Iowa Department of Human Services

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Director

INFORMATIONAL LETTER NO. 1054

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, Community Mental Health, Family Planning, Residential Care Facilities, ICF MR State and Community Based ICF/MR Providers

FROM: Iowa Department of Human Services, Iowa Medicaid Enterprise

DATE: September 16, 2011

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: October 24, 2011

1. Changes to the Preferred Drug List (PDL)[1] Effective October 24, 2011

Preferred	Non-Preferred	Recommended	Non-Recommended
Climara®	Aricept®	Letrozole	Edurant™
Cortisporin® Otic Solution	Betapace AF®		Femara®
Creon® 3000[1]	Budesonide Capsules		Sylatron™
Diabeta®	Carnitor® Injection		Zytiga™
Donepezil	Clonidine Injection		
Estrostep® FE	Cyclobenzaprine ER[1]		
Levocarnitine Injection	Daliresp™		
Levofloxacin	Epinastine		
Metrogel-Vaginal®	Horizant™		
Norethindrone Acetate & Ethinyl Estradiol-FE 1.5mg-30mcg & 1mg-20mcg	Incivek™		
Sotalal HCL (afib/afl)	Levaquin®[2]		
Tri-Norinyl® 28	Lorazepam Intensol™[1,2]		
Tropicamide Ophthalmic Solution	Lorcet® Plus[1]		
Venlafaxine ER Capsules	Methylergonovine		

Yaz®	Methylphenidate ER[1]		
	Methylprednisolone 8mg, 16mg, & 32mg Tablets		
	Mydriacyl®		
	Neomycin-Polymyxin-HC (otic)		
	Nizoral® Shampoo		
	Nitrofurantoin Oral Suspension		
	Norethindrone Acetate & Ethinyl Estradiol 0.5-35/1-35/0.5-35mg-mcg		
	Optivar®		
	Phoslyra™ Oral Solution		
	Piroxicam[1]		
	Restoril™ 7.5mg[1]		
	Sprix® Nasal Solution[1]		
	SPS®		
	Sumatriptan Injection[1]		
	Tradjenta™[1]		
	Triamcinolone Acetonide (nasal)		
	Victrelis™		
	Viibryd™		

[1]Clinical PA Criteria Apply
[2] Will remain preferred through November 24, 2011

Please be aware, effective October 24, 2011, venlafaxine er **capsules** will be preferred. Effective January 1, 2012, it is likely the venlafaxine er **tablets** will become non-preferred. To promote a smooth transition, please consider changing members to the preferred capsule formulation prior to January 1, 2012. The Department will be identifying users of the tablet formulations and contacting pharmacies to assist in this process.

2. Drug Prior Authorization

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

- **Colchicine (Colcrys®):** Prior authorization is not required for colchicine (Colcrys®) for the treatment of acute gout for three (3) tablets per 60-day period. Prior authorization is required for colchicine (Colcrys®) for the treatment of chronic hyperuricemia/gout prophylaxis or Familial Mediterranean fever. Payment will be considered under the following conditions: 1) Chronic hyperuricemia/gout prophylaxis following a trial and therapy failure at a therapeutic dose with allopurinol or probenecid. A quantity limit of sixty (60)

tablets per thirty (30) days will be applied, when criteria for coverage are met. 2) Familial Mediterranean fever. A maximum quantity limit of 120 tablets per thirty (30) days will be applied for this diagnosis. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

- **Fingolimod (Gilenya™):** A prior authorization is required for fingolimod (Gilenya™). Payment will be considered under the following conditions: 1. A diagnosis of relapsing forms of multiple sclerosis, and 2) A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis. The required trial may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

3. Point of Sale (POS) Billing Issues:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *October 24, 2011*. A comprehensive list of all quantity limit edits appears on our website, www.iowamedicaidpdl.com under the heading, "Quantity Limits".

Drug Product	Quantity	Days Supply
Androgel 1.62% Pump	150 gm	30
Dextromethorphan-Guaifenesin 10-100mg/5ml	1800ml	30
Focalin XR 25mg	60	30
Focalin XR 35mg	30	30
Norco 7.5-325mg	240	30
Pegasys Kit	1	28
Pegasys Syringe	4ml	28

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 Synagis® and flu vaccines: As a reminder, Synagis® 5mg Injection and all flu vaccine injections should be billed as 0.5ml.

4. Specialty Drug List: Several additions to the Specialty Drug List will be effective October 24, 2011. Please refer to the complete Specialty Drug List located at: www.iowamedicaidpdl.com under the heading Specialty Drug List.

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. **Recent Program Changes Effective September 1, 2011:** As a reminder the following pharmacy program changes were recently implemented.
   a. **Removal of PDL categories from Medicaid coverage:** Cough and Cold PDL categories (excluding OTC payable pseudoephedrine products and dextromethorphan-guaifenesin syrup) and the Weight Loss PDL category were removed from coverage.
   b. **Implementation of 15 day supply limit on initial fill of select medications:** Designated drugs are limited to a fifteen day initial supply. These drugs are 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 email info@iowamedicaidpdl.com.