Iowa Department of Human Services

Kim Reynolds Governor	Adam Gregg Lt. Governor	Jerry R. Foxhoven Director

INFORMATIONAL LETTER NO.1860-MC-FFS

DATE: November 29, 2017

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 and ICF/ID State and Community Based ICF/ID Providers

APPLIES TO: Managed Care (MC), Fee-for-Service (FFS)

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

RE: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: January 1, 2018

1. **Changes to the Preferred Drug List (PDL) Effective January 1, 2018.** Refer to the PDL website[1] to review the complete PDL.

Preferred	Non-Preferred	Non-Recommended
Abilify Maintena[3]	Adapalene/Benzoyl Peroxide[1]	Alunbrig[1]
Acarbose	Adzenys XR[1]	Idhifa[1]
Aptensio XR[1]	Androgel Packets 1%[1]	Rubraca[1]
Aripiprazole[4]	Armonair RespiClick	Rydapt[1]
Armodafinil[1]	Asmanex	Zejula[1]
Bethkis	Austedo	
Bevespi Aerosphere	Benlysta	
Budesonide Inhalation Solution[5]	Besivance	
Buphenyl	Ciprofloxacin Otic Solution	
Bydureon[1]	Clomipramine Non-Authorized Generic[8]	
Carbamazepine ER	Cotempla[1]	

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

Tablets		
Colchicine Capsules	Dexmethylphenidate ER[1]	
Coly-Mycin S	Eletriptan[1]	
Desipramine	Epaned	
Desvenlafaxine ER	Epzicom	
Farxiga[1]	Flovent Diskus	
Focalin XR[1]	Haegarda	
Granix[1]	Harvoni[1]	
Ingrezza	Ilaris[1]	
Jardiance[1]	Imitrex Subcutaneous Solution[1]	
Lotronex	Kevzara[1]	
Mavyret[1]	Lanthanum	
Moxeza	Latuda[6]	
NovoLog FlexPen	Methylphenidate ER Capsules (CD)[1]	
Ofloxacin Otic Solution	Mitigare	
Quetiapine ER[3]	Mydayis[1]	
Quillivant XR[1]	Neupogen[1]	
Repaglinide	Ofloxacin Ophth Solution	
Sumatriptan Succinate Subcutaneous Solution[1]	Pentasa 250mg	
Synjardy[1]	Prasugrel	
Synjardy XR[1]	Pulmicort Inhalation Solution	
Testosterone Gel Packets 1%[1]	Recombinate[6]	
Tobramycin Nebulization Solution[7]	Scopolamine Patch	
Trintellix	Seebri Neohaler	
Vimpat	Siliq[1]	
Xigduo XR[1]	Sovaldi[1]	
Zomig Nasal Spray[1]	Technivie[1]	
	Tegretol XR[2]	
	Testosterone Solution[1]	
	Tremfya[1]	
	Tymlos	
	Utibron Neohaler	
	Viekira Pak[1]	
	Viekira XR[1]	
	Vigabatrin	
	Vigamox	

	Vosevi[1]	
	Xermelo	
	Xyntha[6]	

[1]Clinical PA Criteria Apply
[2]Grandfather Existing Users with Seizure Diagnosis
[3]Step 2
[4]Step 1
[5] Age Edit
[6] Grandfather Existing Users
[7] Labeler 00093
[8]Labeler 00406 Remains Preferred

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

- **Dupilumab (Dupixent):**
  Prior authorization is required for Dupixent (dupilumab). Payment will be considered for patients when the following criteria are met:
  1. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
  2. Patient is within the FDA labeled age; and
  3. Is prescribed by or in consultation with a dermatologist; and
  4. Patient has failed to respond to good skin care and regular use of emollients; and
  5. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
  6. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
  7. Patient has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and
  8. Patient will continue with skin care regimen and regular use of emollients; and
  9. Dose does not exceed an initial one-time dose of 600mg and maintenance dose of 300mg thereafter given every other week.

If criteria for coverage are met, initial authorizations will be given for 16 weeks to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

3. **Point of Sale Billing Issues:**

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

a. **ProDUR Quantity Limits:** The following quantity limit edits will be implemented effective *January 1, 2018*. A comprehensive list of all quantity limit edits appears on the Quantity Limit Chart[3].

Drug Product	Quantity	Days Supply
Abilify Maintena 300mg	1 syringe	30
Abilify Maintena 400mg	1 syringe	30
Acarbose 25mg	90	30
Acarbose 50mg	90	30
Acarbose 100mg	90	30
Aptensio XR 10mg	30	30
Aptensio XR 15mg	30	30
Aptensio XR 20mg	30	30
Aptensio XR 30mg	30	30
Aptensio XR 40mg	30	30
Aptensio XR 50mg	30	30
Aptensio XR 60mg	30	30
Armodafinil 50mg	30	30
Armodafinil 150mg	30	30
Armodafinil 200mg	30	30
Armodafinil 250mg	30	30
Ingrezza 40mg	30	30
Ingrezza 80mg	30	30
Lotronex 0.5mg	60	30
Lotronex 1mg	60	30
Quetiapine ER Tablet 50mg	60	30
Quetiapine ER Tablet 150mg	30	30
Quetiapine ER Tablet 200mg	30	30
Quetiapine ER Tablet 300mg	30	30
Quetiapine ER Tablet 400mg	60	30
Trintellix 5mg	30	30
Trintellix 10mg	30	30
Trintellix 20mg	30	30

b. **ProDUR Age Edit Tramadol Containing Products:** Effective *January 1, 2018,* an age edit will be implemented restricting use in children under 18 years of age and removing the 72-hour emergency supply allowance for this age group.

c. **Morphine Milligram Equivalents (MME) Edit:** Effective *Spring 2018* prior authorization will be required for use of high-dose opioids ≥ 200 MME per day. Patients undergoing active cancer treatment or end-of-life care will not be subject to prior authorization criteria. The MME edit will gradually be decreased over time to 90 MME per day.

4. **Preferred Brand Name Drugs on the PDL-Pharmacy Clarification**

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

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.

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