INFORMATIONAL LETTER NO. 971

TO: Iowa Medicaid Physician, Dentist, Advanced Registered Nurse Practitioner, Therapeutically Certified Optometrist, Podiatrist, Pharmacy, Home Health Agency, Rural Health Clinic, Clinic, Skilled Nursing Facility, Intermediate Care Facility, Community Mental Health, Family Planning, Residential Care Facility, ICF MR State and Community Based ICF/MR Providers

FROM: Iowa Department of Human Services, Iowa Medicaid Enterprise

DATE: December 6, 2010

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: January 1, 2011

1. Changes to the Preferred Drug List (PDL)[1] Effective January 1, 2011

Preferred	Non-Preferred	Recommended	Non-Recommended
Adcirca®[1]	Adderall XR®[1,3]	Anastrozole	Arimidex®
Agriflu®	Aricept® 23mg		Norvir® Tablets
Balsalazide	Aricept® ODT[1]		
Cefprozil 125mg/5ml Suspension	Asmanex® 30 110mcg		
Cefprozil Tablets	Avinza® 45mg & 75mg		
Desoximetasone 0.25% Cream	Avodart®[3]		
Disopyramide	Belladonna Alkaloids & Opium Suppository 16.2-30mg		
Dulera®	BenzEFoam™[1]		
Eplerenone[1]	Boniva®		
Finasteride	Cambia™[1]		
Hiprex®	Cardizem® LA		
Liposyn®	Cedax®		
Lumigan® 0.01%	Cimzia®[1]		
Metronidazole Lotion[1]	Ciprodex®[4,6]		
Onglyza™[1]	Clindamycin for Oral Solution		
Renvela®	Detrol® LA		
Salicylic Acid Shampoo	Diazepam Gel		
Trandolapril	Elidel®		
Venlafaxine ER Tablet[5]	Enablex®		
	Enoxaparin Injection[1]		
	Inspra™[1]		
	Kadian® 10mg		

	Keppra XR®[1,2]		
	Lescol® XL[1]		
	Livalo®		
	Lodosyn®		
	Lovenox® 300mg/3ml[1]		
	Meropenem		
	MetroLotion®[1]		
	Natazia™		
	Norpace®		
	Omeprazole/Sodium Bicarbonate[1]		
	Ondansetron Oral Solution[1]		
	Pancrelipase™ 5,000 units[1]		
	Paxil CR®[1,3]		
	ProCentra®[1]		
	Proscar®		
	Protopic®		
	Renagel® 800mg		
	Rivastigmine		
	Salex® Shampoo		
	Sanctura XR®		
	Suboxone® Film[1]		
	Tazorac®[1]		
	Tekamlo™		
	Tracleer®[1,3]		
	Tobradex® ST		
	Tribenzor™[1]		
	Trospium		
	Twinject®		
	Urex™		
	Veltin™[1]		
	Venlafaxine ER Capsule		
	Verelan® 120mg		
	Vospire ER®		
	Xeomin®		
	Xerese™		
	Xylocaine® 4% Solution		
	Zencia™ Wash		

[1] Clinical PA Criteria Apply
[2] Grandfather Existing Users for Seizure Disorder
[3] Grandfather Existing Users
[4] 72 Hour Emergency Fill Not Allowed
[5] Upstate Pharma Brand Only-All Others Non-Preferred
[6] Preferred for members 6 months of age to 1 year of age

2. Synagis® Coverage 2010-11 RSV Season

Prior authorization requests for Synagis® may now be submitted to the Iowa Medicaid Pharmacy Prior Authorization Unit. Prior authorizations will be approved for a **maximum of five doses per member.** No allowances will be made for a sixth dose. Please refer to the Palivizumab (Synagis®) Prior Authorization criteria and form located at www.iowamedicaidpdl.com.

3. **Changes to Existing Prior Authorization Criteria-** See complete prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

- **Biologicals for Ankylosing Spondylitis:** Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include *sulfasalazine and methotrexate.*

  Payment for non-preferred biologicals for ankylosing spondylitis will be considered only for cases in which there is documentation of previous *trials and therapy failures with two preferred biological agents.*

- **Biologicals for Inflammatory Bowel Disease:**
  - Crohn's Disease – Payment will be considered following an inadequate response to *two* preferred conventional therapies including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate.
  - Ulcerative colitis (moderate to severe) – Payment will be considered following an inadequate response to *two* preferred conventional therapies including aminosalicylates, and azathioprine/6-mercaptopurine.

- **Biologicals for Plaque Psoriasis:** 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.*

- **Extended Release Formulations:** Payment for a non-preferred extended release formulation will be considered when the following criteria are met:
  1. Previous trial with the preferred immediate release product of the same chemical entity at a therapeutic dose *that resulted in a partial response with a documented intolerance and*
  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.*

- **Lidocaine Patch (Lidoderm®):** Payment will be considered for a diagnosis of pain associated with post-herpetic neuralgia following a previous treatment failure with a preferred agent at therapeutic dose from *two* of the following: tricyclic antidepressant, opioid, gabapentin, *carbamazepine, or valproic acid*.

- **Lipase Inhibitor Drugs:** *Removal of hyperlipidemia as a covered diagnosis of use.*

4. **Point of Sale (POS) Billing Issues:**

a) **Effective January 1, 2011,** the refill tolerance for non-controlled medications will increase from 75% to 85%. The refill tolerance for controlled substances, tramadol, and carisoprodol will remain at 85%.

b) **Effective January 1, 2011,** a 7 day override of certain mental health drugs that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class will be allowed while requesting prior authorization. The pharmacy may use **PA Type Code 7** as a POS override for applicable mental health drugs.

c) **ProDUR Quantity Limits:** The following quantity limit edits will be implemented effective *January 1, 2011*. A comprehensive list of all quantity limit edits appears on our website, www.iowamedicaidpdl.com under the heading, "Quantity Limits".

Drug Product	Quantity	Days Supply
Cymbalta® 30mg	60	30
Ditropan XL® 10mg	60	30
Ditropan XL® 15mg	60	30
Focalin® XR 20mg	60	30
Focalin® XR 30mg	60	30
Focalin® XR 40mg	30	30
Lipitor® 40mg	45	30
Xyrem® 500mg/ml	540ml	30

d). **Preferred Upstate Pharma NDCs for Venlafaxine ER Tablets:**

NDC	Drug Name
00131326532	Venlafaxine 37.5mg ER Tablet
00131326546	Venlafaxine 37.5mg ER Tablet
00131326632	Venlafaxine 75mg ER Tablet
00131326646	Venlafaxine 75mg ER Tablet
00131326732	Venlafaxine 150mg ER Tablet
00131326746	Venlafaxine 150mg ER Tablet
00131326832	Venlafaxine 225mg ER Tablet
00131326846	Venlafaxine 225mg ER Tablet

e). **Proper Billing of Synagis® and flu vaccines:** As a reminder, Synagis® 50mg Injection and all flu vaccine injections should be billed as 0.5ml.

5. **Nonprescription Drug MAC Rate Changes:** Effective January 1, 2011, several OTC MAC rate changes will be implemented. Please refer to the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab for a complete list of all changes.

6. **Preferred Brand Name Drugs on the PDL-Pharmacy Clarification**
   - When a status change occurs for a previously preferred brand name drug to non-preferred status, up to a *minimum* of 30 days transition period is given to pharmacies to help utilize existing brand name product in stock in an effort to decrease a pharmacy's remaining brand name drug inventory (see PDL comment section regarding transition periods exceeding 30 days).
   - If additional stock remains beyond this time period, pharmacies may call the POS Helpdesk at 877-463-7671 or 515-256-4608 (local) to request an override for the non-preferred brand name drug with a recent status change.

7. **DUR Update:** The latest issue of the Drug Utilization Review (DUR) Digest is located at the Iowa DUR website, www.iadur.org under the "Newsletters" link.

We encourage providers to go to the website at **www.iowamedicaidpdl.com** to view all recent changes to the PDL. If you have questions, please contact the Pharmacy Prior Authorization Helpdesk at 877-776-1567 or 515-256-4607 (local in Des Moines) or e-mail info@iowamedicaidpdl.com.

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