Iowa Medicaid
IOWA HHS

INFORMATIONAL LETTER NO. 2498-MC-FFS-D

DATE: August 16, 2023

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), Dental (D)

FROM: Iowa Department of Health and Human Services (HHS), Iowa Medicaid

RE: October 2023 Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: October 1, 2023

1. **New Drug Prior Authorization (PA) Criteria** – See complete PA criteria under the Prior Authorization Criteria tab[1].

- **Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia®):** PA is required for cyclosporine 0.1% ophthalmic emulsion (Verkazia®). Payment will be considered for Food and Drug Administration (FDA) approved or compendia indicated diagnosis for the requested drug when the following conditions are met:
  1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
  2. Patient has a diagnosis of moderate to severe vernal keratoconjunctivitis (VKC); and
  3. Documentation of an adequate trial (two to three weeks) and therapy failure with a preferred topical dual-acting mast cell stabilizer/topical antihistamine (e.g., olopatadine, azelastine); and

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

4. Documentation of an adequate trial (two to three weeks) and therapy failure with a preferred topical ophthalmic corticosteroid (e.g., dexamethasone, prednisolone, fluorometholone, loteprednol); and
5. Is prescribed by or in consultation with an ophthalmologist or optometrist; and
6. Is not prescribed in combination with other ophthalmic cyclosporine products.

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

Initial requests will be approved for six months. Additional authorizations will be considered upon documentation of clinical response to therapy.

2. **Changes to Existing PA Criteria** – *Changes are italicized or stricken.* See complete PA criteria under the Prior Authorization Criteria tab[2].

- **Dupilumab (Dupixent®):**
  1. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and
    a. *Is prescribed by or in consultation with an allergist, immunologist, or dermatologist; and*
    b. *Patient has experienced severe to very severe pruritus, as demonstrated by a current* Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7*; and*
    c. *Patient has ≥ 20 nodular lesions (attach documentation); and*
    d. *Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; and*

- **Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral:**
  1. Requests for elagolix (Orilissa®) *or relugolix, estradiol, norethindrone acetate (Myfembree®)* will be considered under the following conditions:
    a. Requests will be considered *based on drug, dose, and length of therapy:*
      - *Orilissa®* - maximum *duration* of *therapy of* 24 months for the 150mg dose and six (6) months for the 200mg dose*; or*
      - *Myfembree® - maximum duration of therapy of 24 months; or*

  2. Requests for elagolix, estradiol, and norethindrone acetate; elagolix (Oriahnn®) or relugolix, estradiol, norethindrone acetate (Myfembree®) will be considered under the following conditions:

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

a. Requests will be considered for a maximum *duration of therapy* of 24 months.

- **IL-5 Antagonists:** PA is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered *when patient has an FDA approved or compendia indication for the requested drug* under the following conditions:
  1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
  2. *Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP); and*
     - *Documentation mepolizumab will be used as an add-on maintenance treatment with a nasal corticosteroid spray; and*
     - *Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:*
       - *Nasal corticosteroid spray; and*
       - *Oral corticosteroid; and*

  3. Prescribed by or in consultation with an allergist, hematologist, immunologist, *otolaryngologist,* pulmonologist, or rheumatologist.

  If criteria for coverage are met, an initial authorization will be given for three months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis or six months for a diagnosis of hypereosinophilic syndrome *or CRSwNP* 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:

  Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
  1. *Patient has demonstrated positive clinical response to therapy (improvement in symptoms.); and*
  2. *Continues to receive medication as add-on maintenance therapy with a nasal corticosteroid spray.*

- **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 for the requested drug*, excluding requests for the FDA approved indication of alopecia areata,*

vitiligo, or other excluded medical use(s), as defined in Section 1927(d)(2) of the Social Security Act, State Plan, and Rules when the following conditions are met:
*1. Axial spondyloarthritis conditions (e.g., a*nkylosing spondylitis *or nonradiographic axial spondyloarthritis)* (tofacitinib*, upadacitinib*); with

- **Palivizumab (Synagis®):** Respiratory Syncytial Virus (RSV) *surveillance is tracked* by *the national respiratory and enteric virus surveillance system (NREVSS) on* the centers for disease control and prevention of the United States department of health and human services *website.*
  1. Medicaid will use *Iowa* virology data *reported to the NREVSS, as documented under RSV state trends.*
  2. Medicaid will provide coverage of prescription drugs that protect against RSV consistent with the current American Academy of Pediatrics (AAP) Guidelines for Infants and Children at Risk for Severe Illness due to RSV Infection.
  3. *The RSV season in Iowa is predefined as November 1st through March 31st of each RSV season. Prescribers and dispensing pharmacies should monitor state specific virology data and hold administration of palivizumab if data indicates RSV is not prevalent at the beginning of the predefined Iowa RSV season. Consideration of use of palivizumab during interseasonal spread of RSV may be considered by Medicaid with widespread RSV circulation.*

  PA is required for therapy with palivizumab. PAs will be approved for administration during the RSV season for a maximum of five doses per patient. No allowances will be made for a sixth dose. Patients who experience a breakthrough RSV hospitalization *in the prior five months* should have their monthly prophylaxis discontinued, as there is an extremely low likelihood of a second RSV hospitalization in the same season.

- **Select Anticonvulsants:** PA is required for select anticonvulsants. Payment will be considered under the following conditions:
  1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations;* and
  2. Patient has an FDA approved or compendia indicated diagnosis, for requested drug, of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, or tuberous sclerosis complex, *or cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder* with documentation of an adequate trial and inadequate response with at least two preferred concomitant antiepileptic drugs (AEDs), if available; and
  3. Is prescribed by or in consultation with a neurologist; and
  4. Patient's current weight is provided; and

5. The total daily dose does not exceed the following:

    a. *Ganaxolone*
        - *Weight ≤ 28 kg: 63 mg/kg/day; or*
        - *Weight > 28 kg: 1800 mg/day.*

- **Topical Acne and Rosacea Products:** PA is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered *when member has an FDA approved or compendia indication for the requested drug, except for any drug or indication excluded from coverage, as defined in Section 1927 (2)(d) of the Social Security Act, Iowa's CMS approved State Plan, and the Iowa Administrative Code (IAC) when* the following conditions *are met*:
    1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and*
    2. Documentation of diagnosis; and
    3. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and
    4. Payment for non-preferred topical *antibiotic or topical retinoid* 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); and
    5. *Payment for non-preferred topical acne products outside of the antibiotic or retinoid class (e.g., Winlevi®) will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred topical retinoid and at least two other topical acne agents. If criteria for coverage are met, initial requests will be approved for six months; and*

- **Viloxazine (Qelbree®):** PA is required for viloxazine (Qelbree®). Payment will be considered *when patient has an FDA approved or compendia indication for the requested drug* under the following conditions:
    1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and*
    2. Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV); and

3. Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational) and
4. ~~Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred amphetamine stimulant; and~~
5. ~~Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred methylphenidate stimulant; and~~
6. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine *or a preferred stimulant*; and
7. *D*ose does not exceed 400 mg per day *for pediatric patients (< 18 years of age) and 600 mg per day for adult patients*; and

3. Removal of PA Criteria: Clinical PA criteria and associated quantity limits will be removed for the below category. The PA form will no longer be required. PA will continue to be required for non-preferred medications through the Preferred Drug List using form 470-4108 Non-Preferred Drug[3].

- Naloxone Nasal Spray, form 470-5461

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
Verkazia® (cyclosporine ophthalmic emulsion 0.1%)	1 box (120 single-dose vials)	30
Winlevi® (clascoterone cream 1%)	60 gm	30

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

[3] http://iowamedicaidpdl.com/sites/default/files/ghs-files/prior-authorization-forms/2022-08-22/non-preferred-drug-pa-form-npi-oct-22.pdf
[4] http://www.iowamedicaidpdl.com/billing_quantity_limits
[5] http://www.iadur.org/

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 1-877-776-1567, locally in Des Moines at 515-256-4607, or by e-mail at info@iowamedicaidpdl.com.

If you have questions, please contact Iowa Medicaid Provider Services or the appropriate MCO:

Iowa Medicaid Provider Services:
- Phone: 1-800-338-7909
- Email: imeproviderservices@dhs.state.ia.us

Amerigroup Iowa, Inc.:
- Phone: 1-800-454-3730
- Email: iowamedicaid@amerigroup.com
- Website: https://providers.amerigroup.com/ia

Iowa Total Care:
- Phone: 1-833-404-1061
- Email: providerrelations@iowatotalcare.com
- Website: https://www.iowatotalcare.com

Molina Healthcare of Iowa:
- Phone: 1-844-236-1464
- Email: iaproviderrelations@molinahealthcare.com
- Website: https://www.molinahealthcare.com/providers/ia/medicaid/home.aspx
- Provider portal: https://www.availity.com/molinahealthcare

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