Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

INFORMATIONAL LETTER NO.1227

DATE: March 21, 2013

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

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: May 1, 2013

1. Changes to the Preferred Drug List (PDL)[1] Effective May 1, 2013

Preferred	Non-Preferred	Recommended	Non-Recommended
Amoxicillin 200mg/5mL Suspension	Acetic Acid-Aluminum Acetate Otic	Combivir	Abacavir
Auvi-Q	Actos		Bosulif
Benzaclin[1]	Adapalene[1]		Lamivudine/ Zidovudine
Betamethasone Dipropionate Lotion	Alclometasone		Stivarga
Budesonide Oral Capsules	Amlodipine/Atorvastatin		Xtandi
Cleocin Oral Solution 75mg/5mL	Ammonul		
Clobetasol Propionate	Amoxicillin & K Clavulanate 250-62.5mg/5mL Suspension & 250-125mg Tablets		
Desoximetasone	Augmentin 125mg/5mL & 250mg/5mL Suspension		
Differin Cream & Gel[1]	Avalide[1]		
Diprolene Lotion	Aubagio		
Doxycycline Monohydrate 100mg	Betamethasone Dipropionate Cream		

Felbatol	Bromocriptine		
Fluocinolone Acetonide	Candesartan HCT[1]		
Hydrocortisone 2.5% Ointment	Cevimeline		
Irbesartan HCT[1]	Cipro HC		
Metadate CD[1]	Clindamycin-Benzoyl Peroxide[1]		
Methylphenidate SR[1]	Clindamycin Oral Solution 75mg/5mL		
MetroCream[1]	Diclofenac/Misoprostol[1]		
MetroLotion[1]	Diflorasone		
Natroba[3]	Doxycycline Hyclate		
Parlodel	Entacapone		
Paxil 10mg/5mL	Entocort		
Pioglitazone	Felbamate[2]		
Ritalin[1]	Fluticasone Propionate Cream & Lotion		
Rizatriptan[1]	Forfivo XL		
Sildenafil[1]	Giazo		
Solu-Cortef	Hydrocortisone Butyrate		
Trileptal Oral Suspension 300mg/5mL	Hydrocortisone Valerate Cream		
Voriconazole[1]	Ilevro		
Wellbutrin	Lamotrigine ER[1]		
	Linzess		
	Malathion		
	Methylphenidate SA (generic Concerta)[1,4]		
	Metoprolol ER		
	Metronidazole Cream, Gel, & Lotion		
	Mupirocin Cream		
	Myrbetriq		
	Naglazyme		
	Olux & Olux E		
	Onmel[1]		
	Oxcarbazepine Oral Suspension 300mg/5mL[2]		
	Pertzye		
	Pioglitazone/Glimepiride		
	Quillivant XR[1]		
	Ritalin SR[1]		
	Sodium Sulfacetamide-Sulfur (Topical)[1]		
	Topicort		

	Tudorza		
	Ultresa		
	Valsartan HCT[1]		
	Vfend Tablets[1]		
	Xeljanz		

[1]Clinical PA Criteria Apply
[2]Grandfather Existing Users with Seizure Diagnosis
[3]Requires 2 trials of a preferred topical permethrin product in past 30 days
[4]Authorized Generic Distributed by Watson will Remain Preferred with Conditions

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

- **ADD/ADHD/Narcolepsy:** Prior authorization (PA) is required for ADD/ADHD/Narcolepsy agents for patients 21 years of age or older *under the following conditions:*
  1. *Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-IV criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, Snap-IV). 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 environments (social, academic, or occupational).*
  2. *Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG).*
  3. *Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration, or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist.*

  Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. *If a non-preferred long-acting medication is requested, a trial of the preferred immediate release and extended release product of the same chemical entity is required.

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

- **Omalizumab (Xolair®):** Prior authorization is required for Xolair®. Payment for Xolair® will be authorized when the following criteria are met:
  1. Patient has a diagnosis of moderate to severe persistent asthma for *at least one year; and*
  2. Patient is 12 years of age or older; and
  3. *Pretreatment IgE level is between 30 IU/mL and 700 IU/mL; and*
  4. *Patient's weight is between 30 kg and 150kg; and*
  5. *History of positive skin or RAST test to a perennial aeroallergen; and*
  6. *Prescriber is an allergist, immunologist, or pulmonologist; and*
  7. *Patient is currently using a high dose inhaled corticosteroid AND long-acting beta-agonist, is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy.*
  8. *Patient must have access to an EpiPen to treat allergic reactions that may occur after administration of Xolair®.*

  If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to Xolair® therapy and for patients who do not continue concurrent use with a high dose inhaled corticosteroid and long-acting beta-agonist.

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

- **Selected Brand Name Drugs:** Section B of the Iowa Medicaid Medwatch form (page two of the Selected Brand Name Drugs prior authorization form) has been modified to remove the option of "other" from the list of adverse event or contraindication choices.

3. Point of Sale (POS) Billing Issues:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *May 1, 2013*. 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
Auvi-Q	2 units	30
Glycopyrrolate 1mg	90	30
Glycopyrrolate 2mg	120	30
Latuda 20mg	30	30
Latuda 120mg	30	30
Procentra 5mg/5mL	1800mL	30

b. **Coverage of Colgate Products:** Due to the manufacturer's voluntary withdrawal from the drug rebate program, the following products will no longer be covered **effective April 1, 2013:**
   - Periogard
   - Phos-Flur Gel
   - Prevident

c. **Proper Billing of Synagis® and flu vaccines:** As a reminder, Synagis® 50mg Injection and most flu vaccines should be billed as 0.5ml

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. **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.