Iowa Department of Human Services

Terry E. Branstad
Governor

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Director

INFORMATIONAL LETTER NO.1418

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

DATE: August 28, 2014

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: October 1, 2014

1. **Changes to the Preferred Drug List (PDL) Effective October 1, 2014.** Refer to complete PDL located at www.iowamedicaidpdl.com.

Preferred	Non-Preferred	Non-Recommended
Aerospan	Adderall[1]	Alprolix
Amphetamine Salt Combo Tablets[1]	Aldara	Capecitabine
Azithromycin 1gm Powder Packet	Amoxicillin/Clarithromycin/ Lansoprazole	Imbruvica
Blephamide S.O.P.	Anoro Ellipta	Lomustine
Cayston	Aptiom	Zykadia
Cellcept Oral Suspension	Astagraf XL[1,2]	
Clarithromycin 250mg & 500mg Tablets	Atovaquone	
Cyclosporine	Aveed[1]	
Cyclosporine Modified	Biaxin 250mg/5mL Susp	
Dexamethasone Phosphate Ophth Sol	Budesonide (nasal)	
Durezol	Calcipotriene/ Betamethasone Ointment	
Ella	Cellcept Capsules & Tablets[2]	
Gengraf	Copaxone 40mg Injection	
Imiquimod	Cycloserine	
Levonorgestrel (emergency)	Daraprim	
Maxidex Ophth Susp	Doxercalciferol	

Maxitrol	E.E.S.	
Mycophenolate Mofetil	EryPed	
Myfortic	Ery-Tab	
Naloxone	Erythromycin Base	
Namenda XR	Erythromycin Ethylsuccinate	
Pred-G	Eszopiclone[1]	
Prednisolone Sodium Phosphate Ophth Sol	Farxiga[1]	
Propranolol ER	Fluorometholone Ophth Suspension	
Rapamune	Granix[1]	
Sandimmune	Hemangeol	
Sirolimus	Hetlioz[1]	
Tacrolimus	Hydromorphone ER[1]	
Tegretol Tablets	Inderal LA	
Vexol	Lotemax	
X-Viate 40% Cream	Lupaneta	
Zylet	Moxifloxacin	
	Mycophenolate Sodium[2]	
	Myalept	
	Neomycin-Polymyxin-HC Ophth Suspension	
	Neoral[2]	
	Omega-3-Acid 1gm	
	Orenitram[1]	
	Otezla[1]	
	Otrexup[1]	
	Potassium Chloride 20mEq Powder Packet	
	Prednisolone Acetate Ophth Suspension	
	Prograf[2]	
	Raloxifene	
	Sevelamer	
	Telmisartan HCT[1]	
	Tetracycline	
	Velphoro	
	Xartemis XR[1]	
	Xulane	
	Zithromax 600mg Tablet	
	Zohydro ER[1]	
	Zolmitriptan[1]	
	Zortress[2]	

[1]Clinical PA Criteria Apply
[2]Grandfather Existing Users

2. **Pharmacy Prior Authorization:** 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.

1). Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered.

2). All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure.

3). The use of pharmaceutical samples (from the prescriber or manufacturer medication assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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

- **Apixaban (Eliquis®):**
  6. For patients requiring deep vein thrombosis (DVT) prophylaxis undergoing hip or knee replacement. Requests will be considered when the patient has contraindications to use of the preferred agent(s). If patient meets criteria for coverage, requests will be approved for the following doses:
  - *Hip replacement: 2.5mg twice daily for up to 35 days following hip replacement; or*
  - *Knee replacement: 2.5mg twice daily for up to 12 days following knee replacement.*

- **Dabigatran (Pradaxa®):**
  3. Patient has documentation of a previous trial and therapy failure with warfarin (TIA, stroke, *recurrence of DVT/PE,* or inability to maintain a therapeutic INR with a minimum 6 month trial).

  Treatment and prevention of DVT or PE
  - *Patient does not have a CrCl < 30mL/min or is not on dialysis*
  - *For patients with current DVT/PE, in addition to warfarin trial, patient must have documentation of 5 to 10 days of parenteral anticoagulation prior to initiation of dabigatran.*

- **Omalizumab (Xolair®):**
  Chronic Idiopathic Urticaria
  1. *Patient has a diagnosis of moderate to severe chronic idiopathic urticaria; and*
  2. *Patient is 12 years of age or older; and*
  3. *Patient has documentation of a trial and therapy failure with at least one second-generation antihistamine, one of which must be cetirizine at a dose of up to 20mg per day; and*

4. *Patient has documentation of a trial and therapy failure with at least one first-generation antihistamine; and*
5. *Patient has documentation of a trial and therapy failure with at least one potent H1 receptor antagonist (hydroxyzine and/or doxepin); and*
6. *Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first-or second-generation antihistamine.*

If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the needed for continued therapy.

4. Point of Sale Billing Issues:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *October 1, 2014*. 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	Comment
Cayston 75mg	84	28	Every other month dosing allowed
Glucagen	2	30	
Glucagon	2	30	
Namenda XR 7mg	30	30	
Namenda XR 14mg	30	30	
Namenda XR 21mg	30	30	
Namenda XR 28mg	30	30	
Sutent 12.5mg	30	30	
Sutent 37.5mg	30	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

c. Billing of Durable Medical Equipment (DME) products: DME products, other than preferred blood glucose test strips, lancets and syringes, must be billed on the CMS-1500, Health Insurance Claim Form. These items are not billed through pharmacy Point of Sale (POS). Some items may require Medical Prior Authorization (PA). Additional information can be found in the Provider Manual for Medical Equipment and Supply Dealers. Please contact Provider Services at 800-338-7909 or 515-256-4609 locally for additional questions regarding billing of these DME products.

5. 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.

6. **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 email info@iowamedicaidpdl.com.