STATE OF IOWA

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DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

INFORMATIONAL LETTER NO. 1019

TO: Iowa Medicaid Physician, Dentist, Advanced Registered Nurse Practitioner, Therapeutically Certified Optometrist, Podiatrist, Pharmacy, Home Health Agency, Rural Health Clinic, Clinic, Skilled Nursing Facility, Intermediate Care Facility, Community Mental Health, Family Planning, Residential Care Facility, ICF MR State and Community Based ICF/MR Providers

FROM: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

DATE: June 27, 2011

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: July 18, 2011

1. Changes to the Preferred Drug List (PDL)[1] Effective July 18, 2011

Preferred	Non-Preferred	Recommended	Non-Recommended
AccuNeb®	Abstral®[1]	Mercaptopurine	Exemestane
Benzoyl Peroxide 3%, 6%, & 9% Lotion[1]	Albuterol Sulfate Neb Solution 0.63/3ml & 1.25mg/3ml		Purinethol®
Ceftazidime	Armour® Thyroid[2]		
Cefuroxime Sodium	Axiron® Topical Solution		
Coly-Mycin® M	Aygestin®		
Coumadin® 1mg, 2mg, 2.5mg, 3mg, 4mg, & 5mg	Betamethasone Dipropionate Augmented Lotion		
Dexilant™[1]	Colistimethate Sodium		
Diprolene® Lotion & Ointment	Cortenema®		
Dorzolamide Ophthalmic Solution	Cosopt®		
Dorzolamide HCL-Timolol Ophthalmic Solution	Cozaar®[1]		
Hydrocortisone Sodium Succinate	Desipramine[2]		
Lidocaine HCL Local Injection 1.5% & 4%	Diflucan® in Iso-Osmotic Dextrose[1]		

Lidocaine-Prilocaine 2.5-2.5% Cream	Doxycycline Hyclate Delayed Release Tablets[1]		
Losartan Potassium[1]	Edarbi™[1]		
Losartan Potassium& HCTZ[1]	Elocon® Lotion		
Meropenem	Fiorinal®/ Codeine #3[1]		
Methimazole	Fortaz®		
Methscopolamine Bromide	Fortesta™ Gel		
Mometasone Furoate Lotion	Hydrocodone/APAP 5-300mg, 7.5-300mg, & 10-300mg[1]		
Norethindrone Acetate 5mg	Hyzaar®[1]		
Norethindrone & Ethinyl Estradiol 0.4mg-35	Lanoxin®[2]		
Orphenadrine w/ASA & Caffeine 50-770-60 Tablets	Latanoprost		
Primidone	Merrem®		
Ritalin-SR® 20mg[1]	Methadone HCL Intensol™		
Salicylic Acid 6% Cream & Lotion	Methylphenidate SR 20mg[1]		
Sulfacetamide Sodium w/ Sulfur Emulsion 10-1% & 10-5%[1]	Moxeza™		
Sulfacetamide Sodium-Sulfur w/ Sunscreens Cream[1]	Mysoline®[2]		
Timolol Maleate Gel Forming Ophthalmic Solution	Natroba™		
	Nexiclon™ XR[1]		
	Nuedexta™		
	Orphenadrine®-Compound-DS[1]		
	Ovcon®-35		
	Pamine®		
	Pamine® Forte		
	Phenyltoloxamine-APAP 66-600mg Tablet		
	Phenytek®[2]		

	Phenytoin Sodium ER 200mg & 300mg Capsules		
	Potassium Chloride 8mEq & 10mEq Capsules		
	Potassium Chloride 10mEq Tablets		
	Prevacid®[1]		
	Remeron SolTab®[1]		
	Rocephin® 500mg		
	Rosac®[1]		
	Roxicodone®[1]		
	Salex®		
	Silenor®		
	Solu-Cortef®		
	Tapazole®		
	Timoptic-XE®		
	Trusopt®		
	Voriconazole[1]		
	Xylocaine® 2% Gel		
	Xylocaine® -MPF		
	Zinacef®		

[1]Clinical PA Criteria Apply
[2] Grandfather Existing Users

2. Drug Prior Authorization

a. New Drug Prior Authorization Criteria- See prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

- **Immunomodulators-Topical:** Prior authorization is required for topical immunomodulators. Payment for pimecrolimus (Elidel®) or tacrolimus (Protopic®) 0.03% will be considered for non-immunocompromised patients two years of age and older and tacrolimus (Protopic®) 0.1% for patients 16 years of age and older when there is an adequate trial and therapy failure with two preferred topical corticosteroids. If criteria for coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 grams or 100 grams for all other areas. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

b. **Changes to Existing Prior Authorization Criteria-** See complete prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

- **Proton Pump Inhibitors:**
  Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses. Requests for PPIs exceeding one unit per day will be considered *after documentation of a therapeutic trial and therapy failure with concomitant use of once daily PPI dosing and a bedtime dose of a histamine H2-receptor antagonist. Upon failure of the combination therapy, subsequent requests for PPIs exceeding one unit per day will be considered* on a short term basis (up to 3 months). After the three month period, a retrial of the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day.

- **Select Brand-Name Drugs:**
  For prior authorization to be considered, the prescriber must submit a completed Selected Brand Name PA form *and Iowa Medicaid MedWatch form with:*
  1. Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available.
  2. Documentation of the failure must include the specific adverse reaction as defined by the FDA (See Section B of the MedWatch form). Intolerances, such as nausea or vomiting, to the generic drug will not be considered as a basis for approval.
  Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.

- **Vitamins, Minerals and Multiple Vitamins:**
  (Prior approval is not required for *prescribed multi-vitamins with or without iron or vitamin D supplements for patients under 12 months of age or* a prescription product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)

c. **Smoking Cessation Prior Authorization Requests- Effective July 1, 2011,** a new vendor for Quitline Iowa will process prior authorization (PA) requests. The fax referral number for Quitline Iowa will be **1-866-688-7577 starting July 1, 2011.** The number to contact Quitline Iowa via phone will not change. Updated PA forms will be posted to the website at www.iowamedicaidpdl.com under the PA forms link.

3. Point of Sale (POS) Billing Issues:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *July 18, 2011*. A comprehensive list of all quantity limit edits appears on our website at www.iowamedicaidpdl.com under the heading, "Quantity Limits".

Drug Product	Quantity	Days Supply
Abilify 2mg	60	30
Cocet	180	30
Darvocet-N 50	180	30
Darvocet-N 100	180	30
Dexilant 30mg	30	30
Dexilant 60mg	30	30
Epi-Pen	2 units	30
Epi-Pen, Jr	2 units	30
Fioricet	360	30
Fioricet/Codeine	180	30
Hycet Solution	3600 ml	30
Liquicet	2700 ml	30
Lorcet 10/650mg	180	30
Lorcet Plus	180	30
Lortab Elixir	2700 ml	30
Lortab 5/500mg	240	30
Lortab 7.5/500mg	180	30
Lortab 10/500mg	180	30
Maxidone	150	30
Norco 5/325mg	360	30
Norco 7.5/325mg	180	30
Norco 10/325mg	180	30
Panlor SS	150	30
Percocet 5/325mg	360	30
Percocet 7.5/325mg	240	30
Percocet 7.5/500mg	240	30
Percocet 10/325mg	180	30
Percocet 10/650mg	180	30
Revlimid 5mg	30	30
Talacen	180	30
Tylenol w/ Codeine Elixir	2700 ml	30
Tylenol w/ Codeine No.2	390	30
Tylenol w/ Codeine No.3	390	30
Tylenol w/ Codeine No.4	390	30
Vicodin 5/500mg	240	30
Vicodin ES	150	30
Vicodin HP	180	30
Xodol 5/300mg	360	30

Xodol 7.5/300mg	180	30
Xodol 10/300mg	180	30
Zamicet	2700 ml	30
Zovirax 5% Ointment	30 gms	30
Zydone 5/400mg	240	30
Zydone 7.5/400mg	180	30
Zydone 10/400mg	180	30

b. **Duplicate NSAIDs:** Concurrent use of multiple nonsteroidal anti-inflammatory drugs (nsaids) is considered duplicate therapy by Iowa Medicaid. After 60 days of concomitant use, prior authorization will be required.

c. **340b Drug Pricing Program:** The 340b Program is a federal program administered by Health Resources and Services Administration (HRSA). Designated 340b facilities are able to purchase prescription medications at discounted prices. Any provider purchasing drugs through the 340b program is required to bill Medicaid the actual acquisition cost plus the dispensing fee.

d. **Proper Billing of Lovenox®:** As a reminder, Lovenox® injections should be billed as milliliters (ml) submitted in decimal format including the correct day supply.

4. **Requests for travel or vacation medications:** Requests for travel or vacation medication(s) should be planned well in advance of the departure date. The pharmacy can process the first months' prescription(s) as usual, and then may call the Point of Sale (POS) Helpdesk at 877-463-7671 or 256-4608 (locally) to obtain up to a one month supply of medication(s) to total up to a 60 day supply of medication(s). Exceptions to Policy will not be granted if other sources for payment are available.

5. **Updated Preferred Drug List (PDL):** A new version of the PDL has been implemented. This updated version includes linked prior authorization (PA) forms and hover comments. Please be aware, not all drugs requiring prior authorization will have a linked PA form. Notably, the biologicals, non-preferred drugs without clinical PA criteria, and non-preferred brand name drugs will not have the required PA form(s) linked. All PA forms will continue to be available on the website www.iowamedicaidpdl.com under the PA Forms link.

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. **Upcoming Pharmacy Program Changes** *(Effective Date will be announced.)*
   a. **Removal of PDL categories from Medicaid coverage:** Cough and Cold PDL categories (excluding OTC payable psuedoephedrine products and dextromethorphan-guaifenesin syrup) and the Weight Loss PDL category will be removed from coverage.
   b. **Implementation of 15 day supply limit on initial fill of select medications:** Designated drugs will be limited to a fifteen day initial supply. These drugs will be identified on the Fifteen Day Initial Prescription Supply Limit list located on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab.

8. **DUR Update:** The latest issue of the Drug Utilization Review (DUR) Digest is located at the Iowa DUR website www.iadur.org under the "Newsletters" link.

We encourage providers to go to the website at **www.iowamedicaidpdl.com** 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.