Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

INFORMATIONAL LETTER NO.1382

DATE: April 29, 2014

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/ID State and Community Based ICF/ID Providers

FROM: Iowa Department of Human Services, Iowa Medicaid Enterprise

RE: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: June 1, 2014

1. Changes to the Iowa Medicaid PDL[1] Effective June 1, 2014

Preferred	Non-Preferred	Non-Recommended
Bethkis	Adempas[2]	Abacavir/Lamivudine/ Zidovudine
Methylphenidate ER 20mg Tablets [2]	Brintellix	Gilotrif
Paroxetine ER	Clonidine ER[2]	Mycophenolic Acid
	Cyproheptadine[2]	Rixubis
	Dexmethylphenidate ER[2]	Sirolimus
	Diclofenac Gel 3%	
	Duloxetine[2]	
	Epaned[3]	
	Fenoprofen[2]	
	Fetzima	
	Fluocinonide Cream 0.1%	
	Fycompa	
	Gatifloxacin	
	Ketoprofen ER[2]	
	Khedezla[2]	
	Lidocaine Patch[2]	
	Niacin ER	
	Olysio[2]	
	Opsumit[2]	

[1] https://www.iowamedicaidpdl.com/

	Oxaprozin[2]	
	Paricalcitol	
	Procysbi	
	Rabeprazole[2]	
	Ritalin[2]	
	Ritalin SR[2]	
	Telmisartan[2]	
	Telmisartan/Amlodipine[2]	
	Tobramycin Neb Solution	
	Tolterodine ER	
	Trokendi XR[2]	
	Versacloz	
	Zorvolex[2]	

[2]Clinical PA Criteria Apply
[3] Preferred for members < 8 years of age

2. New Drug Prior Authorization Criteria- See prior authorization criteria posted at Iowa Medicaid PDL under the Prior Authorization Criteria tab.

- **Anti-Diabetics, Non-Insulin Agents:** Prior authorization is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions:
  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 maximally tolerated dose, unless evidence is provided that use of the agent would be medically contraindicated.

  Payment for a non-preferred anti-diabetic, non-insulin agent subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with metformin, a preferred DPP-4 Inhbitor or DPP-4 Inhibitor Combination and a preferred Incretin Mimetic at maximally tolerated doses, unless evidence is provided that use of these agents would be medically contraindicated.
  Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented continued improvement in HgbA1C.

- **Trametinib (Mekinist™):** Prior authorization is required for trametinib (Mekinist™). Payment will be considered for patients when the following criteria are met:
  1. Patient is 18 years of age or older; and
  2. Patient has a documented diagnosis of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutation as detected bv an FDA-approved test; and

3. Patient has not received prior therapy with a BRAF-Inhibitor; and
4. Prescriber is an oncologist.
If criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.

3. Point of Sale (POS) Billing Issues:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *June 1, 2014*. A comprehensive list of all quantity limit edits appears on the Iowa Medicaid PDL under the heading, "Quantity Limits".

Drug Product	Quantity	Days Supply
butalbital/apap 50-325mg	60	30
butalbital/apap/caffeine 50-300-40mg	60	30
butalbital/apap/caffeine 50-325-40mg	60	30
butalbital/apap/caffeine/codeine 50-300-40-30mg	60	30
butalbital/apap/caffeine/codeine 50-325-40-30mg	60	30
butalbital/asa/caffeine 50-325-40mg	60	30
butalbital/asa/caffeine/codeine 50-325-40-30mg	60	30
fluocinolone otic	20ml	30
Stromectol	15	30
Transderm Scop	8	30

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

4. 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.

5. DUR Update: The latest issue of the Drug Utilization Review (DUR) Digest[4] is available at the Iowa Medicaid Drug Utilization Review Commission's newsletter webpage.

We encourage providers to go to Iowa Medicaid PDL 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 email info@iowamedicaidpdl.com.

[4] http://www.iadur.org/newsletters