Iowa Department of Human Services

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INFORMATIONAL LETTER NO.1081

DATE: December 19, 2011

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 (IME)

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: January 30, 2012

1. **New Drug Prior Authorization Criteria-** See prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

- **Dextromethorphan and Quinidine (Nuedexta™):** Prior authorization is required for Nuedexta™**.** Payment will be considered under the following conditions:
  1) Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS).
  2) A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI.
  3) Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire.
  4) Subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire.

- **Roflumilast (Daliresp™):** Prior authorization is required for roflumilast (Daliresp™). Payment will be considered for patients 18 years of age or older when the following is met:
  1) A diagnosis of severe COPD with chronic bronchitis as documented by spirometry results, and
  2) A smoking history of ≥ 20 pack-years, and
  3) Currently on a long-acting bronchodilator in combination with an inhaled corticosteroid with documentation of inadequate control of symptoms, and
  4) A history of at least one exacerbation in the past year requiring treatment with oral glucocorticosteroids.

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

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

- **Anti-Acne Products-Topical:** Prior authorization is required for all prescription topical acne products. Payment for the treatment of mild to moderate acne vulgaris will be considered under the following conditions:
  1) Previous trial and therapy failure with a preferred over-the-counter benzoyl peroxide product which is covered by the program without prior authorization.
  2) 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.
  3) If the patient presents with a preponderance of comedonal acne, topical retinoid products may be utilized as first line agents with prior authorization (use Topical Retinoids PA form).

- **Topical Retinoids for Acne (formerly Tretinoin Products):** Prior authorization is required for all prescription topical retinoid products. Payment for prescription topical retinoid products will be considered under the following conditions:
  1) Previous trial and therapy failure with a preferred over-the counter benzoyl peroxide product, and
  2) Previous trials and therapy failures with two preferred topical and/or oral antibiotics for the treatment of mild to moderate acne (non-inflammatory and inflammatory), and drug-induced acne.

  Requests for Tazorac for a psoriasis diagnosis may only be considered after documentation of a previous trial and therapy failure with a preferred topical antipsoriatic agent.

3. Point of Sale (POS) Billing Issues:

a. ProDUR Edits:

- Letrozole (Femara®) will only be payable for members 50 years of age and older without prior authorization.
- Sinecatechins (Veregen®) will only be payable for members 18 years of age and older, a maximum of 15 grams per 28 days and a maximum duration of treatment of 16 weeks per 12 months.

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

4. 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.