



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

INFORMATIONAL LETTER NO. 470

To: Iowa Medicaid Participating Prescribers
From: Iowa Department of Human Services
Date: September 12, 2005
Subject: Drug Prior Authorization Updates
Effective: October 17, 2005

1. Drug Prior Authorization

A. New Prior Authorization Drugs and/or Categories of drugs

Effective October 17, 2005 the following drugs and/or categories of drugs will require prior authorization.

- Regranex[®]
- Spiriva[®]
- Urospecific Alpha-Blockers (Flomax[®], Uroxatral[®])
- Xolair[®]
- Zyvox[®]

The criteria for these drugs and/or categories of drugs are attached (refer to attachment 1). For a complete criteria chart, visit www.iowamedicaidpdl.com. The new PA forms are also available on that site or by calling the PA Provider Help Desk at 877-776-1567 or 725-1106 (local calls)

B. Changes to existing Drug Prior Authorization Categories

Effective October 17, 2005 the following category of drugs will have changes applied to the prior authorization criteria.

- Anti-Thrombotics, Injectable - preferred products will now require a prior authorization after **10** consecutive days of therapy, instead of after 30 days.

The new criterion for this category of drugs is attached (refer to attachment 1).

2. Days Supply Limitation Addition

- **Tamiflu[®]** - Prior authorization is required for Tamiflu[®] for quantities exceeding 14 units per 30 days effective October 17, 2005.

Please call Tiffany Nichols at (515) 725-1125 if you have any questions about this Informational Letter or if you need more information. Thank you.

ATTACHMENT: 1). PA Chart Additions/Changes

Attachment 1

PA Criteria Chart Additions/Changes

Anti-Thrombotics, Injectable	<p>Prior authorization is required for use of any preferred injectable anti-thrombotic agent longer than 10 consecutive days. Prior authorization will be required for all non-preferred injectable anti-thrombotic agents 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 and therapy failure with a preferred agent. Payment for usage of injectable anti-thrombotic agents beyond this limit will be authorized for cases in which there is a clinical diagnosis of:</p> <ol style="list-style-type: none"> 1. Pregnancy or planned pregnancy 2. Cancer-associated thromboembolic disease 3. Anti-thrombin III deficiency 4. Warfarin allergy 5. History of thrombotic event while on therapeutic anticoagulant therapy. 6. Total hip arthroplasty
Regranex[®]	<p>Prior authorization is required for Regranex[®]. Payment for new prescriptions will be authorized for ten weeks for patients who meet the following criteria:</p> <ol style="list-style-type: none"> 1. Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond 2. Inadequate response to 2 weeks of wound debridement and topical moist wound dressing <p>Longer than 10 weeks will be authorized for patients who meet the following criteria: Wound has decreased in size by 30% after 10 weeks</p>
Spiriva[®]	<p>Prior authorization is required for Spiriva[®]. Payment will be authorized for patients who meet all the following criteria:</p> <ol style="list-style-type: none"> 1. Diagnosis of mild, moderate or severe Chronic Obstructive Pulmonary disease according to the GOLD criteria 2. Symptomatic with documented pulmonary test showing obstruction 3. Treatment failure or compliance failure with ipratropium therapy 4. Regularly scheduled ipratropium therapy is discontinued when Spiriva[®] therapy begins
Urospecific Alpha-Blockers (Flomax[®], Uroxatral[®])	<p>Prior authorization is required for urospecific alpha-blockers. Payment will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred alpha1-adrenergic blocker or for patients who meet any of the following criteria:</p> <ol style="list-style-type: none"> 1. History of postural hypotension or hypotension 2. Use of antihypertensive or other medication that may exacerbate hypotension
Xolair[®]	<p>Prior authorization is required for Xolair[®]. Payment for Xolair[®] will be authorized for patients 12 and older when there is a diagnosis of moderate to severe persistent asthma and documentation of previous trial(s) and therapy failure(s) with therapeutic doses of inhaled steroids.</p>
Zyvox[®]	<p>Prior authorization is required for Zyvox[®]. Payment for Zyvox[®] will be authorized when there is documentation that:</p> <ol style="list-style-type: none"> 1. Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable). 2. Patient is being treated for one of the following diagnoses: <ul style="list-style-type: none"> • Vancomycin-resistant Enterococcus (VRE) and no alternative regimens with documented efficacy are available and VRE is not in lower urinary tract**. • Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin* • Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin* <p>*Severe intolerance to vancomycin is defined as:</p> <ul style="list-style-type: none"> – Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration – Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine) <p>**VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.</p>