Iowa Department of Human Services

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INFORMATIONAL LETTER NO.1722-MC-FFS

DATE: September 14, 2016

TO: Iowa Medicaid Physicians, Dentists, Advanced Registered Nurse Practitioners, Therapeutically Certified Optometrists, Podiatrists, Pharmacies, Home Health Agencies, Rural Health Clinics, Clinics, Skilled Nursing Facilities, Intermediate Care Facilities, Nursing Facilities-Mental ILL, Federally Qualified Health Centers (FQHC), Indian Health Service, Maternal Health Centers, Certified Nurse Midwife, Community Mental Health, Family Planning, Residential Care Facilities, ICF/ID State and Community Based ICF/ID Providers

APPLIES TO: Managed Care, Fee-for-Service

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)

RE: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: October 1, 2016

*****This letter replaces Informational Letter No. 1716-MC-FFS dated August 30, 2016*****

1. **Changes to the Preferred Drug List (PDL) Effective October 1, 2016.** Refer to the PDL website[1] to review the complete PDL.

Preferred	Non-Preferred	Recommended	Non-Recommended
Abacavir	Alogliptin[1]	Novoeight	Aptivus
Adzenys XR ODT[1]	Alogliptin-Metformin[1]		Cabometyx[1]
Descovy	Alogliptin-Pioglitazone[1]		Crixivan
Emend[1]	Briviact		Didanosine
Lamivudine	Darifenacin ER		Fuzeon
Narcan Nasal Spray	Durlaza		Invirase
Pradaxa	Dyanavel XR[1]		Kovaltry
Quillichew ER[1]	Envarsus XR[1]		Lexiva
Xarelto	Epivir		Nevirapine
Zepatier[1]	Flurandrenolide[1]		Rescriptor
	Frovatriptan[1]		Trizivir
	Fyavolv		Venclexta[1]
	Miglitol		Videx

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

	Mometasone Nasal		Viramune Oral Suspension
	Monurol		Viramune XR
	Naftifine		
	Odefsey		
	Potassium Chloride Oral Solution		
	Rosuvastatin		
	Sernivo[1]		
	Uptravi[1]		
	Varubi[1]		
	Verapamil ER Capsules		
	Viberzi[1]		
	Vraylar[2]		
	Xeljanz XR[1]		
	Ziagen		

[1]Clinical PA Criteria Apply
[2]Step 3

2. New Drug Prior Authorization Criteria- See complete prior authorization criteria under the Prior Authorization Criteria tab[2].

- **Mepolizumab (Nucala):**
  Prior authorization is required for mepolizumab (Nucala). Requests will not be considered with concurrent use of omalizumab. Payment will be considered under the following conditions:
  1. Patient is 12 years of age or older; and
  2. Patient has a diagnosis of severe asthma with an eosinophilic phenotype; and
  3. Patient has a pretreatment blood eosinophil count of ≥150 cells per mcL within the previous 6 weeks or blood eosinophils of ≥300 cells per mcL within 12 months prior to initiation of therapy; and
  4. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and
  5. Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus an LABA and LTRA; and
  6. A pretreatment forced expiratory volume in 1 second (FEV_1) <80% predicted; and
  7. Prescriber is an allergist, immunologist, or pulmonologist; and
  8. Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility.

[2] http://www.iowamedicaidpdl.com/pa_criteria

If criteria for coverage are met, an initial authorization will be given for 3 months to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met:

1. Patient continues to receive therapy with an ICS, LABA and LTRA; and
2. Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or
3. Patient has experienced a decrease in administration of rescue medication (albuterol); or
4. Patient has experienced a decrease in exacerbation frequency; or
5. Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline.

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

- **Novel Oral Anticoagulants (removal of PA criteria for Pradaxa and Xarelto and combination of existing criteria for remaining non-preferred NOACs):**

  Prior authorization is not required for preferred novel oral anticoagulants (NOACs). Prior authorization is required for non-preferred NOACs. Requests for doses outside of the manufacturer recommended dose will not be considered. Payment will be considered for FDA approved or compendia indications under the following conditions:

  1. Patient does not have a mechanical heart valve; and
  2. Patient does not have active bleeding; and
  3. For a diagnosis of atrial fibrillation or stroke prevention, patient has the presence of at least one additional risk factor for stroke, with a CHA_2DS_2-VASc score ≥1; and
  4. A recent creatinine clearance (CrCl) is provided; and
  5. A recent Child-Pugh score is provided; and
  6. Patient's current body weight is provided; and
  7. Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred NOACs.
  8. For requests for edoxaban, documentation patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin).

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

- **Potassium Binders:**

  Prior authorization (PA) is required for non-preferred potassium binders. Payment will be considered under the following conditions:

  1. Patient is 18 years of age or older; and
  2. Patient has a diagnosis of chronic hyperkalemia; and

3. Patient has documentation of a recent trial and therapy failure with sodium polystyrene sulfonate.

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

- **Topical Acne and Rosacea Products (replaces Anti-Acne Topical Products and Topical Retinoids for Acne prior authorizations):**
  Prior authorization (PA) is required for topical acne agents (topical antibiotics and topical retinoids) and topical rosacea agents. Payment for topical acne and topical rosacea agents will be considered under the following conditions:
  1. Documentation of diagnosis.
  2. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid for moderate to severe acne.
  3. 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 from the requested topical class (topical antibiotic or topical retinoid).
  4. Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical agent.
  5. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products.
  6. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis.
  7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for the preferred tazarotene (Tazorac) product for a psoriasis diagnosis.
  8. Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered.

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

3. Point of Sale Billing Issues:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *October 1, 2016*. A comprehensive list of all quantity limit edits appears on the Quantity Limit Chart[3].

Drug Product	Quantity	Days Supply	Comments
Xarelto 10mg	30	30	
Xarelto 15mg	30	30	Twice daily dosing allowed for 21 days
Xarelto 20mg	30	30	

[3] http://www.iowamedicaidpdl.com/billing_quantity_limits

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 is located at the Iowa DUR website[4] under the "Newsletters" link.

We encourage providers to go to the PDL website[5] 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.

[4] http://www.iadur.org/
[5] http://www.iowamedicaidpdl.com/