STATE OF IOWA

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DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

INFORMATIONAL LETTER NO. 529

To: Iowa Medicaid Participating Providers
From: Iowa Department of Human Services
Date: September 26, 2006
Subject: The purpose of this Information Letter is to inform providers of major changes to the Preferred Drug List (PDL). For all other changes, refer to the PDL.
Effective: October 30, 2006

1. Major Changes to the Preferred Drug List (PDL)[1]

Preferred	Non-Preferred	Recommended	Non-Recommended
Accuzyme® SE	Apidra® Injection & Opticlick Injection	Prezista™	Emsam® Patch
Azithromycin Tablets	Cardura® XL		Sprycel™
Clarinex® D[2]	Citracal® Prenatal + DHA		
Cyclobenzaprine 5mg Tab	Daytrana™ Patch		
Drysol®	Durabac Forte™		
Humira® Pen	Enjuvia™		
Lithium CR 450mg Tab	Finasteride		
Panafil® SE	Opana®		
Spiriva[3]	Opana® ER		
	Optase™		
	Oracea™		
	OsmoPrep™		
	Precare™ Premier		
	Pravastatin		
	Sertraline		
	Simvastatin		
	Solodyn ER™		
	Ultram® ER		
	Vandazole™ 0.75% Gel		
	Vivaglobulin®		
	Vivitrol™ Injection		
	Yaz		
	Zelapar™ ODT		
	Zithromax® Tri-Pak		

[1] Mimyx™ Cream has been removed from the PDL as the FDA no longer considers the product to be a drug per State Medicaid Release #142 from CMS.
[2] Preferred with conditions; see new Antihistamines PA Form or the PA Criteria Chart posted at www.iowamedicaidpdl.com.
[3] Clinical Prior Authorization requirement has been removed in addition to change in status

2. Drug Prior Authorization

A. New Prior Authorization Drugs and/or Categories of drugs

Effective October 30th, 2006, the following drugs and/or categories of drugs will require prior authorization.

- Amylin Mimetic (Symlin ®)
- Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin which include Aloxi®, Anzemet®, Emend®, Kytril®, Zofran® and Zofran ODT®
- Incretin Mimetic (Byetta®)
- Oxycodone CR/ER and Oxycontin®

B. Changes to existing Drug Prior Authorization Categories

- Proton Pump Inhibitors-Add the diagnosis of erosive esophagitis as an appropriate condition for prior authorization approval. The sentence stating that concurrent PPI and H2RA therapy is considered duplicative will be removed.
- Spiriva®- Effective October 30th, 2006 the Clinical Prior Authorization requirement will be removed from Spiriva® in addition to change in status from nonpreferred to preferred.
- The Prior Authorization Criteria for Polyethylene Glycol 3350 has been rescinded. The product will remain on the PDL as a non-preferred drug. Prior authorization will still be required (use the Non-Preferred Drug PA Form).

3. Additions to the Over-the-Counter Payable List (Effective immediately)

OTC Product	OTC MAC per unit
Magnesium Hydroxide Suspension 400mg/5mL	$0.0074
Senna Syrup 176mg/5mL	$0.0874
Sennosides Syrup 8.8mg/5mL	$0.0668

4. Release of Iowa Medicaid PDL on ePocrates

Effective August 1st, 2006, the Iowa Medicaid Preferred Drug List became available on Personal Data Assistants (PDAs) using ePocrates software. The Recommended Drug List is not available as part of this software package. Searches for drugs on the RDL while using ePocrates will be referenced to the website. Please visit www.epocrates.com to download the Iowa Medicaid Preferred Drug List to your PDA. Once a personal account is created, please click on the "Add Formularies" link at the top of the page. There is no charge for using ePocrates software. The ePocrates version of the PDL will be updated succinctly with the online PDL. To ensure the most accurate PDL is available on your PDA, be sure to update the ePocrates software regularly.

5. Change in Pharmacy PA and POS Helpdesk Hours

Effective October 30th, 2006, the Iowa Medicaid Pharmacy Prior Authorization and Point-of-Sale Helpdesk will be available 8:00 a.m. to 5:00 p.m. Monday through Friday (after hours on call available).

We would encourage providers to go to the website at www.iowamedicaidpdl.com to view all recent changes to the PDL. If you have any questions, please contact the Pharmacy Prior Authorization Provider Hotline at 877-776-1567 or 515-725-1106 (local in Des Moines) or e-mail info@iowamedicaidpdl.com.

ATTACHMENT: 1) PA Chart Additions/Change

Attachment 1

Amylino Mimetic (Symlin®) *Use Amylino Mimetic (Symlin®) form*	Prior authorization is required for amylino mimetics (Symlin®). Payment will be approved under the following conditions, 1) Diagnosis of Type 1 or Type 2 diabetes mellitus, 2) Concurrent use of mealtime insulin therapy, 3) Documented inadequate glycemic control with mealtime insulin therapy.
Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents Use *Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents form*	Prior authorization is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the following dosage limits per month. Payment for antiemetics beyond this limit will be approved on a case-by-case basis. Prior authorization will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent in this class. Note: Aprepitant (Emend®) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy. Aloxi (N) 4 vials (0.25mg/5mL) Anzemet (N) 5 – 50mg/100mg tablets; 4 vials (100mg/5mL); 8 ampules (12.5mg/0.625mL) Emend (P) 4 – 125mg capsules; 8 – 80mg capsules Kytril (N) 8 – 1mg tablets; 30mL – oral solution (1mg/5mL); 8 vials (1mg/mL); 2 vials (4mg/mL) Zofran (P) 12 – 4mg tablets; 12 – 8mg tablets; 4 – 24mg tablets; 50mL/month – oral solution (4mg/5mL); 4 – 20mL vials (2mg/mL); 8 – 2mL vials (2mg/mL) Zofran ODT (P) 12 – 4mg tablets; 12 – 8mg tablets
Incretin Mimetic (Byetta®) *Use Incretin Mimetic form*	Prior authorization is required for incretin mimetics (Byetta®). Payment will be approved under the following conditions, 1) Diagnosis of Type 2 diabetes mellitus, 2) Documented inadequate glycemic control with or contraindication to metformin, sulfonylurea, and metformin/sulfonylurea combination therapy, 3) Concurrent therapy with metformin and/or sulfonylurea unless contraindicated.
Oxycodone CR/ER (Oxycontin®) *Use Oxycodone CR/ER form or Select Brand Name PA form for Oxycontin®*	Oxycodone ER should be dosed every 12 hours. Prior authorization is required for Oxycodone ER for: 1. doses exceeding two tablets per day of the same strength or 2. for more than two strengths per month. Prior authorization for Oxycodone ER at any dose twice daily for cancer pain will be approved. In order to receive approval for quantities or strengths of Oxycodone ER that require prior authorization, the prescriber must provide information to document the need for the medication at the prescribed dosage or quantity.