

Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

<p>Acute Migraine Treatments</p> <p><i>Use Acute Migraine Treatments PA form</i></p>	<p>No prior authorization (PA) is required for preferred acute migraine treatments, as indicated on the Preferred Drug List (PDL). PA is required for acute migraine treatments under the following conditions:</p> <ol style="list-style-type: none"> 1. A diagnosis of acute migraine; and 2. Patient meets the FDA approved age for requested agent; and 3. For preferred acute migraine treatments where PA is required, as indicated on the PDL, documentation of previous trials and therapy failures with two preferred agents that do not require PA; and/or 4. For non-preferred acute migraine treatments, documentation of previous trials and therapy failures with two preferred agents that do not require PA. Requests for non-preferred CGRP inhibitors will also require documentation of a trial and therapy failure with a preferred CGRP inhibitor; and/or 5. For quantities exceeding the established quantity limit for each agent, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications; and/or 6. For non-preferred combination products, documentation of separate trials and therapy failures with the individual ingredients, in addition to the above criteria for preferred or non-preferred acute migraine treatments requiring PA. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<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 (PA) Criteria.</i></p>

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Updated 10/01/2022

	<p>following conditions:</p> <ul style="list-style-type: none"> a. Patient continues therapy with a maximally tolerated statin dose and remains at goal; and b. Patient continues to follow an appropriate low fat diet; and c. Documentation of LDL reduction is provided. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</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> <ul 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.

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Updated 10/01/2022

<p>Antidepressants</p> <p><i>Aplenzin</i> <i>Fetzima</i> <i>Viibryd</i></p> <p><i>Use Antidepressants PA form</i></p>	<p>Prior authorization (PA) 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 (PA) 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. Patient has an FDA approved or compendia indicated diagnosis, and 2. Patient meets the FDA approved or compendia indicated age, and 3. For the treatment of Type 2 Diabetes Mellitus, the patient has not achieved HgbA1C goals after a minimum three month trial with metformin at maximally tolerated dose. 4. Requests for non-preferred anti-diabetic, non-insulin agents subject to clinical criteria, will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. Requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document 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>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 PAs will be considered on an individual basis after review of medical necessity and documented continued improvement in symptoms (such as HgbA1C for Type 2 Diabetes).</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 (PA) 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>PA 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>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 (1mg/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></td> </tr> <tr> <td style="padding-left: 20px;">2 – 300/0.5mg capsules</td> <td></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 (1mg/mL)	Ondansetron Oral Solution (N)/ Zofran Oral Solution (N)	2 vials (4mg/mL)	50mL/month – oral solution (4mg/5mL)	Akynzeo (N):		2 – 300/0.5mg capsules	
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<p>Anti-Fungal- Oral / Injectable</p> <p><i>Use Anti-Fungal PA form</i></p>	<p>Prior authorization (PA) is not required for preferred antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. PA will be required for all non-preferred antifungal therapy beginning the first day of therapy. Payment for a non-preferred 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 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 PA requirement does not apply to nystatin.</p>																										

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Updated 10/01/2022

<p>Antihistamines</p> <p><i>Use Antihistamine PA form</i></p>	<p>Prior authorization (PA) 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 PA, prior to the approval of a non-preferred oral antihistamine. Two of the trials must be with cetirizine and loratadine.</p> <p>Patients 20 years of age and younger must have unsuccessful trials with cetirizine and loratadine prior to the approval of a non-preferred oral antihistamine.</p> <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>Apremilast (Otezla)</p> <p><i>Use Apremilast (Otezla) PA form</i></p>	<p>Prior authorization (PA) is required for apremilast (Otezla). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and 2. Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints); with <ol style="list-style-type: none"> a. 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); or 3. Patient has a diagnosis of plaque psoriasis; with <ol style="list-style-type: none"> a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; or 4. Patient has a diagnosis of Behçet disease; with <ol style="list-style-type: none"> a. Documentation of active oral ulcers associated with Behçet disease; and b. Documentation of a previous trial and inadequate response, at a therapeutic dose, to colchicine. <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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<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>Ixekizumab (Taltz)</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> <i>Risankizumab (Skyrizi)</i></p> <p><i>Use Biologicals for Arthritis PA form</i></p>	<p>Prior authorization (PA) is required for biologicals used for arthritis. Request must adhere to all FDA approved labeling, including age, indication, dosing, and contraindications. Payment for non-preferred biologicals for arthritis 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> <ol style="list-style-type: none"> 1. Patient has been screened for hepatitis B and C. Patients with evidence of active hepatitis B infection (hepatitis surface antigen positive > 6 months) must have documentation they are receiving or have received effective antiviral treatment; and 2. 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 3. Patient has a diagnosis of rheumatoid arthritis (RA);with <ol style="list-style-type: none"> a. Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (hydroxychloroquine, sulfasalazine, or leflunomide may be used if methotrexate is contraindicated); or 4. Patient has a diagnosis of moderate to severe psoriatic arthritis; with <ol style="list-style-type: none"> a. Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 5. Patient has a diagnosis of moderate to severe juvenile idiopathic arthritis; with <ol style="list-style-type: none"> 1. Documentation of a trial and inadequate response to intraarticular glucocorticoid injections and methotrexate at a maximally tolerated dose (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and <p>In addition to the above: Requests for TNF Inhibitors:</p> <ol style="list-style-type: none"> 1. 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 2. 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> <ol style="list-style-type: none"> 1. 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 10/01/2022

<p>Biologicals for Plaque Psoriasis <i>Adalimumab (Humira)</i> <i>Etanercept (Enbrel)</i> <i>Secukinumab (Cosentyx)</i> <i>Ustekinumab (Stelara)</i> <i>Brodalumab (Siliq)</i> <i>Ixekizumab (Taltz)</i> <i>Guselkumab (Tremfya)</i> <i>Certolizumab (Cimzia)</i> <i>Risankizumab (Skyrizi)</i></p> <p><i>Use Biologicals for Plaque Psoriasis PA form</i></p>	<p>Prior authorization (PA) 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> <ol style="list-style-type: none"> 1. Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and 2. 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 3. 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> <ol style="list-style-type: none"> 1. 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 2. 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> <ol style="list-style-type: none"> 1. 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 10/01/2022

<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 PA for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website. Requests will be considered for an FDA approved age for the submitted diagnosis. Payment for CNS stimulants and atomoxetine will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. 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 improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. Adults (≥ 21 years of age) are limited to the use of long-acting agents only. If supplemental dose with a short-acting agent is needed for an adult in the mid to late afternoon, requests will be considered under the following circumstances: the dose of the long-acting agent has been optimized, documentation is provided a short-acting agent of the same chemical entity is medically necessary (e.g. employed during the day with school in the evening, and will be limited to one unit dose per day. Children (< 21 years of age) are limited to the use of long-acting agents with one unit of a short acting agent per day. 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) <ol style="list-style-type: none"> a. Patient is 18 to 55 years of age; and b. Patient meets DSM-5 criteria for Binge Eating Disorder (BED); and c. 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 d. 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 e. Prescription is written by a psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and f. Patient has a BMI of 25 to 45; and g. Patient does not have a history of cardiovascular disease; and h. Patient has no history of substance abuse; and i. Is not being prescribed for the treatment of obesity or weight loss; and j. Doses above 70mg per day will not be considered. k. Initial requests will be approved for 12 weeks.
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Updated 10/01/2022

<p><i>Use CNS Stimulants and Atomoxetine or Binge Eating Disorder Agents PA form</i></p>	<p>1. Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week.</p> <p><u>DSM-5 Criteria</u></p> <ul style="list-style-type: none"> 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 ii. The binge eating episodes are marked by at least three of the following: <ul style="list-style-type: none"> 1. Eating more rapidly than normal 2. Eating until feeling uncomfortably full 3. Eating large amounts of food when not feeling physically hungry 4. Eating alone because of embarrassment by the amount of food consumed 5. Feeling disgusted with oneself, depressed, or guilty after overeating; and iii. Episodes occur at least 1 day a week for at least 3 months; and iv. No regular use of inappropriate compensatory behaviors (e.g. purging, fasting, or excessive exercise) as are seen in bulimia nervosa; and v. Does not occur solely during the course of bulimia nervosa or anorexia nervosa. <p><u>Moderate to Severe BED</u></p> <p>Based on the number of binge eating episodes per week:</p> <ul style="list-style-type: none"> Moderate - 4 to 7 Severe – 8 to 13 Extreme – 14 or more <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 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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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 18

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 10/01/2022

<p>Dalfampridine (Ampyra)</p> <p><i>Use Dalfampridine (Ampyra™) PA form</i></p>	<p>Prior authorization (PA) 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 PAs 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>PAs will not be considered for patients with a seizure diagnosis or in patients will moderate to severe renal impairment.</p>
<p>Deferasirox (Exjade)</p>	<p>Prior authorization (PA) is required for deferasirox. Requests will only be considered for FDA approved dosing. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance <40mL/min; and 2. Patient does not have a poor performance status; and 3. Patient does not have a high-risk myelodysplastic syndrome; and 4. Patient does not have advanced malignancies; and 5. Patient does not have a platelet count < 50 x 10⁹/L. <p>Transfusional Iron Overload</p> <p><u>Initiation of Therapy</u></p> <ol style="list-style-type: none"> 1. Patient is 2 years of age or older; and 2. Patient has documentation of iron overload related to anemia (attach documentation); and 3. Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overload; and 4. Serum ferritin is consistently > 1000 mcg/L (attach lab results dates within the past month); and 5. Starting dose does not exceed: Exjade- 20mg/kg/day or Jadenu- 14mg/kg/day. Calculate dose to the nearest whole tablet. 6. Initial requests will be considered for up to 3 months. <p><u>Continuation of Therapy</u></p> <ol style="list-style-type: none"> 1. Serum ferritin has been measured within 30 days of continuation of therapy request (attach documentation); and 2. Ferritin levels are > 500mcg/L; and 3. Dose does not exceed: Exjade- 40mg/kg/day or Jadenu- 28mg/kg/day. <p>Non-Transfusional Iron Overload</p> <p><u>Initiation of Therapy</u></p> <ol style="list-style-type: none"> 1. Patient is 10 years of age or older; and 2. Patient has documentation of iron overload related to anemia (attach documentation); and 3. Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); 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.

Updated 10/01/2022

<p><i>Use Deferasirox (Exjade) PA form</i></p>	<ol style="list-style-type: none"> 4. Serum ferritin levels are > 300mcg/L; and 5. LIC are > 5mg Fe/g dw; and 6. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 20mg/kg/day (if LIC is > 15mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 14mg/kg/day (if LIC is > 15mg Fe/g dw). 7. Initial authorization will be considered for up to 6 months. <p><u>Continuation of Therapy</u></p> <ol style="list-style-type: none"> 1. Serum ferritin and LIC have been measured within 30 days of continuation of therapy request; and 2. Serum ferritin levels are ≥ 300mcg/L; and 3. LIC is ≥ 3mg Fe/g dw; and 4. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw) or Jadenu- 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw).
<p>Deflazacort (Emflaza)</p> <p><i>Use Deflazacort (Emflaza™) PA form</i></p>	<p>Prior authorization (PA) 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)</p> <p><i>Use Dextromethorphan and Quinidine (Nuedexta) PA form</i></p>	<p>Prior authorization (PA) 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>

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 21

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 10/01/2022

Duplicate Therapy Edits Antipsychotics NSAIDs <i>Use Duplicate Therapy</i> <i>Edit Override PA form</i>	Designated therapeutic classes are subject to duplicate therapy edits. Providers should submit a Prior Authorization request for override consideration.
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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 24

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 10/01/2022

<p>Erythropoiesis Stimulating Agents</p> <p><i>Use Erythropoiesis Stimulating Agent PA form</i></p>	<p>Prior authorization (PA) 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 PA 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>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 for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. 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 3. 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 (PA) is required for the following extended release formulation(s): Adoxa, Amoxicillin ER, Astagraf XL, Augmentin XR, Cardura XL, Carvedilol ER, Coreg CR, Doryx, Elepsia XR, Envarsus XR, Glumetza, Gocovri, Gralise, Kapsargo, Keppra XR, Lamictal XR, Luvox CR, Memantine ER, Mirapex ER, Moxatag, Namenda XR, Oleptro, Osmolex ER, Oxtellar XR, Pramipexole ER, Pregabalin 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 (PA) 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>

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 26

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 10/01/2022

<p>Fentanyl, Short Acting Products</p> <p><i>Use Short Acting Fentanyl Products PA form</i></p>	<p>Prior authorization (PA) 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> <ol style="list-style-type: none"> 1. 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. 2. 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 (PA) request for override consideration. Documentation of medical necessity, excluding patient convenience, is required for consideration of the fifteen day initial supply override.</p>
<p>Finerenone (Kerendia)</p>	<p>Prior authorization (PA) is required for finerenone (Kerendia). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Request adheres to all FDA approved labeling, including age, dosing, contraindications, warnings and precautions, and drug interactions; and 2. Patient has a diagnosis of chronic kidney disease (CKD) associated with Type 2 Diabetes (T2D); and 3. Patient is currently receiving a maximally tolerated dose of an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB); and 4. Patient is currently receiving a maximally tolerated dose of a sodium-glucose co-transporter 2 (SGLT2) inhibitor indicated to reduce the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, and hospitalization for heart failure in adults with chronic kidney disease [i.e., dapagliflozin (Farxiga)]; and 5. Patient has the following baseline tests prior to initiation of treatment with finerenone: <ol style="list-style-type: none"> a. Serum potassium is ≤ 5.0 mEq/L; and b. Estimated glomerular filtration rate (eGFR) is ≥ 25 mL/min/1.73m²; and c. Urine albumin to creatinine ration (UACR) is ≥ 30 mg/g. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Initial authorizations will be approved for six months. Additional PAs will be considered with the following documentation:</p>

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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

<p><i>Use Finerenone (Kerendia) PA form</i></p>	<ol style="list-style-type: none"> 1. Patient's serum potassium is < 5.5 mEq/L; and 2. Patient's eGFR is ≥ 25 mL/min/1.73m²; and 3. Patient remains on a maximally tolerated dose of an ACEi or ARB; and 4. Patient remains on a maximally tolerated dose of an SGLT2 inhibitor.
<p>GLP-1 Agonist/Basal Insulin Combinations</p> <p><i>Use GLP-1 Agonist/Basal Insulin Combinations PA form</i></p>	<p>Prior authorization (PA) 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>Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral</p>	<p>Prior authorization (PA) is required for oral gonadotropin-releasing hormone (GnRH) antagonists. Payment for non-preferred oral GnRH antagonists may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent. Payment will be considered for patients when the following is met:</p> <ol style="list-style-type: none"> 1. Pregnancy has been ruled out; and 2. Patient does not have osteoporosis; and 3. Request adheres to all FDA approved labeling for requested drug, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 4. Requests for elagolix (Orilissa) will be considered under the following conditions: <ol style="list-style-type: none"> a. Patient has a diagnosis of moderate to severe pain associated with endometriosis; and

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 10/01/2022

<p><i>Use Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral PA form</i></p>	<ul style="list-style-type: none"> b. Patient has documentation of a previous trial and therapy failure with at least one preferred oral NSAID and at least one preferred 3-month course of a continuous hormonal contraceptive taken concurrently; and c. Patient has documentation of a previous trial and therapy failure with a preferred GnRH agonist. d. Initial requests will be considered for 3 months. Additional requests will be considered upon documentation of improvement of symptoms e. Requests will be considered for a maximum of 24 months for the 150mg dose and six (6) months for the 200mg dose; or <p>5. Requests for elagolix, estradiol, and norethindrone acetate; elagolix (Oriahnn) or relugolix, estradiol, norethindrone acetate (Myfembree) will be considered under the following conditions:</p> <ul style="list-style-type: none"> a. Patient is premenopausal; and b. Patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids); and c. Patient has documentation of a previous trial and therapy failure with at least one preferred 3-month course of a continuous hormonal contraceptive; and d. Patient has documentation of a previous trial and therapy failure with tranexamic acid. e. Initial requests will be considered for 6 months. Additional requests will be considered upon documentation of improvement of symptoms. f. Requests will be considered for a maximum of 24 months of treatment. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Granulocyte Colony Stimulating Factor Agents</p> <p><i>Use Granulocyte Colony Stimulating Factor PA form</i></p>	<p>Prior authorization (PA) 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> <ul 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. <p>On current chemotherapy drug(s) that would cause severe neutropenia.</p>
<p>Growth Hormone</p>	<p>Prior authorization (PA) is required for therapy with growth hormones. Requests will only be considered for FDA approved dosing. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. The following FDA approved indications for Growth Hormone therapy are considered not medically necessary and requests will be denied: Idiopathic Short Stature (ISS) and Small for Gestational Age (SGA). Payment will be considered under the following conditions:</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 10/01/2022

	<p>Children with Growth Hormone Deficiency</p> <ol style="list-style-type: none"> 1. Standard deviation of 2.0 or more below mean height for chronological age; and 2. No expanding intracranial lesion or tumor diagnosed by MRI; and 3. Growth rate below five centimeters per year; and 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter; and 5. Annual bone age testing is required. A Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 6. Epiphyses open. <p>Pediatric Chronic Kidney Disease</p> <ol style="list-style-type: none"> 1. Is prescribed by or in consultation with a nephrologist; and 2. Standard deviation of 2.0 or more below mean height for chronological age; and 3. No expanding intracranial lesion or tumor diagnosed by MRI; and 4. Growth rate below five centimeters per year; and 5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 6. Epiphyses open. <p>Turner's Syndrome</p> <ol style="list-style-type: none"> 1. Chromosomal abnormality showing Turner's syndrome; and 2. Prescribed by or in consultation with an endocrinologist; and 3. Standard deviation of 2.0 or more below mean height for chronological age; and 4. No expanding intracranial lesion or tumor diagnosed by MRI; and 5. Growth rate below five centimeters per year; and 6. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 7. Epiphyses open. <p>Prader Willi Syndrome</p> <ol style="list-style-type: none"> 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; and 3. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 4. Epiphyses open. <p>Noonan Syndrome</p> <ol style="list-style-type: none"> 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; 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.

Updated 10/01/2022

<p><i>Use Growth Hormone PA form</i></p>	<ol style="list-style-type: none"> 3. Standard deviation of 2.0 or more below mean height for chronological age; and 4. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 5. Epiphyses open. <p>SHOX (Short stature Homeobox)</p> <ol style="list-style-type: none"> 3. Diagnosis is confirmed by appropriate genetic testing (attach results); and 4. Prescribed by or in consultation with an endocrinologist; and 5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 6. Epiphyses open. <p>Adults with Growth Hormone Deficiency</p> <ol style="list-style-type: none"> 1. Patients who were growth hormone deficient during childhood (childhood onset) and who have a continued deficiency; or 2. Patients who have growth hormone deficiency (adult onset) as a result of pituitary or hypothalamic disease (e.g., panhypopituitarism, pituitary adenoma, trauma, cranial irradiation, pituitary surgery); and 3. Failure of at least one growth hormone stimulation test as an adult with a peak growth hormone value of ≤ 5 mcg/L after stimulation. <p>Adults with AIDS Wasting/Cachexia</p> <ol style="list-style-type: none"> 1. Greater than 10% of baseline weight loss over 12 months that cannot be explained by a concurrent illness other than HIV infection; and 2. Patient is currently being treated with antiviral agents; and 3. Patient has documentation of a previous trial and therapy failure with an appetite stimulant (i.e. dronabinol or megestrol). <p>Short Bowel Syndrome</p> <p>If the request is for Zorbtive [somatropin (rDNA origin) for injection] approval will be granted in patients receiving specialized nutritional support. Zorbtive therapy should be used in conjunction with optimal management of Short Bowel Syndrome. PA will be considered for a maximum of 4 weeks.</p> <p>If the criteria for coverage is met, initial requests will be given for 12-month periods, unless otherwise stated above. Additional PAs will be considered upon documentation of clinical response to therapy and patient continues to meet the criteria for the submitted diagnosis.</p>
<p>Hematopoietics/ Chronic ITP</p>	<p>Prior authorization (PA) is required for hematopoietics/chronic ITP agents. Request must adhere to all FDA approved labeling. Payment for a non-preferred hematopoietic/chronic ITP agent will be considered following documentation of a recent trial and therapy failure with a preferred hematopoietic/ITP agent, when applicable, unless such a trial would be medically contraindicated. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. A diagnosis of thrombocytopenia with chronic immune thrombocytopenia (ITP) (Doptelet, Promacta, Nplate, Tavalisse) <ol style="list-style-type: none"> a. Patient has documentation of an insufficient response to a corticosteroid, immunoglobulin, or splenectomy. 2. A diagnosis of severe aplastic anemia (Promacta) <ol style="list-style-type: none"> a. Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy; 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.

Updated 10/01/2022

<p><i>Use Hematopoietics/Chronic ITP PA form</i></p>	<ul style="list-style-type: none"> b. Patient has a platelet count less than or equal to $30 \times 10^9/L$. c. If criteria for coverage are met, initial authorization will be given for 16 weeks. Documentation of hematologic response after 16 weeks of therapy will be required for further consideration. <p>3. A diagnosis of thrombocytopenia with chronic liver disease in patients who are scheduled to undergo a procedure with the following documentation (Doptelet, Mulpleta):</p> <ul style="list-style-type: none"> a. Pre-treatment platelet count; and b. Scheduled dosing prior to procedure; and c. Therapy completion prior to scheduled procedure; and d. Platelet count will be obtained before procedure.
<p>Hepatitis C Treatments, Direct Acting Antivirals</p>	<p>Prior authorization (PA) is required for hepatitis C direct-acting antivirals (DAA). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions:</p> <ul style="list-style-type: none"> 1. Patient has a diagnosis of chronic hepatitis C; and 2. Patient's age and/or weight is within the FDA labeled age and/or weight; and 3. Patient has had testing for hepatitis C virus (HCV) genotype; and 4. Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and 5. Patient has been tested for hepatitis B (HBV) prior to initiating treatment of HCV and individuals with active HBV infection are treated (either at same time as HCV therapy or before HCV therapy is started); and 6. Patient's prior HCV DAA treatment history is provided (treatment naïve or treatment experienced); and 7. 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 8. Patient has been evaluated to determine the patient's readiness for HCV treatment with scales or assessment tools, such as SAMHSA-HRSA Center for Integrated Health Solutions – Drug & Alcohol Screening Tools and the Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment (PREP-C); and 9. Patient has been educated on the importance of abstinence from IV drug use and alcohol use, the importance of compliance with HCV treatment, and how to prevent HCV transmission. If patient is currently using IV drug and/or alcohol, recommend the patient participate in alcohol and/or substance abuse counseling; and 10. HCV treatment is prescribed by or in consultation with a digestive disease, liver disease, or infectious disease provider practice; and 11. DAAs approved for pediatric use will be considered for those under the age of 18 when used in accordance with current AASLD guidelines including for indication and age; and

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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

<p><i>Use Hepatitis C Treatments, Direct Acting Antivirals PA form</i></p>	<ol style="list-style-type: none"> 12. 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 13. Prescriber has reviewed the patient’s current medication list and acknowledged that there are no significant drug interactions with the DAA; and 14. Documentation is provided for patients who are ineligible to receive ribavirin; and 15. Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved; and 16. Patient does not have limited life expectancy (less than 12 months) due to non-liver related comorbid conditions. 17. 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. 18. Lost or stolen medication replacement requests will not be authorized. 19. The 72-hour emergency supply rule does not apply to DAAs. <p>Requests for treatment-experienced patients (with previous DAA) will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient must meet all criteria for treatment approval above; and 2. Patients who previously achieved SVR that have HCV recurrence due to IV drug use must have documentation that the patient has completed or is participating in a recovery program, receiving alcohol or substance abuse counseling services, or seeing an addiction specialist as part of HCV treatment, and can be managed as an initial infection; and 3. The requested therapy is FDA approved as therapy for treatment-experienced patients and follows current AASLD guidelines; and 4. Patient has not been previously treated with and failed the requested DAA therapy; and 5. Documentation is provided patient has a documented presence of detectable HCV RNA at least 12 weeks after completing previous DAA treatment.
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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

High Dose Opioids	<p>Prior authorization (PA) is required for use of high-dose opioids \geq 90 morphine milligram equivalents (MME) per day (See CDC Guideline for Prescribing Opioids for Chronic Pain at https://www.cdc.gov/drugoverdose/prescribing/guideline.html). Patients undergoing active cancer treatment or end-of-life care will not be subject to the criteria below. Payment will be considered when the following is met:</p> <ol style="list-style-type: none"> 1. Requests for non-preferred opioids meet criteria for coverage (see criteria for Long-Acting Opioids and/or Short-Acting Opioids); and 2. Patient has a diagnosis of severe, chronic pain with a supporting ICD-10 code. Requests for a diagnosis of fibromyalgia or migraine will not be considered; and 3. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 4. Patient has tried and failed at least two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants); and 5. There is documentation demonstrating an appropriate upward titration or an appropriate conversion from other opioid medications; and 6. Pain was inadequately controlled at the maximum allowed dose without prior authorization for the requested opioid(s); and 7. Pain was inadequately controlled by 2 other chemically distinct preferred long-acting opioids at the maximum allowed dose without prior authorization; and 8. Chart notes from a recent office visit for pain management is included documenting the following: <ol style="list-style-type: none"> a. Treatment plan – including all therapies to be used concurrently (pharmacologic and non-pharmacologic); and b. Treatment goals; and 9. Patient has been informed of the risks of high-dose opioid therapy; and 10. The prescriber has reviewed the patient’s use of controlled substances on the Iowa Prescription Monitoring Program website and determined that use of high-dose opioid therapy is appropriate for this patient; and 11. The patient’s risk for opioid addiction, abuse and misuse has been reviewed and prescriber has determined the patient is a candidate for high-dose opioid therapy; and 12. A signed chronic opioid therapy management plan between the prescriber and patient dated within 12 months of this request is included; and 13. The requested dosing interval is no more frequent than the maximum FDA-approved dosing interval; and 14. Patient has been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose; and 15. Patient has been educated on opioid overdose prevention; and 16. Patient’s household members have been educated on the signs of opioid overdose and how to administer naloxone; and 17. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with initial and subsequent requests; and 18. A documented dose reduction is attempted at least annually.
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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

<p><i>Use High Dose Opioids PA form</i></p>	<p>If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of high-dose opioid therapy will be considered every 6 months with the following:</p> <ol style="list-style-type: none"> 1. High-dose opioid therapy continues to meet treatment goals, including sustained improvement in pain and function; and 2. Patient has not experienced an overdose or other serious adverse event; and 3. Patient is not exhibiting warning signs of opioid use disorder; and 4. The benefits of opioids continue to outweigh the risks; and 5. A documented dose reduction has been attempted at least annually, and the prescriber has determined the dose cannot be reduced at this time; and 6. The prescriber has reviewed the patient’s use of controlled substances on the Iowa Prescription Monitoring Program website and determined that continued use of high-dose opioid therapy is appropriate for this patient; and 7. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with subsequent requests. 8. Patient has been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose; and 9. Patient has been reeducated on opioid overdose prevention; and 10. Patient’s household members have been reeducated on the signs of opioid overdose and how to administer naloxone.
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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

<p>IL-5 Antagonists</p> <p><i>Fasenra</i> <i>Nucala</i></p>	<p>Prior authorization is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. 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. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Is requested for an FDA approved or compendia indicated diagnosis; and 2. Patient meets the FDA approved or compendia indicated age and dose for submitted diagnosis; and 3. Patient has a diagnosis of severe asthma with an eosinophilic phenotype, and <ol style="list-style-type: none"> a. Patient has a pretreatment blood eosinophil count of ≥ 150 cells/mcL within the previous 6 weeks or blood eosinophils ≥ 300 cells/mcL within 12 months prior to initiation of therapy; and b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and c. Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and d. A pretreatment forced expiratory volume in 1 second (FEV₁) < 80% predicted in adults and < 90% in adolescents; or 4. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis, and <ol style="list-style-type: none"> a. Patient has documentation of an adequate trial and therapy failure with systemic glucocorticoids; and b. One of the following: <ol style="list-style-type: none"> i. Eosinophil count > 1000 cells/mcL; or ii. Eosinophil count > 10% of the total leukocyte count; and 5. Patient has a diagnosis of hypereosinophilic syndrome (HES); and <ol style="list-style-type: none"> a. Patient has been diagnosed with HES for ≥ 6 months prior to starting treatment; and b. Documentation that non-hematologic secondary causes of HES have been ruled out; and c. Documentation patient does not have FIP1L1-PDGFRα kinase-positive HES; and d. Documentation of ≥ 2 HES flares within the previous 12 months while on stable HES therapy (e.g., chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy); and e. Patient has a blood eosinophil count $\geq 1,000$ cells/mcL; and f. Medication will be used in combination with stable doses of at least one other HES therapy; and 6. Prescribed by or in consultation with an allergist, hematologist, immunologist, pulmonologist, or rheumatologist. <p>If criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis or 6 months for a diagnosis of hypereosinophilic syndrome to assess the need for</p>
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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

<p><i>Use IL-5 Antagonists PA form</i></p>	<p>continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met: Severe Asthma with an Eosinophilic Phenotype:</p> <ol style="list-style-type: none"> 1. Patient continues to receive therapy with an ICS, LABA and LTRA; and 2. Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or 3. Patient has experienced a decrease in administration of rescue medication (albuterol); or 4. Patient has experienced a decrease in exacerbation frequency; or 5. Patient has experienced an increase in predicted FEV₁ from the pretreatment baseline. <p>Eosinophilic Granulomatosis with Polyangiitis</p> <ol style="list-style-type: none"> 1. Patient has demonstrated a positive clinical response to therapy (increase in remission time). <p>Hypereosinophilic Syndrome:</p> <ol style="list-style-type: none"> 1. Patient has demonstrated positive clinical response to therapy (improvement of symptoms and/or reduction in the number of flares); and 2. Medication continues to be used in combination with stable doses or at least one other HES therapy. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Immunomodulators-Topical</p> <p><i>Elidel</i> <i>Protopic</i></p> <p><i>Use Immunomodulators-Topical PA form</i></p>	<p>Prior authorization (PA) is required for topical immunomodulators. Payment for non-preferred topical immunomodulator products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment for pimecrolimus (Elidel) or tacrolimus (Protopic) 0.03% will be considered for non-immunocompromised patients two years of age and older and tacrolimus (Protopic) 0.1% for patients 16 years of age and older when there is an adequate trial and therapy failure with one preferred topical corticosteroid, except on the face or groin. If criteria for coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 grams or 100 grams for all other areas. 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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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

Janus Kinase Inhibitors	<p>Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:</p> <ol style="list-style-type: none"> 1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3. Patient has a diagnosis of: <ol style="list-style-type: none"> a. Moderate to severe rheumatoid arthritis; with <ol style="list-style-type: none"> i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR b. Psoriatic arthritis; with <ol style="list-style-type: none"> i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR c. Moderately to severely active ulcerative colitis; with <ol style="list-style-type: none"> i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and ii. A documented trial and inadequate response with a preferred TNF inhibitor; and iii. If requested dose is for tofacitinib 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit; OR d. Polyarticular Course Juvenile Idiopathic Arthritis; with <ol style="list-style-type: none"> i. A documented trial and inadequate response to intraarticular glucocorticoid injections; and ii. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and iii. A documented trial and inadequate response with a preferred TNF inhibitor; OR e. Ankylosing spondylitis; with <ol style="list-style-type: none"> i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR f. Atopic dermatitis; with
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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

<p><i>Use Janus Kinase Inhibitor PA form</i></p>	<ul style="list-style-type: none"> i. Documentation patient has failed to respond to good skin care and regular use of emollients; and ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and iv. For mild to moderate atopic dermatitis: <ul style="list-style-type: none"> a. A documented trial and therapy failure with crisaborole; and b. Affected area is less than 20% of body surface area (BSA); and c. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or v. For moderate to severe atopic dermatitis: <ul style="list-style-type: none"> a. A documented trial and therapy failure with cyclosporine or azathioprine; and b. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg. <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 <i>Use Ketorolac PA form</i></p>	<p>Prior authorization (PA) 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.</p> <p>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 10/01/2022

Long-Acting Opioids	<p>Prior authorization (PA) is required for all non-preferred long-acting opioids. PA is also required for members when the total daily opioid use (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment; and 2. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 3. Patient has tried and failed at least two nonopioid pharmacologic therapies (e.g. acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants); and 4. There is documentation of previous trial and therapy failure with one preferred long-acting opioid at maximally tolerated dose; and 5. A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization; and 6. The prescriber must review the patient’s use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and determine if use of a long-acting opioid is appropriate for this member based on review of PMP and the patient’s risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and. 7. Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids. 8. Requests for long-acting opioids will only be considered for FDA approved dosing intervals. As-needed (PRN) dosing will not be considered; and 9. For patients taking concurrent benzodiazepines, the prescriber must document the following: <ol style="list-style-type: none"> a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. <p>If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient has experienced improvement in pain control and level of functioning; and 2. Prescriber has reviewed the patient’s use of controlled substances on the Iowa PMP and has determined continued use of a long-acting opioid is appropriate for this member; and 3. For patients taking concurrent benzodiazepines, the prescriber must document the following: <ol style="list-style-type: none"> a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and
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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

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 10/01/2022

<p><i>Use Long-Acting Opioids PA form</i></p>	<p>c. A plan to taper the benzodiazepine is provided, if appropriate.</p> <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Lupron Depot – Adult</p> <p><i>Use Lupron Depot-Adult PA form</i></p>	<p>Prior authorization (PA) 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 meets the FDA approved age; 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 which concurrent therapy with a preferred NSAID and at least one preferred 3 month continuous course of a 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> <ol style="list-style-type: none"> 1. 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. 2. Uterine leiomyomata – 3 month approval. 3. 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).

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 45

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 10/01/2022

<p>Mannitol Inhalation Powder (Bronchitol)</p> <p><i>Use Mannitol Inhalation Powder (Bronchitol) PA form</i></p>	<p>Prior authorization is required for mannitol inhalation powder (Bronchitol). Payment will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of cystic fibrosis; and 2. Patient meets the FDA approved age; and 3. Prescriber is a cystic fibrosis specialist or pulmonologist; and 4. Documentation is provided that patient has successfully completed the Bronchitol tolerance test (BTT); and 5. Patient will pre-medicate with a short-acting bronchodilator; and 6. Dose does not exceed the FDA approved dose. <p>If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met:</p> <ol style="list-style-type: none"> 1. Adherence to mannitol inhalation powder (Bronchitol) therapy is confirmed; and 2. Patient has demonstrated improvement or stability of disease symptoms, such as improvement in FEV₁, decrease in pulmonary exacerbations, decrease in hospitalizations, or improved quality of life.
<p>Methotrexate Injection</p> <p><i>Otrexup Rasuvo</i></p> <p><i>Use Methotrexate Injection PA form</i></p>	<p>Prior authorization (PA) is required for non-preferred methotrexate injection. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Diagnosis of severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (PJIA) and ALL of the following: <ol style="list-style-type: none"> a. Prescribed by a rheumatologist; and b. Patient has a documented trial and intolerance with oral methotrexate; and c. Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD (hydroxychloroquine, leflunomide, or sulfasalazine); and d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and e. Patient does not reside in a long-term care facility. 2. Diagnosis of severe, recalcitrant, disabling psoriasis and ALL of the following: <ol style="list-style-type: none"> a. Patient is 18 years of age or older; and b. Prescribed by a dermatologist; and c. Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy). d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and e. Patient does not reside in a long-term care facility. <p>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 10/01/2022

<p>Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment</p> <p><i>Use Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment PA form</i></p>	<p>Prior Authorization (PA) is required for miconazole-zinc oxide-white petrolatum (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>
<p>Mifepristone (Korlym)</p> <p><i>Use Mifepristone (Korlym) PA form</i></p>	<p>Prior authorization (PA) is required for mifepristone (Korlym). Payment will be considered for patients when the following is met:</p> <ol style="list-style-type: none"> 1. The patient is 18 years of age or older: and 2. Has a diagnosis of endogenous Cushing’s Syndrome with hyperglycemia secondary to hypercortisolism in patients with Type 2 Diabetes or glucose intolerance: and 3. Patient must have failed surgery or is not a candidate for surgery: and 4. Prescriber is an endocrinologist: and 5. Female patients of reproductive age must have a negative pregnancy test confirmed within the last 7 days and must use a non-hormonal method of contraception during treatment and for one month after stopping treatment.
<p>Modified Formulations</p> <p><i>Use Modified Formulations PA form</i></p>	<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> <p>Prior authorization is required for the following modified dosage forms: Abilify Discmelt, Alkindi, Aricept ODT, Baqsimi, Binosto, Dartisla, Drizalma, Elyxyb, Eprontia, Exservan, Ezallor, FazaClo, Gimoti, Horizant, Invega, Lamotrigine ODT, Metoclopramide ODT, Norliqva, Remeron SolTab, Risperidone ODT, Sertraline Caps, Sitavig, Spritam, Sympazan, Tramadol Oral Solution, Trilipix, Xopenex, Zyprexa Zydis.</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 48

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 10/01/2022

<p>Multiple Sclerosis Agents-Oral</p> <p><i>Use Multiple Sclerosis Agents-Oral PA form</i></p>	<p>For patients initiating therapy with a preferred oral multiple sclerosis agent, a manual prior authorization (PA) is not required if a preferred injectable interferon or non-interferon agent is found in the member’s pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member’s pharmacy claims, documentation of the following must be provided:</p> <ol style="list-style-type: none"> 1. A diagnosis of relapsing forms of multiple sclerosis; and 2. Request must adhere to all FDA approved labeling, including indication, age, dosing, contraindications, and warnings and precautions; and 3. Documentation of a previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis. <p>Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent.</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>Muscle Relaxants</p> <p><i>Use Muscle Relaxant PA form</i></p>	<p>Prior authorization (PA) is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. * If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.</p>
<p>Naloxone Nasal Spray</p> <p><i>Use Naloxone Nasal Spray PA form</i></p>	<p>Prior authorization (PA) is required for a patient requiring more than 2 doses of 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 naloxone nasal spray (accidental overdose, intentional overdose, other reason); and 2. 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.

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 49

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 10/01/2022

<p>Narcotic Agonist-Antagonist Nasal Sprays</p> <p><i>Use Narcotic Agonist/Antagonist Nasal Spray PA form</i></p>	<p>Prior authorization (PA) 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 (PA) is required for Bystolic. Payment will be considered in cases where there are documented trials and therapy failures with two preferred cardio-selective beta-blockers of a different chemical entity at a therapeutic dose. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.</p>
<p>New to Market Drugs</p> <p><i>Use New to Market Drugs PA form</i></p>	<p>Prior authorization (PA) is required for newly marketed drugs. Payment will be considered for patients when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient has an FDA approved or compendia indication for the requested drug; and 2. If the requested drug falls in a therapeutic category/class with existing prior authorization criteria, the requested drug must meet the criteria for the same indication; or 3. If no clinical criteria are established for the requested drug, patient has tried and failed at least two preferred drugs, when available, from the Iowa Medicaid Preferred Drug List (PDL) for the submitted indication; and 4. Request must adhere to all FDA approved labeling. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Once newly marketed drugs are reviewed by the Pharmaceutical & Therapeutics Committee, they will be placed on the PDL which will dictate ongoing PA criteria, if applicable.</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 50

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 10/01/2022

<p>Non-Biologic Agents for Ulcerative Colitis</p> <p><i>Use Non-Biologic Agents for Ulcerative Colitis PA form</i></p>	<p>Prior authorization is required for select non-biologicals for ulcerative colitis (UC). Payment for non-preferred select non-biologics for UC may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent(s). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of moderately to severely active ulcerative colitis (UC) and 2. Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and 3. A documented trial and inadequate response to two preferred conventional therapies (immunomodulators) including aminosalicylates and azathioprine/6-mercaptopurine; and 4. A documented trial and inadequate response with a preferred biological DMARD; and 5. Will not be taken concomitantly with immunomodulators or biologic therapies. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products</p> <p><i>Use Non-Parenteral Vasopressin Deriv. of Posterior Pituitary Hormone Products PA form</i></p>	<p>Prior authorization (PA) is required for non-parenteral vasopressin derivatives of posterior pituitary hormone products. No PA is required for members 6 years of age or older when dosed within established quantity limits for desmopressin acetate tablets. Payment for preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses:</p> <ol style="list-style-type: none"> 1. Diabetes Insipidus. 2. Hemophilia A. 3. Von Willebrand's disease. <p>Requests for desmopressin nasal spray for the treatment of nocturnal enuresis will not be considered. Payment for non-preferred non-parenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial and therapy failure with the preferred agent. Please refer to the Selected Brand-Name Drugs prior authorization form is requesting a non-preferred brand-name product.</p>
<p>Non-Preferred Drug</p> <p><i>Use Non-Preferred Drug PA form</i></p>	<p>Prior authorization (PA) is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-preferred medication will be considered for an FDA approved or compendia indicated diagnosis only for cases in which there is documentation of previous trial and therapy failure with the preferred agent(s), unless evidence is provided that use of these agents would be medically contraindicated. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations.</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 10/01/2022

<p>Nonsteroidal Anti-inflammatory Drugs</p> <p><i>Use Non-Steroidal Anti-inflammatory Drug PA form</i></p>	<p>Prior authorization (PA) is required for all non-preferred nonsteroidal anti-inflammatory drugs (NSAIDs). Payment for a non-preferred NSAID will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Documentation of previous trials and therapy failures with at least three preferred NSAIDs; and 2. Requests for a non-preferred extended release NSAID must document previous trials and therapy failures with three preferred NSAIDs, one of which must be the preferred immediate release NSAID of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Odevixibat (Bylvay)</p> <p><i>Use Odevixibat (Bylvay) Drug PA form</i></p>	<p>Prior authorization (PA) is required for odevixibat (Bylvay) Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Request adheres to all FDA approved labeling including age, dosing, contraindications, warnings and precautions, and drug interactions; and 2. Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) type 1 or 2; and 3. Genetic testing does not indicate PFIC type 2 with ABCB 11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and 4. Patient has moderate to severe pruritis associated with PFIC; and 5. Patient’s current weight in kg is provided; and 6. Is prescribed by or in consultation with a hepatologist or gastroenterologist. <p>Initial authorizations will be approved for 3 months for initial treatment or after a dose increase. Additional authorizations will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient’s current weight in kg is provided; and 2. Documentation is provided the patient has responded to therapy and pruritis has improved. If there is no improvement in pruritis after 3 months of treatment with the maximum 120 mcg/kg/day dose, further approval of odevixibat will not be granted.

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 10/01/2022

Omalizumab (Xolair)	<p>Prior authorization (PA) is required for omalizumab (Xolair) prefilled syringe. Requests for omalizumab (Xolair) lyophilized powder for reconstitution will not be considered through the pharmacy benefit. Payment for omalizumab (Xolair) prefilled syringe will be considered for FDA approved and compendia indications under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient meets the FDA approved age; and 2. Therapy will be initiated in a healthcare setting, under the guidance of a healthcare provider, where the patient can be closely observed for anaphylaxis and safety of therapy has been established after a minimum of 3 doses of omalizumab; and 3. The healthcare provider has determined self-administration with omalizumab is appropriate based on careful assessment of risk for anaphylaxis and mitigation strategies, as outlined in the label; and 4. Dose follows the FDA approved dosing for indication; and 5. Prescriber is an allergist, dermatologist, immunologist, otolaryngologist or pulmonologist; and 6. Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of omalizumab (Xolair); and 7. Prescriber and dispensing pharmacy will educate patient on proper storage and administration. Improperly stored medications will not be replaced. <p><u>Moderate to Severe Persistent Asthma</u></p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and 2. Pretreatment IgE level is within the following range: <ol style="list-style-type: none"> a. Adults and adolescent patients 12 years of age or older - 30 IU/mL to 700 IU/mL; or b. Pediatric patients 6 to less than 12 years of age - 30 IU/mL to 1300 IU/mL; and 3. Patient's weight is within the following range: <ol style="list-style-type: none"> a. Adults and adolescent patients 12 years of age or older - 30 kg to 150 kg; or b. Pediatric patients 6 to less than 12 years of age - 20 kg to 150 kg; and 4. History of positive skin or RAST test to a perennial aeroallergen; and 5. Patient is currently using a high dose inhaled corticosteroid, long-acting beta-agonist, AND a leukotriene receptor antagonist, and is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy; and 6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances.
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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 10/01/2022

	<p>If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a high dose corticosteroid, long-acting beta-agonist, and leukotriene receptor antagonist.</p> <p><u>Chronic Idiopathic Urticaria</u></p> <ol style="list-style-type: none">1. Patient has a diagnosis of moderate to severe chronic idiopathic urticaria; and2. Patient has documentation of a trial and therapy failure with at least one preferred second-generation antihistamine, one of which must be cetirizine at a dose up to 20 mg per day; and3. Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine; and4. Patient has documentation of a trial and therapy failure with at least one preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin); and5. Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second-generation antihistamine. <p>If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy.</p> <p><u>Nasal Polyps</u></p> <ol style="list-style-type: none">1. Patient has a diagnosis of nasal polyps; and2. Pretreatment IgE level is within the following range:<ol style="list-style-type: none">a. Adults and adolescent patients 12 years of age or older - 30 IU/mL to 1500 IU/mL; and3. Patient's weight is within the following range:<ol style="list-style-type: none">a. Adults and adolescent patients 12 years of age or older - 30 kg to 150 kg; and4. Patient has documentation of an adequate trial and inadequate response with at least two nasal corticosteroids at a maximally tolerated dose; and5. Will be used concurrently with a nasal corticosteroid; and6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances.
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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 55

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 10/01/2022

<p><i>Use Omalizumab (Xolair) PA form</i></p>	<p>If criteria for coverage are met, the initial authorization will be given for 24 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a nasal corticosteroid.</p> <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Ophthalmic Agents for Presbyopia</p> <p><i>Use Ophthalmic Agents for Presbyopia PA form</i></p>	<p>Prior authorization (PA) is required for ophthalmic agents indicated for presbyopia. Requests will be considered when patient has an FDA approved or compendia indication for the requested drug. Payment for a non-preferred agent will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a documented diagnosis of presbyopia; and 3. Patient is aged 40-55 years old at start of therapy; and 4. Is prescribed by or in consultation with an ophthalmologist or optometrist; and 5. Patient has documentation of a therapeutic failure with corrective lenses (eyeglasses or contact lenses), unless contraindicated or clinically significant intolerance. <p>If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient has a documented improvement in presbyopia defined as the patient gained 3 lines or more in mesopic, high contrast, binocular distance corrected near vision acuity (DCNVA), without losing more than 1 line (5 letters) of corrected distance visual acuity (CDVA); and 2. Patient is not experiencing adverse effects from the drug.

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 56

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 10/01/2022

	<p>If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation of therapy may be provided if prescriber documents adequate response to treatment.</p>
<p>Oral Immunotherapy <i>Oralair</i> <i>Use Oral Immunotherapy PA form</i></p>	<p>Prior authorization (PA) is required for sublingual allergen immunotherapy. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Medication is prescribed in consultation with an allergist; and 2. Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and 3. Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines); and 4. Patient has a documented intolerance to immunotherapy injections; and 5. The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration). 6. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved. <p><u>Grass Pollen (Oralair) In addition to the above criteria being met:</u></p> <p>Oralair</p> <ol style="list-style-type: none"> 1. Patient is 10 through 65 years of age; and 2. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cockfoot, perennial rye, timothy, and Kentucky blue/June grass. 3. If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season.

<p>Ospemifene (Osphena)</p>	<p>Prior authorization (PA) is required for ospemifene (Osphena). Requests for a diagnosis of moderate to severe dyspareunia are considered not medically necessary and will be denied. Payment will be considered under the following conditions:</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 58

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 10/01/2022

<p><i>Use Ospemifene (Osphena) PA form</i></p>	<ol style="list-style-type: none"> 1. Patient is a post-menopausal woman with a diagnosis is moderate to severe vaginal dryness due to vulvar and vaginal atrophy; and 2. Patient has documentation of an adequate trial and therapy failure with a preferred vaginal estrogen agent; and 3. Patient does not have any contraindications to ospemifene as listed in the FDA approved label; and 4. Will not be used with estrogens, estrogen agonist/antagonists, fluconazole, or rifampin; and 5. Patient does not have severe hepatic impairment (Child-Pugh Class C); and 6. Patient will be evaluated periodically as clinically appropriate to determine if treatment is still necessary as ospemifene should be used for the shortest duration consistent with treatment goals and risks for the individual woman; and 7. Dose does not exceed the FDA approved dose. <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Initial requests will be approved for 3 months. Additional PAs will be considered upon documentation of clinical response to therapy.</p>
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<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>
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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 59

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 10/01/2022

<i>Use Palivizumab PA form</i>	<ol style="list-style-type: none"> 1. 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. 2. 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. 3. 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 (PA) is required for therapy with palivizumab. PAs 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> <ol style="list-style-type: none"> 1. 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). 2. 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> <ol style="list-style-type: none"> 1. 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> <ol style="list-style-type: none"> 1. 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> <ol style="list-style-type: none"> 1. 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> <ol style="list-style-type: none"> 1. 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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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 10/01/2022

<p>PCSK9 Inhibitors</p> <p><i>Praluent</i> <i>Repatha</i></p>	<p>Prior authorization (PA) is required for PCSK9 Inhibitors. Payment for a non-preferred PCSK9 Inhibitor will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient meets the FDA approved age for indication; AND 2. Dosing follows the FDA approved dose for the submitted diagnosis; AND 3. 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 4. Is to be prescribed as an adjunct to a low fat diet; AND 5. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; AND 6. 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. 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: <ul style="list-style-type: none"> <u>Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH)</u> <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 one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. <u>Diagnosis of Clinical Atherosclerotic Cardiovascular Disease (ASCVD)</u>
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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 10/01/2022

<p><i>Use PCSK9 Inhibitors PA form</i></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 one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. <p>Diagnosis of Primary Hyperlipidemia (not associated with ASCVD or HeFH)</p> <ol style="list-style-type: none"> 1. <u>Baseline LDL-C ≥ 190 mg/dL; and</u> 2. <u>Unable to reach goal LDL-C < 100 mg/dL while on high-intensity statin therapy</u> (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. <p><u>Diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) – Repatha (evolocumab) only</u></p> <ol style="list-style-type: none"> 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 one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. <p>The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. <u>Initial requests will be approved for 6 months. Additional requests will be considered under the following conditions:</u></p> <ol style="list-style-type: none"> 1. <u>Documentation of positive clinical response to PCSK9 Inhibitor therapy (current LDL-C lab provided); and</u> 2. <u>Patient continues therapy with a maximally tolerated statin; and</u> 3. <u>Patient has continued compliance with a low-fat diet.</u>
<p>Peanut Allergen Powder-dnfp (Palforzia)</p>	<p>Prior authorization (PA) is required for Peanut (<i>Arachis hypogaea</i>) Allergen Powder-dnfp (Palforzia). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient has a confirmed diagnosis of peanut allergy, as documented by a skin prick test to peanut ≥ 3 mm compared to control or a peanut-specific serum IgE ≥ 0.35 kUA/L (kilos of allergen-specific units per liter); and 2. Patient is 4 to 17 years of age at initiation of therapy or 4 years of age and older for continued up-dosing and maintenance therapy; and

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Iowa Medicaid Drug Prior Authorization Criteria

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Updated 10/01/2022

<p><i>Use Peanut Allergen Powder-dnfp (Palforzia) PA form</i></p>	<ol style="list-style-type: none"> 3. Prescribed by or in consultation with an allergist or immunologist; and 4. Patient has access to injectable epinephrine; and 5. Will be used in conjunction with a peanut-avoidant diet; and 6. Patient does not have any of the following: <ol style="list-style-type: none"> a. Uncontrolled asthma; and/or b. A history of eosinophilic esophagitis or other eosinophilic gastrointestinal disease; and 8. The initial dose escalation and the first dose of each new up-dosing level is administered under the supervision of a health care professional in a health care setting with the ability to manage potentially severe allergic reactions, including anaphylaxis. Initial dose escalation and the first dose of all up-dosing levels is not to be billed to the Iowa Medicaid outpatient pharmacy program as the initial dose escalation is administered in the provider office and should be billed via the medical benefit and the first dose of all up-dosing levels is provided via the Office Dose Kit; and 9. Follows FDA approved dosing; and 10. PA is required for all up-dosing dose levels (dose 1 through 11); and 11. Maintenance dosing will be considered with documentation patient has successfully completed all dose levels of up-dosing.
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<p>Pegcetacoplan (Empaveli)</p>	<p>Prior authorization (PA) is required for pegcetacoplan (Empaveli). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Request adheres to all FDA approved labeling including age, dosing, contraindications, and warnings and precautions; and 2. Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH); and 3. Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or $\geq 10\%$ PNH cells; and 4. History of at least one red blood cell transfusion in the previous 12 months; and 5. Documentation of hemoglobin < 10.5 g/dL; and
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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 63

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 10/01/2022

<p><i>Use Pegcetacoplan (Empaveli) PA form</i></p>	<ol style="list-style-type: none"> 6. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris), unless the patient is in a 4 week period of cross-titration between eculizumab (Soliris) and pegcetacoplan (Empaveli); and 7. Is prescribed by or in consultation with a hematologist; and 8. Medication will be administered in the member's home; and 9. Member or member's care giver has been properly trained in subcutaneous infusion and prescriber has determined home administration is appropriate. <p>Initial authorizations will be approved for 4 weeks if within cross-titration period with eculizumab (Soliris) to verify eculizumab has been discontinued, or for 6 months otherwise.</p> <p>Additional authorizations will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Documentation of a positive clinical response to therapy (e.g., increased or stabilization or hemoglobin levels or reduction in transfusions); and 2. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris).
<p>Pirfenidone (Esbriet) / Nintedanib (Ofev)</p>	<p>Prior authorization (PA) is required for pirfenidone (Esbriet) and nintedanib (Ofev). Dosing outside of the FDA approved dosing will not be considered. Concomitant use of pirfenidone and nintedanib 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 meets the FDA approved age; and 2. Is prescribed by a pulmonologist; and 3. Patient does not have hepatic impairment as defined below: <ol style="list-style-type: none"> a. Nintedanib- Patient does not have moderate or severe hepatic impairment (Child Pugh B or C) or b. Pirfenidone- Patient does not have severe hepatic impairment (Child Pugh C); and 4. Patient does not have renal impairment as defined below: <ol style="list-style-type: none"> a. Nintedanib- Patient does not have severe renal impairment (CrCl <30ml/min) or end-stage renal disease or b. Pirfenidone- Patient does not have end-stage renal disease requiring dialysis; and 5. Patient does not utilize non-prescribed inhalants, such as vaping or other inhaled tobacco products, prior to initiating therapy and has been instructed to avoid tobacco products while using pirfenidone or nintedanib; and 6. Patient has a diagnosis of idiopathic pulmonary fibrosis (nintedanib or pirfenidone) as confirmed by one of the following (attach documentation): <ol style="list-style-type: none"> a. Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or b. A surgical lung biopsy demonstrating usual interstitial pneumonia (UIP); and c. Prescriber has excluded other known causes of interstitial lung disease (ILD) such as domestic and occupational exposures, connective tissue disease, and drug toxicity; 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.

Updated 10/01/2022

<p><i>Use Pirfenidone (Esbriet) / Nintedanib (Ofev) PA form</i></p>	<ul style="list-style-type: none"> d. Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC) \geq50% predicted; and e. Patient has a carbon monoxide diffusion capacity (%DLco) of \geq30% predicted; or <p>7. Patient has a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) (nintedanib) as confirmed by the following (attach documentation):</p> <ul style="list-style-type: none"> a. Documentation of a chest high resolution computed tomography (HRCT) scan showing fibrosis affecting \geq 10% of the lungs; and b. Patient has documented pulmonary function tests within the prior 60 days showing FVC \geq 40% predicted; and c. Patient has a carbon monoxide diffusion capacity (%DLco) of \geq 30-89% predicted; or <p>8. Patient has a diagnosis of chronic fibrosing interstitial lung disease with a progressive phenotype (nintedanib) as confirmed by the following (attach documentation):</p> <ul style="list-style-type: none"> a. Documentation of a chest high resolution computed tomography (HRCT) scan showing fibrosis affecting \geq 10% of the lungs; and b. Patient has documented pulmonary function tests within the prior 60 days showing FVC \geq 45% predicted; and c. Patient has a carbon monoxide diffusion capacity (%DLco) of \geq 30-79% predicted; and d. Patient has at least one sign of clinical progression for interstitial lung disease within the last 24 months despite standard treatment with an agent other than nintedanib or pirfenidone: <ul style="list-style-type: none"> i. A relative decline in the FVC of at least 10% predicted; or ii. A relative decline in the FVC of 5-9% predicted combined with at least one of the following: <ul style="list-style-type: none"> 1. Worsening respiratory symptoms; or 2. Increased extent of fibrosis on HRCT; or iii. Worsening of respiratory symptoms and an increased extent of fibrotic changes on HRCT only. <p>If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met:</p> <ul style="list-style-type: none"> 1. Adherence to pirfenidone (Esbriet) or nintedanib (Ofev) is confirmed; and 2. Documentation of a positive response to therapy, defined as meeting at least one of the following: <ul style="list-style-type: none"> a. Rate of lung function decline slowed; or b. Improved or no worsening of symptoms of cough, shortness of breath; and 3. Documentation is provided that the patient has remained tobacco-free; and 4. ALT, AST, and bilirubin are assessed periodically during therapy.
Potassium Binders	Prior authorization (PA) is required for non-preferred potassium binders. Payment will be considered under the following conditions:

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 10/01/2022

<p><i>Use Potassium Binders PA form</i></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>Proton Pump Inhibitors</p> <p><i>Use Proton Pump Inhibitor PA form</i></p>	<p>Prior authorization (PA) 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, Erosive esophagitis, or Peptic stricture (Please fax a copy of the scope results with the initial request); or 2. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, and multiple endocrine adenomas); or 3. Recurrent peptic ulcer disease; or 4. Gastroesophageal reflux disease will be considered after documentation of a therapeutic trial and therapy failure with the requested PPI at maximal dose within the established quantity limit of one per day. 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 dose reduction to 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; or 5. 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 (PA) 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 (PA) request for override consideration.</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 10/01/2022

<p>Repository Corticotropin Injection (H.P. Acthar Gel) <i>Use Repository Corticotropin Injection (H.P. Acthar Gel) PA form</i></p>	<p>Prior authorization (PA) 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 and2. 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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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 10/01/2022

<p>Satralizumab (Enspryng)</p> <p><i>Use Satralizumab (Enspryng) PA form</i></p>	<p>Prior authorization (PA) is required for satralizumab (Enspryng). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of neuromyelitis optica spectrum disorder (NMOSD); and 2. Patient is anti-aquaporin 4 (AQP4) seropositive (attach documentation); and 3. Patient meets the FDA approved age and dosing; and 4. Patient has a history of at least 1 relapse in the previous 12 months prior to initiation of therapy; and 5. Patient has been tested for tuberculosis prior to the initiation of therapy and does not have active or untreated latent tuberculosis; and 6. Patient has been tested for hepatitis B virus (HBV) prior to the initiation of therapy and confirmed negative for active HBV; and 7. Prescribed by a neurologist. <p>If criteria for coverage are met, initial requests will be given for 1 year. Additional authorizations will be considered upon documentation of clinical response to therapy (i.e. a reduction in the frequency of relapse).</p>
<p>Sedative/Hypnotics-Non-Benzodiazepine</p> <p><i>Use Sedative/Hypnotics-Non-Benzodiazepine PA form</i></p>	<p>Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits. Requests for doses above the manufacturer recommended dose will not be considered.</p> <p>PA 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>

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 71

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 10/01/2022

<p>Select Preventative Migraine Treatments</p>	<p>Prior authorization (PA) is required for select preventative migraine agents. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred, select preventative migraine agent. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient has one of the following diagnoses: <ol style="list-style-type: none"> a. Chronic Migraine, defined as: <ol style="list-style-type: none"> i. ≥ 15 headache days per month for a minimum of 3 months; and ii. ≥ 8 migraine headaches days per month for a minimum of 3 months; or b. Episodic Migraine, defined as: <ol style="list-style-type: none"> i. 4 to 14 migraine days per month for a minimum of 3 months; or c. Episodic Cluster Headache, defined as: <ol style="list-style-type: none"> i. Occurring with a frequency between one attack every other day and 8 attacks per day; and ii. With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods ≥ 3 months; and iii. Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting < 3 months, for at least 1 year); and 2. Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and 3. The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and 4. Patient has been evaluated for and does not have medication overuse headache; and 5. For Episodic and Chronic Migraine, patient has documentation of three trials and therapy failures, of at least 3 months per agent, at a maximally tolerated dose with a minimum of two different migraine prophylaxis drug classes (i.e. anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]); or 6. For Episodic Cluster Headache, patient has documentation of <ol style="list-style-type: none"> a. A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and
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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

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 10/01/2022

	<p style="margin-left: 40px;">b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy.</p> <p>7. Lost, stolen, or destroyed medication replacement requests will not be authorized.</p> <p>Initial requests will be approved for 3 months. Additional PAs will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency).</p> <p>The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.</p>
<p>Select Oncology Agents</p> <p><i>Use Select Oncology Agents PA form</i></p>	<p>Prior authorization (PA) 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 PA 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>Selected Brand Name Drugs</p> <p><i>Use Selected Brand Name PA forms</i></p>	<p>Prior authorization (PA) 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 PA to be considered, the prescriber must submit a completed Selected Brand Name PA form and Iowa Medicaid MedWatch form with:</p> <ol style="list-style-type: none"> 1. Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available. 2. Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval. <p>Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.</p>

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 74

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 10/01/2022

<p>Sodium Oxybate Products</p> <p><i>Xyrem</i> <i>Xywav</i></p> <p><i>Use Sodium Oxybate Products PA form</i></p>	<p>Prior authorization (PA) is required for sodium oxybate (Xyrem). Payment will be considered 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; or 2. 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; and 3. Patient meets the FDA approved age; and 4. Is prescribed within the FDA approved dosing; and 5. Patient and prescriber are enrolled in the Xyrem[®] REMS Program; and 6. Patient has been instructed to not drink alcohol when using Xyrem; and 7. Patient has been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence; and 8. Requests for patients with concurrent use of a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered. 9. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website prior to requesting PA. <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.iowamedicaidpd.com under the Preferred Drug Lists tab. Providers should submit a Prior Authorization (PA) request for override consideration.</p> <p>Therapeutic Classes Included: Antipsychotics-Atypicals</p>

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, 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 10/01/2022

<p><i>Use Testosterone Products PA form</i></p>	<ul style="list-style-type: none"> • Cryptorchidism • Bilateral torsion • Orchitis • Vanishing testes syndrome • Orchiectomy • Klinefelter’s syndrome • Chemotherapy • Toxic damage from alcohol or heavy metals <p>b. Hypogonadotropic hypogonadism</p> <ul style="list-style-type: none"> • Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency • Pituitary-hypothalamic injury from tumors, trauma, or radiation <p>4. Patient does not have:</p> <ol style="list-style-type: none"> a. Breast or prostate cancer b. Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL c. Hematocrit > 50% d. Untreated severe obstructive sleep apnea e. Severe lower urinary tract symptoms f. Uncontrolled or poorly controlled heart failure <p>If criteria for coverage are met, initial authorization will be given for 3 months. Requests for continuation of therapy will require the following:</p> <ol style="list-style-type: none"> 1. An updated testosterone level (Please attach lab result); and 2. Documentation the patient has not experienced a hematocrit > 54% or an increase in PSA > 1.4ng/mL in the past 12 months. <p>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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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 78

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 10/01/2022

<p>Topical Acne and Rosacea Products</p> <p><i>Use Topical Acne and Rosacea Products PA form</i></p>	<p>Prior authorization (PA) is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Documentation of diagnosis; and 2. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and 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); and 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; and 5. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and 6. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis; and 7. 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 (PA) 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 79

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 10/01/2022

<p>Vesicular Monoamine Transporter (VMAT) 2 Inhibitors</p>	<p>Prior authorization (PA) is required for VMAT 2 inhibitors. Payment for non-preferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered under the following conditions:</p> <p><u>Tardive Dyskinesia</u> (Ingrezza or Austedo)</p> <ol style="list-style-type: none"> 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following: <ol style="list-style-type: none"> a. Involuntary athetoid or choreiform movements b. Documentation or claims history of current or prior chronic use (≥ 3 months or 1 month in patients ≥ 60 years old) of a dopamine receptor blocking agent (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.) c. Symptoms lasting longer than 4-8 weeks; and 3. Prescribed by or in consultation with a neurologist or psychiatrist; and 4. Prescriber has evaluated the patient's current medications for consideration of a dose reduction, withdrawal, or change of the dopamine receptor blocking agent causing the TD; and 5. Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS); and 6. For Ingrezza: <ol style="list-style-type: none"> a. Will not be used concurrently with MAO inhibitors (e.g., isocarboxazid, phenelzine, rasagiline, safinamide, selegiline, tranlycypromine, etc.) or strong CYP3A4 inducers (e.g., carbamazepine, phenytoin, phenobarbital, rifampin and related agents, St. John's wort, etc.); and b. Will not be used concurrently with other vesicular monoamine transporter 2 (VMAT2) inhibitors; and c. Is prescribed within the FDA approved dosing; or 7. For Austedo: <ol style="list-style-type: none"> a. Patient does not have hepatic impairment; b. Will not be used concurrently with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and c. Patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed 36mg per day (18mg twice daily); and d. Is prescribed within the FDA approved dosing. <p>If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient continues to meet the criteria for initial approval; and
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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

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 10/01/2022

<p><i>Use Vesicular Monoamine Transporter (VMAT) 2 Inhibitors PA form</i></p>	<p>2. Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS).</p> <p><u>Chorea associated with Huntington’s disease (Austedo or tetrabenazine)</u></p> <ol style="list-style-type: none"> 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of Huntington’s disease with chorea symptoms; and 3. Prescribed by or in consultation with a neurologist or psychiatrist; and 4. Is prescribed within the FDA approved dosing; and 5. Patient is not suicidal, or does not have untreated or inadequately treated depression; and 6. Patient does not have hepatic impairment; and 7. Patient does not have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and 8. For tetrabenazine, patients requiring doses above 50mg per day have been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor metabolizer or extensive metabolizer; and 9. In patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed the following: <ol style="list-style-type: none"> a. Austedo - 36mg per day (18mg single dose) or b. Tetrabenazine – 50mg per day (25mg single dose) <p>If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met:</p> <ol style="list-style-type: none"> 1. Patient continues to meet the criteria for initial approval; and 2. Documentation of improvement in chorea symptoms is provided.
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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

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 10/01/2022

<p>Viloxazine (Qelbree)</p> <p><i>Use Viloxazine (Qelbree) PA form</i></p>	<p>Prior authorization is required for viloxazine (Qelbree). Payment will be considered under the following conditions:</p> <ol style="list-style-type: none"> 1. Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV); and 2. Patient is between 6 and 17 years of age; and 3. 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) and 4. Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred amphetamine stimulant; and 5. Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred methylphenidate stimulant; and 6. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine; and 7. Is dosed based on FDA approved dosing, and dose does not exceed 400 mg per day; and 8. Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. <p>The required trials may be overridden when documented evidence is provided that 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 (PA) 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>

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 84

