Iowa Department of Human Services

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INFORMATIONAL LETTER NO.1746-MC-FFS-D

DATE: November 28, 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 and Dental

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

RE: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: January 1, 2017

1. **Changes to the Preferred Drug List (PDL) Effective January 1, 2017.** Refer to the PDL website[1] to review the complete PDL.

Preferred	Non-Preferred	Recommended
Acanya[1]	Abilify[2]	Hydroxyprogesterone Caproate[1]
Alphagan P 0.1%	Advate	
Alphanate	Adynovate	
Alphanine SD	Aerospan	
Amlodipine-Valsartan[1]	Afstyla	
Amlodipine-Valsartan-HCTZ[1]	Alprolix	
Amphetamine-Dextroamphetamine ER[1]	Armodafinil[1]	
Androgel 1% Packets[1]	BenzaClin[1]	
Aripiprazole[6]	BPO-Erythromycin Gel[1]	
Azelastine Ophth Solution	Bethkis	

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

Bebulin	Bevespi Aerosphere	
Benefix	Byvalson	
Canasa	Ciloxan Ophth Ointment	
Ciprofloxacin Otic Solution	Clindamycin Phosphate-Tretinoin[1]	
Clonidine ER Tablets[1,4]	Coagadex	
Dexmethylphenidate ER[1]	Colchicine[1]	
Differin Lotion[1]	Coumadin[3]	
Durezol	Crestor	
Epclusa[1]	Dipentum	
Epinephrine Auto-Injector	Dofetilide	
Galantamine Tablets[5]	Eloctate	
Helixate FS	Emverm	
Hemofil M	EpiPen	
Humate-P	Ethacrynic Acid	
Ilevro	Exelon Patch[5]	
Koate-DVI	Exforge[1]	
Kogenate FS	Exforge HCT[1]	
Kogenate FS Bio-Set	Feiba	
Lamotrigine Chewable Tablets	Fenofibrate 40mg, 54mg, 120mg & 160mg Tablets	
Methitest[1]	Focalin XR[1]	
Methylphenidate ER (CD)[1,4]	Fragmin	
Mitigare[1]	Idelvion	
Monoclate-P	Ixinity	
Mononine	Jentadueto XR[1]	
Natroba	Kovaltry	
Novoeight	Lazanda[1]	
Novoseven	Metadate CD[1]	
Olopatadine Ophth Solution[4]	Methyltestosterone[1]	
Profilnine SD	MetroGel Vaginal	
Recombinate	Nasonex	
Rosuvastatin	Nevanac	
Sulfacetamide-Prednisolone Ophth Suspension	Nuwiq	
Viekira XR[1]	Obizur	
Wilate	Ocaliva	
Xyntha	Onzetra Xsail[1]	
	Pataday	

	Patanol	
	Qbrelis	
	Quillivant XR[1]	
	Rixubis	
	Spritam[1]	
	Sulfacetamide Sod Ophth Solution & Ointment	
	Taltz[1]	
	Testim[1]	
	Timolol Ophth Gel Forming Solution	
	Ulesfia	
	Vonvendi	
	Xiidra	
	Xtampza ER[1]	
	Zembrace[1]	
	Zinbryta	

[1]Clinical PA Criteria Apply
[2]Step 3
[3]Grandfather Existing Users
[4]Authorized Generic Only
[5]Age Edit
[6]Step 2

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

- **Lupron Depot - Pediatric:**
  Prior authorization is required for Lupron Depot-Ped. Payment will be considered for patients when the following is met:
  1. Patient has a diagnosis of central precocious puberty (CPP); and
  2. Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males; and
  3. Patient is currently < 11 years of age for females or < 12 years of age for males; and
  4. Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test is provided (attach results); and
  5. Documentation of advanced bone age (defined as greater than or equal to two standard deviations above the gender/age related mean); and
  6. Baseline evaluations including the following have been conducted and/or evaluated:
     a. Height and weight measurements; and

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

b. Sex steroid (testosterone or estradiol) levels have been obtained; and
c. Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor; and
d. Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors; and
e. Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor; and
f. Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia; and

7. Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility.

When criteria for coverage are met, an initial authorization will be given for six months.

Additional approvals will be granted at six month intervals until the patient is ≥ 11 years of age for females and ≥ 12 years of age for males. If therapy beyond the aforementioned ages is required, documentation of medical necessity will be required.

- **Lupron Depot - Adult:**
  Prior authorization is required for Lupron Depot (leuprolide acetate). Payment will be considered for patients under the following conditions:

1. Patient is 18 years of age or older; and
2. Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility; and
3. Patient has a diagnosis of endometriosis for whom therapy with NSAIDs and at least one preferred 3 month course of a continuous hormonal contraceptive has failed; or
4. Patient has a diagnosis of uterine leiomyomata with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively; or
5. Patient has a diagnosis of advanced prostate cancer.

Therapy will be limited as follows:

- Endometriosis – initial six month approval. If symptoms of endometriosis recur after the first course of therapy, a second course of therapy with concomitant norethindrone acetate 5 mg daily will be considered. Retreatment is not recommended for longer than one additional six month course.
- Uterine leiomyomata – three month approval.
- Advanced prostate cancer – initial six month approval. Renewal requests must document suppression of testosterone levels towards a castrate level of < 50 ng/dL (attach lab).

3. Changes to Existing Prior Authorization Criteria- *Changes are italicized.* See complete prior authorization criteria under the Prior Authorization Criteria tab[3].

- **Buprenorphine/Naloxone:**

  Prior authorization is required for *oral* buprenorphine or buprenorphine/naloxone. Requests for doses above 24mg per day or greater than once daily dosing will not be considered. Initial requests will be considered for up to three months. Requests for maintenance doses above 16mg per day will not be considered on a long-term basis. Concomitant use with opioids, tramadol and hypnotics will be prohibited. Benzodiazepines will be allowed up to a cumulative 30 days per 12 month period. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. *Requests for surgically implanted buprenorphine products will not be considered through the pharmacy benefit and should be directed to the member's medical benefit.* Payment will be considered for patients when the following is met:

  5. *Documentation is provided that transmucosal buprenorphine will not be used concomitantly with the buprenorphine implant.*

  Requests for renewal must include:

  - *Documentation the patient is not using transmucosal buprenorphine with the buprenorphine implant.*

- **Short-Acting Opioids:**

  Prior authorization is required for all non-preferred short acting *opioids*. Payment will be considered *under the following conditions:*

  1. *Patient has pain severe enough to require opioid treatment; and*
  2. *Patient has tried and failed at least two non-pharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and*
  3. *Patient has tried and failed at least two non-opioid pharmacologic therapies (acetaminophen or NSAIDs); and*
  4. *Patient has* documentation of previous trials and therapy failures with three (3) chemically distinct preferred short acting *opioids* (based on *opioid* ingredient only) at therapeutic doses; *and*
  5. *The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring program website and has determined that use of a short-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and*
  6. *Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious*

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

adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids.

If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met:

1. *Patient has experienced improvement in pain control and level of functioning; and*
2. *Prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at https://pmp.iowa.gov/IAPMPWebCenter/ and has determined continued use of a short-acting opioid is appropriate for this member.*

The required trials may be overridden when documented evidence is provided that use of these agents and/or non-pharmacologic therapies would be medically contraindicated.

4. Point of Sale Billing Issues:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *January 1, 2017*. A comprehensive list of all quantity limit edits appears on the Quantity Limit Chart[4].

Drug Product	Quantity	Days Supply
Adzenys XR ODT 3.1mg	30	30
Adzenys XR ODT 6.3mg	30	30
Adzenys XR ODT 9.4mg	30	30
Adzenys XR ODT 12.5mg	30	30
Adzenys XR ODT 15.7mg	30	30
Adzenys XR ODT 18.8mg	30	30
Aripiprazole 2mg	60	30
Aripiprazole 5mg	30	30
Aripiprazole 10mg	30	30
Aripiprazole 15mg	30	30
Aripiprazole 20mg	30	30
Aripiprazole 30mg	30	30
Loperamide 2mg	120	30
Loperamide 1mg/5mL oral liquid	1200mL	30

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

Methylergonovine 0.2mg Tablets	28	30
Natroba	240mL	30
Quillichew 20mg	30	30
Quillichew 30mg	60	30
Quillichew 40mg	30	30

b. ProDUR High Dollar Edit: Effective *January 1, 2017,* the threshold for the high dollar claims edit will be reduced from $10,000 to $5,000. All claims submitted in excess of $5,000 will be rejected if a prior authorization is not on file. After verifying that the quantity and days' supply of the claim are correct, contact the Pharmacy POS Help Desk for Fee-for-Service members or the applicable MCO Help Desk. An override will be granted if quantity and days' supply are accurate and consistent. Additional medical documentation may be required for longer overrides.

c. ProDUR Antipsychotic Edit: Effective *March 1, 2017,* the following edits will be implemented:

- Age edit on risperidone for members less than five (5) years of age.
- Age edit on all other antipsychotics for members less than six (6) years of age.
- Duplicate therapy edit on all antipsychotics for members 0 through 17 years of age. A 30 day grace period will be allowed to allow transition between antipsychotic medications.
- Quantity limits:

Drug Product	Quantity	Days Supply
Olanzapine 15mg	30	30
Olanzapine 20mg	30	30
Risperidone 1mg	60	30
Risperidone 2mg	60	30

5. Non-Drug Product List: The following products will be added effective *January 1, 2017.* A comprehensive non-drug product list appears on the Non-Drug Product List[5].

Non-Drug Products	✓Indicates Prior Authorization Required
DEKAs Chewable Tablets	✓
DEKAs Liquid	✓
DEKAs Softgels	✓

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

[5] http://www.iowamedicaidpdl.com/preferred_drug_lists

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[6] under the "Newsletters" link.

We encourage providers to go to the PDL website[7] 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

[6] http://www.iadur.org/
[7] http://www.iowamedicaidpdl.com/