



# STATE OF IOWA

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DEPARTMENT OF HUMAN SERVICES  
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## INFORMATIONAL LETTER NO. 487

**To:** Iowa Medicaid Participating Providers  
**From:** Iowa Department of Human Services  
**Date:** February 17, 2006  
**Subject:** Drug Prior Authorization Updates  
**Effective:** March 20, 2006

### 1. Drug Prior Authorization

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

- I. Effective March 20, 2006, the following drugs and/or categories of drugs will require prior authorization:
  - Sedative/Hypnotics-Non-Benzodiazepine
  - Pulmonary Arterial Hypotension Agents (*Flolan*®, *Revatio*®, *Ventavis*®, *Tracleer*®)
  - *Strattera*®
- II. The PA Criteria for these drugs and/or categories of drugs are attached (refer to attachment 1). The new PA forms and updated PA Criteria Chart are available at [www.iowamedicaidpdl.com](http://www.iowamedicaidpdl.com). Providers may also call the PA Provider Help Desk at 877-776-1567 or 515-725-1106 (locally in Des Moines)

#### B. Changes To Existing Drug Prior Authorization Categories

- I. Effective March 20, 2006, the following category of drugs will have changes applied to the prior authorization criteria:
  - Erythropoiesis Stimulating Agents: **Hemoglobin** values will be evaluated interchangeably with hematocrit for initiation and/or continuation of erythropoiesis therapy.
  - Isotretinoin: The new name of this category is **Oral Isotretinoin**. Patients and providers must be registered in, and meet all requirements of the iPLEDGE ([www.ipledgeprogram.com](http://www.ipledgeprogram.com)) risk management program.
  - Narcotic Agonist-Antagonist Nasal Sprays: A PA is required starting on **day 1** of treatment. Quantities are limited to 5 milliliters/50mg per 30 days.
  - Proton Pump Inhibitors: Prior authorization is not required for *Prevacid Granules*® for oral suspension for children 12 years old or younger. Prior authorization is required for *Prevacid Granules*® for oral suspension for patients over 12 years of age. Authorization will be considered for those patients who cannot tolerate a solid oral dosage form.
  - Psychostimulants: The new name of this category is **ADD/ADHD/Narcolepsy Agents**
- II. The new criterion for this category of drugs is attached (refer to attachment 1).

**2. ProDUR Edits**

**A. New proDUR Edits with a Maximum Allowed Ratio of One (Quantity/Day)**

- *Premarin® 0.625mg*
- *Abilify® 5mg*
- *Crestor® 5mg, 10mg, 20mg*
- *Lescol® 20mg*
- *Paxil® (including paroxetine) 10mg, 20mg*
- *Pravachol® 40mg*
- *Xanax XR® 0.5mg, 1mg*
- *Zocor® 5mg*

**B. New proDUR Edit with a Maximum Allowed Ratio of 1.5 (Quantity/Day)**

- *Celexa® (including citalopram) 10mg, 20mg*

Please call the Pharmacy Prior Authorization provider PA Hotline at 877-776-1567 or 515-725-1106 (local in Des Moines) or email [info@iowamedicaidpdl.com](mailto:info@iowamedicaidpdl.com) if you have any questions about this Informational Letter or if you need more additional information. Thank you.

**ATTACHMENT:**

**1) PA Criteria Chart Additions/Changes**