STATE OF IOWA

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DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

INFORMATIONAL LETTER NO. 397

To: Iowa Medicaid Participating Providers

From: Iowa Department of Human Services

Date: December 15, 2004

Subject: The purpose of this Informational Letter is to inform providers of changes to the Prior Authorization (PA) Program and Nonprescription Drug Maximum Allowable Cost (MAC) payable list that have resulted from the Preferred Drug List (PDL).

Effective: These changes are effective upon implementation of the Preferred Drug List (PDL) on **January 15, 2005.**

A. The following therapeutic categories have been **added** to the Prior Authorization Program:

1. Actiq®
2. Alpha$_1$-Proteinase Inhibitor Enzymes
3. Anti-thrombotics, Injectable
4. Digestive Enzymes
5. Inspra®
6. Muscle Relaxants
7. Non-preferred drugs
8. Pre-Filled Insulin Pens
9. Pulmozyme®
10. Zelnorm®

Please see the attached PA Criteria Chart for specific requirements.

B. The following therapeutic categories have been **deleted** from the Prior Authorization Program:

1. Cephalexin Monohydrate Hydrochloride
2. H2 Receptor Antagonists
3. Misoprostol
4. Sucralfate

Prior authorization is no longer required for these therapeutic categories as long as the preferred agent, as listed on the PDL, is used.

C. The following therapeutic categories have been **revised**:

1. Antihistamines: OTC Loratadine is now payable.
2. Benzodiazepines: If the long-acting medication is requested, one of the trials must include the immediate release form of the requested benzodiazepine.
3. Erythropoeisis Stimulating Agents: Category name changed from erythropoietin.
4. Growth Hormone: Zorbtive® has been added with specific criteria for its use.
5. Selected Brand Name Drugs: The Selected Brand Name PA form will be submitted to the Iowa Medicaid Drug PA Unit only instead of the FDA MedWatch form. Once approved, the Drug PA Unit will submit information to the FDA if applicable.

Please see the attached PA Criteria Chart for specific requirements.

Enclosed you will find the following items:

1. **The Prior Authorization Criteria Chart**
2. **Nonprescription Drug Maximum Allowable Cost (MAC) payable list-changes are in bold.**

Thank you for your patience and cooperation as we begin to implement the Iowa Medicaid Preferred Drug List. Shortly you will be receiving a hard copy of the Preferred Drug List (PDL) by mail. We would encourage providers to go to the website at **www.iowamedicaidpdl.com** to download the prior authorization forms and view the latest version of the PDL. If you have any questions, please contact Sheryl Hove at (515) 453-8048.

ATTACHMENTS (2)

Actiq®. *Use Actiq® PA form*	Prior authorization is required for Actiq®. Payment will be authorized only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. This product carries a **Black Box Warning**. Actiq®: • Is 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. • Is 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.
Alpha$_1$-Proteinase Inhibitor Enzymes *Use Miscellaneous PA form*	Prior authorization is required for Alpha$_1$-Proteinase Inhibitor enzymes. Payment will be authorized only for cases in which there is a diagnosis of congenital alpha$_1$-proteinase inhibitor (alpha$_1$–PI; alpha1-antitrypsin) deficiency with clinically demonstrable panacinar emphysema. Payment for a non-preferred Alpha$_1$-Proteinase Inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s).
Anti-Acne *Use Anti-Acne PA form*	Prior authorization is required for all prescription topical acne products for the treatment of mild to moderate acne vulgaris. Payment for non-preferred topical acne products will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure(s) with a preferred agent(s). An initial treatment failure of an over-the-counter benzoyl peroxide product, which is covered by the program, is required prior to the initiation of a prescription product, or evidence must be provided that use of these agents would be medically contraindicated. If the patient presents with a preponderance of comedonal acne, tretinoin products may be utilized as first line agents with prior authorization.
Anti-Fungal *Use Anti-Fungal PA form*	Prior authorization is not required for preferred oral antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. Prior authorization will be required for all non-preferred oral antifungal therapy as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for a non-preferred oral antifungal will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Payment for any oral antifungal therapy beyond a cumulative 90 days of therapy per 12-month period per patient will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This prior authorization requirement does not apply to nystatin.
Antihistamines	**Prior authorization is required for non-preferred and single-source antihistamines including single active ingredient and combination products. PA is not required for preferred multiple source antihistamines (for example loratadine). Single source is defined as the brand-name drug or the innovator of a multiple-source drug.** **Patients 21 years of age and older must have two unsuccessful trials with other covered multiple-source antihistamines unless evidence is provided that the use of these agents would be medically contraindicated, prior to the utilization of single-source or non-preferred antihistamines. One of the multiple source antihistamine trials will be a low/non-sedating antihistamine (for example loratadine).** Patients 20 years of age and younger must have at least one unsuccessful trial with another covered multiple-source antihistamine, including loratadine, unless evidence is provided that the use of these agents would be medically

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.

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Use Antihistamine PA form	contraindicated prior to the utilization of single-source or non-preferred antihistamines.
Anti-Thrombotics, Injectable *Use Anti-Thrombotic Injectable PA form*	Prior authorization is required for use of any preferred injectable anti-thrombotic agent longer than 30 consecutive days. Prior authorization will be required for all non-preferred injectable anti-thrombotic agents as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred anti-thrombotic injectable agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Payment for usage of injectable anti-thrombotic agents beyond this limit will be authorized for cases in which there is a clinical diagnosis of: 1. Pregnancy or planned pregnancy 2. Cancer-associated thromboembolic disease 3. Anti-thrombin III deficiency 4. Warfarin allergy 5. History of thrombotic event while on therapeutic anticoagulant therapy.
Benzodiazepines *Use Benzodiazepine PA form*	Prior authorization is required for non-preferred benzodiazepines. Payment for non-preferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. Prior authorization will be approved for up to 12 months for documented: 1. Generalized anxiety disorder. 2. Panic attack with or without agoraphobia. 3. Seizure. 4. Non-progressive motor disorder. 5. Dystonia. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine. Prior authorization requests will be approved for up to a three-month period for all other diagnoses related to the use of benzodiazepines.
Digestive Enzymes *Use Miscellaneous PA form*	Prior authorization is required all digestive enzymes. Payment for preferred digestive enzymes will be authorized only for cases in which there is a clinical diagnosis of malabsorption due to pancreatic insufficiency. Payment for non-preferred digestive enzymes will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s).
Ergotamine Derivatives	Prior authorization is required for preferred ergotamine derivatives used for migraine headache treatment for quantities exceeding 18 unit doses of tablets, injections, or sprays per 30 days. Payment for ergotamine derivatives for migraine headache treatment beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred ergotamine derivatives as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred Ergotamine agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). For

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Use Ergotamine Derivative PA form	only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). For consideration, the following information must be supplied: 1. The diagnosis requiring therapy. 2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.
Erythropoiesis Stimulating Agents *Use Erythropoesis Stimulating Agent PA form*	Prior authorization is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for non-preferred erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Patients who meet all of the following criteria may receive prior authorization for the use of erythropoiesis stimulating agents: 1. Hematocrit less than 30 percent. If renewal of prior authorization is being requested, hematocrit over 36 percent will require dosage reduction or discontinuation. Consideration will be given for continuing therapy for higher hematocrit values on an individual basis after reviewing medical documentation submitted. Hematocrit laboratory values must be dated within six 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.
Granulocyte Colony Stimulating Factor Agents *Use Granulocyte Colony Stimulating Factor PA form*	Prior authorization is required for therapy with granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Laboratory values for complete blood and platelet count must be contained 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: 1. Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy. 2. Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant. 3. Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy. 4. Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.

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

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.

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Growth Hormone *Use Growth Hormone PA form*	Prior authorization is required for therapy with growth hormones. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). All of the following criteria must be met for approval for prescribing of growth hormones: 1. Standard deviation of 2.0 or more below mean height for chronological age. 2. No intracranial lesion or tumor diagnosed by MRI. 3. Growth rate below five centimeters per year. 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter. 5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males. 6. Epiphyses open. Prior authorization will be granted for 12-month periods per recipient as needed. If the request is for **Zorbtive**® [somatropin (rDNA origin) for injection] approval will be granted for the treatment of Short Bowel Syndrome in patients receiving specialized nutritional support. Zorbtive® therapy should be used in conjunction with optimal management of Short Bowel Syndrome.
Inspra® *Use Miscellaneous PA form*	Prior authorization is required for Inspra®. Payment will be authorized only in cases where there is documented trial and therapy failure on Aldactone® or documented cases of gynecomastia from Aldactone® therapy.
Isotretinoin *Use Isotretinoin PA form*	Prior authorization is required for isotretinoin therapy. Payment will be approved for preferred isotretinoin products for acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata. 2. There is a confirmed negative serum pregnancy test, if appropriate. 3. There is a plan for contraception in place, if appropriate Payment for non-preferred isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

Ketorolac – Oral *Use Ketorolac PA form*	Prior authorization is required for ketorolac tromethamine (oral), a nonsteroidal anti-inflammatory drug indicated for short-term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions. This product carries a **Black Box Warning**. Oral ketorolac tromethamine is indicated only as a continuation therapy to ketorolac tromethamine IV/IM, and the combined duration of use of ketorolac tromethamine IV/IM and oral ketorolac tromethamine is not to exceed five (5) days. Payment will be approved for the preferred product under the following conditions: 1. 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 duration of therapy is 5 days per month. 3. Diagnosis indicating moderately severe, acute pain. Payment for a non-preferred product will be authorized only for cases in which there is documentation of trial(s) and therapy failure with the preferred agent(s).
Lipase Inhibitor Drugs *Use Lipase Inhibitor PA form*	Prior authorization is required for lipase inhibitor drugs. Payment for lipase inhibitor drugs will be authorized for the clinical diagnosis of hyperlipidemia. Requests for lipase inhibitor drugs for weight loss must include documentation showing failure of other weight loss programs, a body mass index (BMI) equal to or greater than 30, one or more co-morbidity conditions, and a weight management plan including diet and exercise. Prior authorization may be given for up to six months. Additional prior authorizations may be given on an individual basis after review of medical necessity and documented significant weight loss (at least 10 percent) from the individual's weight at the beginning of the previous prior authorization period.
Male Sexual Dysfunction *Use Male Sexual Dysfunction PA form*	Prior authorization is required for drugs used for the treatment of male sexual dysfunction. For prior authorization to be granted for preferred agents, the patient must: 1. Be 21 years of age or older. 2. Have a confirmed diagnosis of impotence of organic origin or psychosexual dysfunction. 3. Not be taking any medications, which are contraindicated for concurrent use with the drug prescribed for treatment of male sexual dysfunction. Approval for these drugs, with the exception of yohimbine, will be limited to four doses in a 30-day period. Payment for non-preferred products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with the preferred agent(s). ***The 72-hour emergency supply rule found below does not apply for drugs used for the treatment of male sexual dysfunction.***
Muscle Relaxants *Use Muscle Relaxant PA form*	Prior authorization is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least two preferred muscle relaxants.

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.

Narcotic Agonist-Antagonist Nasal Sprays *Use Narcotic Agonist/Antagonist Nasal Spray PA form*	Prior authorization is required for preferred narcotic agonist-antagonist nasal sprays for quantities exceeding 10 milliliters (approximately 60 doses) per 30 days. 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. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation. 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.
Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products *Use Non-Parenteral Vasopressin Deriv. of Posterior Pituitary Hormone Products PA form*	Prior authorization is required for non-parenteral vasopressin derivatives of posterior pituitary hormone products. Payment for preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses: 1. Diabetes Insipidus. 2. Hemophilia A. 3. Von Willebrand's disease. Payment for non-parenteral vasopressin derivatives of posterior pituitary hormone products used in the treatment of primary nocturnal enuresis will be authorized for patients who are six years of age or older for periods of six months. Approvals will be granted for subsequent six-month periods only after a drug-free interval to assess the need for continued therapy. Payment for non-preferred non-parenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial(s) and therapy failure with the preferred agent(s).
Non-Preferred Drug ***Use Non-Preferred Drug PA form***	Prior authorization is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-preferred medication will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with the preferred agent(s), unless evidence is provided that use of these agents would be medically contraindicated.
Non-Steroidal Anti-inflammatory Drugs *Use Non-Steroidal Anti-inflammatory Drug PA form*	Prior authorization is required for non-preferred non-steroidal anti-inflammatory drugs, Mobic® and **all COX-2 inhibitors**. Requests must document previous trials and therapy failure with at least two preferred non-steroidal anti-inflammatory drugs.
Palivizumab (RSV Prophylaxis) ***Use Palivizumab PA form***	Prior authorization is required for therapy with palivizumab. Payment for palivizumab shall be authorized for patients who meet one of the following criteria: 1. Patient is less than 24 months of age at start of therapy and has chronic lung disease requiring medication or oxygen within the last six months. 2. Patient is less than 12 months of age at start of therapy with a gestational age of less than or equal to 28 weeks. 3. Patient is less than 6 months of age at start of therapy with a gestational age between 28 weeks and 31 weeks. 4. Patient is less than 6 months of age at start of therapy with a gestational age of 32 weeks to 35 weeks and has at least one additional risk factor.
Pre-Filled Insulin	Prior authorization is required for pre-filled insulin pens. Prior authorization is granted when documentation indicates:

Pens *Use Pre-filled Insulin Pen PA form*	• The member's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin, and • There is no caregiver available to provide assistance. Prior authorization for non-preferred insulin pens will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure(s) with a preferred agent.
Proton Pump Inhibitors *Use Proton Pump Inhibitor PA form*	Prior authorization is not required for the preferred proton pump inhibitors (PPI) for a cumulative 60-days of therapy per 12-month period. Prior authorization will be required for all non-preferred proton pump inhibitors as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for a non-preferred proton pump inhibitor will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with the preferred agent(s). Prior authorization is required for any PPI usage longer than 60 days or more frequently than one 60-day course per 12-month period. The 12-month period is patient specific and begins 12 months before the requested date of prior authorization. Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of: 1. Specific Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas). 2. Barrett's esophagus. 3. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses. 4.Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or a negative Helicobacter pylori test result. Proton pump inhibitors prescribed concurrently with histamine H2-receptor antagonists shall be considered duplication of therapy. Payment for duplication of therapy will be considered on an individual basis after review of submitted documentation of medical necessity.
Psychostimulants *Use Psychostimulant PA form*	Prior authorization is required for psychostimulants for recipients 21 years of age or older. Prior approval shall be granted if there is documentation of one of the following: 1. Attention deficit disorder. 2. Attention deficit hyperactivity disorder. 3. Narcolepsy.
Pulmozyme® *Use Miscellaneous PA form*	Prior authorization is required for Pulmozyme®. Payment will be authorized only for cases in which there is a diagnosis of cystic fibrosis.
Selected Brand Name Drugs *Use Selected Brand Name PA form*	Prior authorization is required for selected brand-name drugs as determined by the Department for, which there is available, an "A" rated bioequivalent generic product as determined by the Federal Food and Drug Administration unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For prior authorization to be considered, evidence of a treatment failure with the bioequivalent generic drug must be provided. A copy of a completed Selected Brand Name PA form shall be considered as evidence of treatment failure. The list of selected brand-name drugs includes the drugs on the Federal Upper Limit (FUL) list and the State Maximum Allowable Cost (SMAC) list at www.mslciowa.com.

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.

Serotonin 5-HT1-receptor Agonists *Use Serotonin 5-HT1-receptor Agonists PA form*	Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for quantities exceeding 18 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). For consideration, the following information must be supplied: 1. The diagnosis requiring therapy. 2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.
Tretinoin Products (topical) *Use Topical Tretinoin PA form*	Prior authorization is required for all tretinoin prescription products. Payment for non-preferred tretinoin products will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Alternatives such as topical benzoyl peroxide (OTC), and topical or oral antibiotics must first be tried (unless evidence is provided that use of these agents would be medically contraindicated) for the following conditions: endocrinopathy, mild to moderate acne (non-inflammatory and inflammatory), and drug-induced acne. Trials and therapy failure will not be required for those patients presenting with a preponderance of comedonal acne. Upon treatment failure with the above-mentioned products or if medically contraindicated, tretinoin products will be approved for three months. If tretinoin therapy is effective after the three-month period, approval will be granted for a one-year period. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of tretinoin products.
Vitamins, Minerals and Multiple Vitamins *Use Vitamin/Mineral PA form*	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 recipients aged 20 or under 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 a legend 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.)
Zelnorm® *Use Miscellaneous PA form*	Prior authorization is required for Zelnorm®. Payment for Zelnorm will be authorized only for short-term treatment of irritable bowel syndrome (IBS) with the primary bowel symptom of constipation and for patients less than 65 years of age with a clinical diagnosis of chronic idiopathic constipation with documented constipation treatment failures.

DRUG or GM	MAC per Tablet, ML
Acetaminophen Tablets, 325 mg	.0156
Acetaminophen Tablets, 500 mg	.0225
Acetaminophen Elixir, 120 mg/5 ml	.0039
Acetaminophen Elixir, 160 mg/5 ml	.0061
Acetaminophen Solution, 100 mg/ml	.1693
Acetaminophen Suppositories, 120 mg	.4575
Artificial Tears Ophthalmic Solution	**.2112**
Artificial Tears Ophthalmic Ointment	**.9427**
Aspirin, 81 mg (plain, chewable, enteric-coated)	.0497
Aspirin Tablets, 325 mg	.0099
Aspirin Tablets, 650 mg	.0287
Aspirin Tablets, Enteric-Coated, 325 mg	.0197
Aspirin Tablets, Enteric-Coated, 650 mg	.0263
Aspirin Tablets, Buffered, 325 mg	.0170
Bacitracin Ointment, 500 units/gm	.0880
Benzoyl Peroxide 5% Gel	.0422
Benzoyl Peroxide 5% Lotion	.0537
Benzoyl Peroxide 5% Wash	.0632
Benzoyl Peroxide 10% Gel	.0440
Benzoyl Peroxide 10% Lotion	.0550
Benzoyl Peroxide 10% Wash	.0676
Chlorpheniramine Maleate Tablets, 4 mg	.0103
Diphenhydramine Hydrochloride Capsules, 25 mg	.0225
Diphenhydramine Hydrochloride Liquid, 6.25 mg/5 ml	.0163
Diphenhydramine Hydrochloride Liquid, 12.5 mg/5 ml	.0061
Ferrous Sulfate Tablets, 300 mg	.0147
Ferrous Sulfate Tablets, 325 mg	.0147
Ferrous Sulfate Elixir, 220 mg/5 ml	.0050
Ferrous Sulfate Drops, 75 mg/0.6 ml	.0388
Ferrous Gluconate Tablets, 320 mg	.0159
Ferrous Gluconate Tablets, 325 mg	.0149
Ferrous Gluconate Elixir, 300 mg/5 ml	.0138
Ferrous Fumarate Tablets, 300 mg	.0152
Ferrous Fumarate Tablets, 325 mg	.0159
Guaifenesin, 100 mg/5 ml with Dextromethorphan, 10 mg/5 ml liquid	.0204

DRUG or GM	MAC per Tablet, ML
Ibuprofen Tablets, 200 mg	**.0479**
Lactic Acid (Ammonium Lactate) Lotion, 12%	**.0425**
Loperamide HCl Liquid, 1mg/5ml	**.0416**
Loperamide HCl Tablets, 2 mg	**.2108**
Loratadine Tablets, 10 mg	**.3795**
Loratadine Syrup, 10 mg/ml	**.0710**
Meclizine Hydrochloride Tablets, 12.5 mg	.0192
Meclizine Hydrochloride Tablets, 25 mg	.0255
Miconazole Nitrate Cream, 2% Topical	.1045
Miconazole Nitrate Cream, 2% Vaginal	.2398
Miconazole Nitrate Vaginal Suppositories, 100 mg	1.6210
Neomycin-Bacitracin-Polymyxin Ointment	**.1451**
Niacin tablets, 50mg	.0175
Niacin tablets, 100mg	.0195
Niacin tablets, 250mg	.0360
Niacin tablets, 500mg	.0284
Omeprazole Magnesium Delayed Release Tablets, 20 mg (Base Equivalent)	**.6053**
Pediatric Oral Electrolyte Solutions	.0054
Permethrin Liquid	.1363
Pseudoephedrine Syrup, 30 mg/5 ml	.0200
Pseudoephedrine Tablets, 30 mg	.0210
Pseudoephedrine Tablets, 60 mg	.0410
Salicyclic Acid Liquid, 17%	.1396
Sennosides-Docusate Sodium Tablets, 8.6-50 mg	**.1085**
Sennosides Tablets, 8.6 mg	**.0422**
Sennosides Granules, 15 mg/5 ml	**.0622**
Senna Tablets, 187 mg	**.0391**
Sodium Chloride Hypertonic Ophthalmic Ointment, 5%	**2.9593**
Sodium Chloride Hypertonic Ophthalmic Solution, 5%	**.7653**
Sodium Chloride Solution 0.9% for inhalation with metered dispensing value	.0451
Tolnaftate 1% Cream	.1167
Tolnaftate 1% Powder	.0700
Tolnaftate 1% Solution	.2290

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