



Iowa Department of Human Services

INFORMATIONAL LETTER NO.1966-MC-FFS

DATE: November 28, 2018

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: January 1, 2019

1. **Changes to the Preferred Drug List (PDL) Effective January 1, 2019.** Refer to the [PDL website](#)¹ to review the complete PDL.

<u>Preferred</u>	<u>Non-Preferred</u>	<u>Non-Recommended</u>
Advate	Adapalene Solution ¹	Pifeltro
Amitiza ¹	Adzenys ER Oral Suspension ¹	Viracept Tablets
Ampyra ¹	Aimovig ¹	
Angeliq	Ajovy ¹	
Asmanex	Azopt	
Atazanavir	Bethkis	
Aubagio ^{1,2}	Blephamide Ophth Suspension	
Austedo ¹	Blephamide S.O.P.	
Brilinta	Combivent Respimat	
Buprenorphine-Naloxone SL Tablets ¹	Crotan	
Climara Pro	Dalfampridine ER ¹	

¹ <http://www.iowamedicaidpdl.com/>

Combipatch	Delstrigo	
Complete Natal DHA	Dexamethasone Therapy Pack	
Completenate Tablets	Diastat Rectal Gel	
Delzicol	Dorzolamide/Timolol PF	
Depo-SubQ Provera 104	Durezol	
Diazepam Rectal Gel	Estradiol Weekly Patch	
Elidel ¹	Fulphila ¹	
Entresto ¹	Golytely Powder Pack	
Fiasp	Imiquimod 3.75%	
Fiasp FlexTouch	Ingrezza ¹	
Firazyr ³	Kadian 20mg, 30mg, 50mg, 60mg, 80mg, 100mg & 200mg ¹	
Flovent Diskus	Kapsargo ¹	
FML Forte	Kitabis Pak	
Haegarda ³	Kogenate FS	
Midazolam Injection	Kogenate FS Bio-Set	
Neomycin-Bacitracin-Poly-HC Ophth Ointment	Lamotrigine Kits	
Niva-Plus Tablets	Lexiva	
Odefsey	Lokelma ¹	
Ozempic ¹	Lopinavir-Ritonavir Oral Solution	
Pennsaid	Lotemax	
Perseris ⁴	Luliconazole	
PNV 29-1 Tablets	Lupron Depot-Ped Syringe Kit ¹	
Praluent ¹	Menest	
Preplus Tablets	Methylphenidate ER Capsules (CD) ¹	
Pretab Tablets	Methylphenidate ER Capsules (LA) ¹	
Prezcobix	Mircera ¹	
ProAir Respiclick	Moxeza	
Protopic ¹	Mulpleta ¹	
Recombinate	Noctiva Nasal Emulsion	
Ruconest ³	Olumiant ¹	
Sklice	Orilissa	
Suprep	Otovel	
Synarel	Plenvu	
Symfi	Plixda Pads ¹	

Tecfidera ^{1, 2}	Reyataz	
Tetrabenazine ¹	RoxyBond ¹	
Thrivite RX Tablets	Siklos	
Tresiba FlexTouch	Stavudine Capsules	
Triveen-Duo DHA	Suboxone ¹	
Viberzi ¹	Symtuza	
Virt-Nate Tablets	Tadalafil ¹	
Vol-tab RX	Takhzyro	
Voltaren Gel	Tavalisse ¹	
Zemplar Capsules	Tegretol Tablets ⁵	
Zyprexa Relprevv ⁴	Vivelle-Dot	
	Zepatier ¹	

¹Clinical PA Criteria Apply

²Step Therapy

³PA required for diagnosis confirmation

⁴ Step 2

⁵Grandfather existing users with seizure diagnosis

2. Pharmacy Benefit Policy Changes- Effective January 1, 2019, coverage for the drugs listed below will be removed under the pharmacy benefit. Coverage will continue, however, to be available through the medical benefit for Abraxane, Alimta, Amifostine Crystalline, Arranon, Avastin, Bleomycin Sulfate, Busulfex, Camptosar, Cisplatin, Cytarabine, Dexrazoxane, Doxil, Doxorubicin HCL, Erbitux, Faslodex, Fluorouracil, Foltyn, Gemcitabine HCL, Gemzar, Gliadel Wafer, Herceptin, Ifosfamide & Mesna, Intron-A, Irinotecan, Istodax, Mesna, Mesnex, Navelbine, Paclitaxel, Proleukin, Taxotere, Velcade, Vidaza, Vinblastine Sulfate, Vincristine Sulfate, Vinorelbine Tartrate, and Zinecard.

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

▪ **CGRP Inhibitors:**

Prior authorization is required for CGRP Inhibitors. Payment will be considered for patients when the following is met:

1. Patient has a diagnosis of migraine as defined by one of the following:
 - a. Chronic Migraine
 - i. ≥ 15 headache days per month for a minimum of 3 months; and
 - ii. ≥ 8 migraine headache days per month for a minimum of 3 months; or
 - b. Episodic Migraine
 - i. 4 to 14 migraine days per month for a minimum of 3 months; and
2. Patient meets the FDA approved age; and

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

3. Patient has been evaluated for and does not have medication overuse headache; and
4. Patient has documentation of three trials and therapy failures, of at least 3 months per agent, at a maximally tolerated dose with a minimum of two different migraine prophylaxis drug classes (i.e. anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadalol, propranolol, timolol], antidepressants, [amitriptyline, venlafaxine]); and
5. The requested dose does not exceed the maximum FDA labeled dose; and
6. Lost, stolen, or destroyed medication replacement requests will not be authorized.

Initial requests will be approved for 3 months. Additional prior authorizations will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days).

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

4. Changes to Existing Prior Authorization Criteria- *Changes are italicized or stricken.* See complete prior authorization criteria under the [Prior Authorization Criteria tab](#)³.

▪ **Hepatitis C Treatments:**

Prior authorization is required for hepatitis C treatments. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions:

7. Patient has advanced liver disease corresponding to a Metavir score of 2 or greater fibrosis as confirmed by one of the following:
 - Liver biopsy confirming Metavir score $\geq F2$; or
 - Transient elastography (FibroScan) score $\geq 7.5kPa$; or
 - FibroSURE (FibroTest) score ≥ 0.48 ; or
 - APRI score > 0.7 ; or
 - Radiological imaging consistent with cirrhosis (i.e. evidence of portal hypertension); or
 - Physical findings or clinical evidence consistent with cirrhosis; or
 - Patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), proteinuria, nephritic syndrome, or membranoproliferative glomerulonephritis.
12. HCV treatment is prescribed by *or in consultation with* a digestive disease, liver disease, or infectious disease provider practice; and
21. *Only one treatment attempt will be allowed per calendar year, regardless of compliance.*

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

▪ **Janus Kinase Inhibitors:**

Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered *for an FDA approved or compendia indicated diagnosis* when the following conditions are met:

2. Patient is not using or planning to use a *JAK inhibitor* in combination with *other JAK inhibitors*, biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and
10. Patient has a diagnosis of:
 - c. *Patient has a diagnosis of moderately to severely active ulcerative colitis, and*
 - i. *Has a documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and*
 - ii. *Has a documented trial and inadequate response with a preferred biological DMARD; and*
 - iii. *If requested dose is for 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit.*

▪ **Multiple Sclerosis Agents:**

For patients initiating therapy with a *preferred oral agent*, a manual prior authorization is not required if a preferred injectable interferon or non-interferon agent is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided:

2. *Patient meets the FDA approved age; and*

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

ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *January 1, 2019*. A comprehensive list of all quantity limit edits appears on the [Quantity Limit Chart](#)⁴.

Drug Product	Quantity	Days Supply
Aubagio 7mg & 14mg	30	30
Brilinta 60mg & 90mg	60	30
Midazolam Injection	10 mL	30
Odefsey	30	30
Pennsaid 2%	112 gms	28
Perseris 90mg & 120mg	1 syringe	30
Prezcobix 800-150mg	30	30
ProAir Respiclick	3 inhalers	30
Sklice	117 gms	30
Symfi	30	30

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

Tecfidera 120mg & 240mg	60	30
Voltaren Gel 1%	900 gms	30
Xarelto 2.5mg	60	30
Zyprexa Relprevv 210mg& 300mg	2 vials	28
Zyprexa Relprevv 405mg	1 vial	28

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 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](#)⁵ under the “Newsletters” link.

We encourage providers to go to the [PDL website](#)⁶ 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.

⁵ <http://www.iadur.org/>

⁶ <http://www.iowamedicaidpdl.com/>