every month for 3 months.
- Renewal
 - Lipid profile required after 3 months (third dose) and every 6 months thereafter; and
 - Continued therapy with a maximally tolerated statin dose.
 - If LDL-C at goal, continue therapy at 420mg every month for six months.
 - If LDL-C not at goal, discontinue Repatha; and
 - Patient has continued compliance with a low fat diet.

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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<p><i>Use PCSK9 Inhibitors PA form</i></p>	<p><u>Quantity Limits</u> Praluent/Repatha for HeFH or ASCVD</p> <ul style="list-style-type: none"> • A quantity limit of one syringe/pen/autoinjector per fill will apply (requires refill every 14 days). <p>Repatha for HoFH only</p> <ul style="list-style-type: none"> • A quantity limit of one three-pack per month
<p>Potassium Binders</p> <p><i>Use Potassium Binders PA form</i></p>	<p>Prior authorization (PA) is required for non-preferred potassium binders. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient is 18 years of age or older; and 2. Patient has a diagnosis of chronic hyperkalemia; and 3. Patient has documentation of a recent trial and therapy failure with sodium polystyrene sulfonate. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Pregabalin (Lyrica®)</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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. 48

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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<p>Proton Pump Inhibitors</p> <p><i>Use Proton Pump Inhibitor PA form</i></p>	<p>Prior authorization is not required for preferred proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day.</p> <p>Requests for PPIs exceeding one unit per day will be considered for the following diagnoses with additional documentation regarding the medical necessity:</p> <ol style="list-style-type: none"> 1. Barrett’s esophagus (Please fax a copy of the scope results with the initial request) 2. Erosive esophagitis (Please fax a copy of the scope results with the initial request) 3. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, and multiple endocrine adenomas). 4. Recurrent peptic ulcer disease 5. Gastroesophageal reflux disease will be considered after documentation of a therapeutic trial and therapy failure with concomitant use of once daily PPI dosing and a bedtime dose of a histamine H2-receptor antagonist. Upon failure of the combination therapy, subsequent requests for PPIs exceeding one unit per day will be considered on a short term basis (up to 3 months). After the three month period, a retrial of the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day. 6. Helicobacter pylori will be considered for up to 14 days of treatment with documentation of active infection. <p>Payment for a non-preferred proton pump inhibitor will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred products.</p>
<p>Pulmonary Arterial Hypertension Agents</p> <p><i>Use Pulmonary Arterial Hypertension Agents PA form</i></p>	<p>Prior Authorization is required for agents used to treat pulmonary hypertension. Payment will be approved under the following conditions:</p> <ol style="list-style-type: none"> 1. Diagnosis of pulmonary arterial hypertension
<p>Quantity Limit Override</p> <p><i>Use Quantity Limit Override PA form</i></p>	<p>Designated drugs are limited to specific quantity limitations. These drugs are identified on the Iowa Medicaid Quantity Limit Chart posted on the website www.iowamedicaidpdl.com under the Billing/Quantity Limits tab. Providers should submit a Prior Authorization request for override consideration.</p>
<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>

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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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<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) when dosed within the established quantity limits. Requests for doses above the manufacturer recommended dose will not be considered.</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 previous trials and therapy failures with, at a minimum, three (3) preferred agents. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> 1. A diagnosis of insomnia; and 2. Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued; and 3. Enforcement of good sleep hygiene is documented; and 4. All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses. 5. In addition to the above criteria, requests for suvorexant (Belsomra) will require documentation of a trial and therapy failure with at least one non-preferred agent, other than suvorexant, prior to consideration of coverage. 6. Non-preferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Select Oncology Agents</p> <p>(Drugs included on the right)</p> <p><i>Use Select Oncology Agents PA form</i></p>	<p>Prior authorization is required for select oncology agents. Patient must have a diagnosis that is indicated in the FDA approved package insert or the use is for an indication supported by the compendia (including National Comprehensive Cancer Network (NCCN) compendium level of evidence 1, 2A, or 2B). The following must be submitted with the prior authorization request: copies of medical records (i.e. diagnostic evaluations and recent chart notes), location of treatment (provider office, facility, home health, etc.) if medication requested is not an oral agent, the original prescription, and the most recent copies of related laboratory results. If criteria for coverage are met, initial authorization will be given for three (3) months. Additional authorizations will be considered for up to six (6) month intervals when criteria for coverage are met. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued unless otherwise justified.</p> <p>Brand/generic and all dosage forms of the following agents are subject to this criteria: Afinitor, Alecensa, Bosulif, Cabometyx, Cotellic, Erbitux, Erivedge, Gilotrif, Gleevec, Herceptin, Hycamtin, Hydroxyprogesterone Caproate, Ibrance, Imbruvica, Inlyta, Istodax, Kisqali, Lonsurf, Lupron Depot, Lynparza, Mekinist, Nexavar, Ninlaro, Odomzo, Pomalyst, Revlimid, Sprycel, Stivarga, Sutent, Tafinlar, Tagrisso, Tarceva, Tassigna, Temodar, Tretinoin (chemotherapy), Tykerb, Venclexta, Votrient, Xalkori, Xeloda, Zelboraf, Zydelig, Zykadia.</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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05 53

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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<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><u>Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.</u></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.

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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05 54

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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<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 18 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® REMS 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. Patients with and without a history of substance abuse have been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence. 6. Requests for patients with concurrent use of a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered. 7. 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. <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>
<p>Tasimelteon (Hetlioz®)</p> <p><i>Use Tasimelteon (Hetlioz®) PA form</i></p>	<p>Prior authorization is required for tasimelteon (Hetlioz®). Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as confirmed by a sleep specialist; and 2. Patient is 18 years of age or older; and 3. Documentation the patient is totally blind with no perception of light is provided; and 4. Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and 5. Patient has a documented trial and therapy failure with ramelteon (Rozerem®). <p>If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered when the patient has received 3 months of continuous therapy and patient has achieved adequate results with tasimelteon (Hetlioz®), such as entrainment, significant increases in nighttime sleep, and/or significant decreases in daytime sleep.</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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 6/1/2018

<p>Topical Acne and Rosacea Products</p> <p><i>Use Topical Acne and Rosacea Products PA form</i></p>	<p>Prior authorization (PA) is required for topical acne agents (topical antibiotics and topical retinoids) and topical rosacea agents. Payment for topical acne and topical rosacea agents will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Documentation of diagnosis. 2. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid. 3. 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 from the requested topical class (topical antibiotic or topical retinoid). 4. Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical agent. 5. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products. 6. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis. 7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for the preferred tazarotene (Tazorac) product for a psoriasis diagnosis. 8. Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) 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>Topical Antifungals for Onychomycosis</p> <p><i>Use Topical Antifungals for Onychomycosis PA form</i></p>	<p>Jublia® (efinaconazole) and Kerydin® (tavaborole) will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of onychomycosis of the toenail(s) confirmed by a positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy (attach results) without dermatophytomas or lunula (matrix) involvement; and 2. Patient is 18 years of age or older; and 3. Patient has documentation of a complete trial and therapy failure or intolerance to oral terbinafine; and 4. Patient has documentation of a complete trial and therapy failure or intolerance to ciclopirox 8% topical solution; and 5. Patient is diabetic or immunosuppressed/immunocompromised. <p>If the criteria for coverage are met, a one-time authorization of 48 weeks will be given. Requests for reoccurrence of infection will not be considered</p> <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Topical Corticosteroids</p> <p><i>Use Topical Corticosteroids PA form</i></p>	<p>Prior authorization is required for non-preferred topical corticosteroids. Payment will be considered for patients when there is documentation of adequate trials and therapy failures with at least two preferred, chemically distinct, topical corticosteroid agents within the same potency class or a higher potency class in the past 12 months. The required trials may be overridden when documented evidence is provided that the 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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered. 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. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 6/1/2018

<p>Valsartan/Sacubitril (Entresto™)</p> <p><i>Use Valsartan/Sacubitril (Entresto) PA form</i></p>	<p>Prior authorization is required for valsartan/sacubitril (Entresto™). Requests 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. Patient is 18 years of age or older; and 2. Patient has a diagnosis of NYHA Functional Class II, III, or IV heart failure; and 3. Patient has a left ventricular ejection fraction (LVEF) ≤40%; and 4. Patient is currently tolerating treatment with an ACE inhibitor or angiotensin II receptor blocker (ARB) at a therapeutic dose, where replacement with valsartan/sacubitril is recommended to further reduce morbidity and mortality; and 5. Is to be administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB (list medications patient is currently taking for the treatment of heart failure); and 6. Will not be used in combination with an ACE inhibitor or ARB; and 7. Will not be used in combination with aliskiren (Tekturna) in diabetic patients; and 8. Patient does not have a history of angioedema associated with the use of ACE inhibitor or ARB therapy; and 9. Patient is not pregnant; and 10. Patient does not have severe hepatic impairment (Child Pugh Class C); and 11. Prescriber is a cardiologist or has consulted with a cardiologist (telephone consultation is acceptable). <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>Vorapaxar (Zontivity™)</p> <p><i>Use Vorapaxar (Zontivity) PA form</i></p>	<p>Prior authorization is required for vorapaxar (Zontivity™). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient has a history of myocardial infarction (MI) or peripheral artery disease (PAD); and 2. Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and 3. Patient has documentation of an adequate trial and therapy failure with aspirin plus clopidogrel; and 4. Patient will use vorapaxar concurrently with aspirin and/or clopidogrel. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</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, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05