Department of HUMAN SERVICES

INFORMATIONAL LETTER NO. 2337-MC-FFS

DATE: April 26, 2022

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, and Physician Assistants

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

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

RE: June 2022 Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: June 1, 2022

1. **Changes to the Preferred Drug List (PDL) Effective June 1, 2022.** Refer to the PDL website[1] to review the complete PDL.

Preferred	Non-Preferred	Non-Recommended
Alosetron	Acanya[1]	Exkivity[1]
Benztropine Inj	Adbry	Scemblix[1]
Bosentan Tabs[1]	Ancobon[1]	Welireg[1]
Carbamazepine Oral Susp	Brimonidine/Timolol Ophth Sol	
Caspofungin[1]	Cancidas[1]	
Clindamycin Phos-BPO 1.2-2.5%[1]	Carglumic Acid	
Colesevelam	Carnitor SF Oral Sol	
Deferisirox Sol Tabs[1]	Cogentin Inj	
Erlotinib[1]	Cortrophin Inj Gel[1]	
Ertapenem	Dexilant[1]	
Esomeprazole Magnesium Caps	Dexlansoprazole[1]	

[1] Iowa Medicaid PDL

Lansoprazole Caps	Difluprednate Ophth	
Levocarnitine Oral Sol	Elyxyb[1]	
Liothyronine Tabs & IV Sol	Epclusa 200-50mg Tab[1]	
Lopinavir-ritonavir	Eprontia[1]	
Micafungin Sol[1]	Exjade[1]	
Naloxone Nasal Spray[4]	Glycopyrrolate Oral Sol	
Otezla[1]	Harvoni Oral Packet 33.75-150mg[1]	
Paricalcitol Caps	Harvoni 45-200mg Tab[1]	
Protonix Oral Packet	Insulin Glargine Pen	
Pyridostigmine ER Tabs	Insulin Glargine Vial	
Rabeprazole	Invanz	
Tacrolimus Ointment[1]	Kaletra	
Tazarotene Cream[1]	Livmarli	
Varenicline	Livtencity	
Vfend Oral Suspension[1]	Loreev XR[1]	
Voriconazole IV Sol[1]	Lotronex	
Xeljanz[1]	Lybalvi[3]	
	Mestinon Timespan	
	Nebivolol[1]	
	Opzelura	
	Protopic Ointment[1]	
	Qulipta[1]	
	Recorlev	
	Rezurock	
	Sertraline Caps[1]	
	Skytrofa[1]	
	Tarceva[1]	
	Tavneos	
	Tegretol Oral Suspension[2]	
	Tracleer Tabs[1]	
	Triostat	
	Trudhesa Nasal Aerosol Sol	
	Tyrvaya	
	Vfend IV Sol[1]	
	Voriconazole Oral Suspension[1]	
	Voxzogo	
	Vuity	
	Welchol Tabs	
	Xarelto Oral Suspension[1]	
	Zemplar Caps	

[1] Clinical prior authorization (PA) criteria apply
[2] Grandfather established users with seizure diagnosis
[3] Step 3
[4] Labeler 00781

2. New Drug PA Criteria – See complete PA criteria under the Prior Authorization Criteria tab[2].

- **Triheptanoin (Dojolvi):**
  PA is required for triheptanoin (Dojolvi). Payment will be considered under the following conditions:
  1. Request adheres to all Food and Drug Administration (FDA)-approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and
  2. Patient has a diagnosis of long-chain fatty acid oxidation disorder (LC-FAOD), with supporting documentation of gene mutation(s) associated with LC-FAOD (LC-FAODs include: CPT I, CACT, CPT II, VLCAD, TFP, LCHAD); and
  3. Patient will not be using another medium chain triglyceride (MCT) product; and
  4. Documentation of patient's daily caloric intake (DCI) is provided; and
  5. Patient's target daily dosage is provided as a percentage of the patient's total daily prescribed DCI, not to exceed 35%; and
  6. Is prescribed by or in consultation with an endocrinologist, geneticist, or metabolic disease specialist.

  If the criteria for coverage are met, initial requests will be approved for four months. Additional authorizations will be considered upon documentation of a positive clinical response to therapy.

3. Changes to Existing PA Criteria – ***Changes are italicized or stricken****.* See complete PA criteria under the Prior Authorization Criteria tab[3].

- **Apremilast (Otezla):**
  PA is required for apremilast (Otezla). Payment will be considered under the following conditions:
  1. *Request adheres to all FDA-approved labeling for indication, including age, dosing, and contraindications*; and
  ~~2. Patient does not have severe renal impairment (CrCl < 30 mL/min)*; and*~~
  3. Patient has a diagnosis of active psoriatic arthritis (≥ three swollen joints and ≥ three tender joints); *with*
     a. Documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).
     b. ~~Patient has documentation of trials and therapy failures with two preferred biological agents indicated for psoriatic arthritis.*;*~~ or
  4. Patient has a diagnosis of ~~moderate to severe~~ plaque psoriasis; *with*
     a. *Documentation* of a trial and inadequate response to phototherapy,

[2] Prior Authorization Criteria | Iowa Medicaid PDL
[3] Prior Authorization Criteria | Iowa Medicaid PDL

systemic retinoids, methotrexate, or cyclosporine.

b. ~~Patient has documentation of trials and therapy failures with two preferred biological agents indicated for plaque psoriasis.~~

5. *Patient has a diagnosis of Behçet disease; with*
    a. *Documentation of active oral ulcers associated with Behçet disease; and*
    b. *Documentation of a previous trial and inadequate response, at a therapeutic dose, to colchicine.*

- **Biologicals for Arthritis:**

PA is required for biologicals used for arthritis. Request must adhere to all FDA-approved labeling*, including age, indication, dosing, and contraindications*. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions:

3. Patient has a diagnosis of rheumatoid arthritis (RA)*; with*
    a. *Documentation of a* trial and inadequate response*, at a maximally tolerated dose, with methotrexate* ~~to two preferred disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD~~ (hydroxycholoroquine, sulfasalazine, or leflunomide *may be used if methotrexate is contraindicated*)~~.~~

~~Upon an unsuccessful methotrexate trial in patients with established RA, the combination trial with a second DMARD may be overridden if there is evidence of severe disease documented by radiographic erosions~~; or

4. Patient has a diagnosis of moderate to severe psoriatic arthritis*; with*
    a. *Documentation of a* trial and inadequate response, *at a maximally tolerated dose with* methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or
5. Patient has a diagnosis of moderate to severe juvenile idiopathic arthritis*; with*
    a. *Documentation of a* trial and inadequate response to intraarticular glucocorticoid injections and methotrexate *at a maximally tolerated dose* (leflunomide or sulfasalazine may be used if methotrexate is contraindicated)

- **Janus Kinase Inhibitors:**

PA is required for Janus kinase (JAK) inhibitors. *Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated.* Payment will be considered for an FDA-approved or compendia indicated diagnosis when the following conditions are met:

1. Patient meets the FDA-approved age *for indication*; and
10. Patient has a diagnosis of:

a. Moderate to severe rheumatoid arthritis; with
    i. A documented trial and inadequate response*, at a maximally tolerated dose, with methotrexate*; and
    ii. A documented trial and inadequate response to *one* preferred *TNF inhibitor*; OR
b. Psoriatic arthritis; with
    i. A documented trial and inadequate response*, at a maximally tolerated dose, with* methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
    ii. Documented trial and therapy failure with *one* preferred *TNF inhibitor* used for psoriatic arthritis~~.~~*; OR*
c. Moderately to severely active ulcerative colitis; with
    i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and
    ii. A documented trial and inadequate response with a preferred *TNF inhibitor*; and
    iii. If requested dose is for tofacitinib 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*; OR*
d. Polyarticular Course Juvenile Idiopathic Arthritis; with
    i. A documented trial and inadequate response to intraarticular glucocorticoid injections; and
    ii. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
    iii. A documented trial and inadequate response with a preferred TNF inhibitor.

- **Select Preventative Migraine Treatments (formerly CGRP Inhibitors):** PA is required for *select preventative migraine agents*. *Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred, select preventative migraine agent.* Payment will be considered under the following conditions:

11. *Request adheres to all FDA-approved labeling for indication, including age, dosing, contraindications, warnings and precautions*; and
12. *The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine.*

4. Point of Sale Billing Updates:

ProDUR Quantity Limits: The following quantity limit edits will be implemented. A comprehensive list of all quantity limit edits appears on the Quantity Limit Chart[4].

Drug Product	Quantity	Days Supply
Alendronate 35MG	4	28
Otezla 30MG	60	30

5. Drug Utilization Review (DUR) Update: The latest issue of the DUR Digest is located at the Iowa DUR website[5] under the "Newsletters" link.

6. Pharmacy Average Actual Acquisition Cost (AAC): For information regarding the AAC rate setting process, visit Iowa Medicaid Pharmacy Reimbursement[6]. Rate review requests may be submitted here[7].

We encourage providers to visit the PDL website[8] to view all recent changes to the PDL. If you have questions, please contact the Pharmacy PA Helpdesk at 877-776-1567, locally in Des Moines at 515-256-4607, or by e-mail at info@iowamedicaidpdl.com.

[4] Billing/Quantity Limits | Iowa Medicaid PDL
[5] Iowa Medicaid Drug Utilization Review Commission | Iowa Medicaid Drug Utilization Review Commission (iadur.org)
[6] Iowa Department of Human Services (mslc.com)
[7] Iowa Department of Human Services (mslc.com)
[8] Iowa Medicaid PDL