Iowa Department of Human Services

Terry E. Branstad
Governor

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Lt. Governor

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Director

INFORMATIONAL LETTER NO.1325

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

DATE: November 25, 2013

RE: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: **January 1, 2014**

1. Changes to the Preferred Drug List (PDL)[1] Effective January 1, 2014

Preferred	Non-Preferred	Recommended	Non-Recommended
Alfuzosin	Acamprosate Calcium	Abraxane	Astagraf XL
Anafranil	Acitretin		Cometriq
Atralin[1]	Adcirca[1,2]		Mekinist
Ciclopirox Solution	Adefovir Dipivoxil		Tafinlar[1]
Cipro HC	Adrenaclick		Temozolomide
Coly-Mycin S	Amphetamine Salt Combo Tablets[1]		Tivicay
Combivent Respimat	Auvi-Q		
Coumadin	Avapro[1]		
Depakote ER	Bacitracin Ophth Ointment		
Dovonex Cream	Benicar[1]		
Escitalopram Oral Solution	Benicar HCT[1]		
Extavia	Breo Ellipta		
Fluconazole 50mg Tablets[1]	Brisdelle		
Fluocinolone Acetonide (Otic)	Buprenorphine/Naloxone SL Tablets[1]		
Glipizide-Metformin	Candesartan[1]		
Glipizide ER	Carbamazepine Oral Suspension[3]		
Inderal LA	Ciclopirox Shampoo		

Irbesartan[1]	Clindesse		
Loprox Gel	Clomipramine		
Lovenox	Completenate Chew Tab		
Methylphenidate IR Tablets[1]	Desonide		
Nateglinide	Diclegis		
Nevanac	Diovan HCT[1]		
Nitrofurantoin Oral Suspension	Divalproex ER[3]		
Norditropin[1]	Emsam[2]		
Oxybutynin ER	Enoxaparin		
Phenelzine	Epinephrine Injection		
Phoslyra	Esomeprazole[1]		
Prenate Plus	Fabior[1]		
Pulmicort Flexhaler	Fluocinolone Acetonide Topical Oil		
Pylera	Furadantin		
Rebif	Glycopyrrolate Injection		
Retin-A[1]	Grifulvin V[1]		
Ribavirin 200mg Tablets	Griseofulvin Tablets[1]		
Suboxone[1]	Hectorol[2]		
Trifluridine	Helidac		
Trinatal GT	Hiprex		
Trinatal RX1	Jentadueto[1]		
Trinatal Ultra	Ketoconazole Foam		
Ulesfia[5]	Ketoconazole Tablets[1]		
Valsartan-HCTZ[1]	Lexapro Oral Solution		
Vimpat[5]	Macrodantin		
Vol-Nate 28-1mg	Metformin ER (generic Fortamet)[1]		
Zetia[5]	M-Vite 27-1mg		
Zubsolv[1]	Naftin Cream & Gel		
	Nardil		
	Neomycin-Bacitracin-Polymyxin Ophth. Ointment		
	Neomycin-Polymyxin-Gramicidin Ophth Solution		
	Nutropin AQ[1]		
	Nymalize		
	Nystatin-Triamcinolone		
	Pancreaze		
	Permethrin 5% Cream		
	Plavix 300mg Tablets		
	Procentra[1]		

	Propranolol ER		
	Pulmicort 1mg Inhalation Solution		
	Quartette		
	Ravicti		
	Renvela		
	Repaglinide		
	Rescula		
	Riluzole		
	Sirturo		
	Starlix		
	Ticlopidine		
	Tolbutamide		
	Tradjenta[1]		
	Tricare 27-1mg		
	Viroptic		
	Zemplar[2]		

[1]Clinical PA Criteria Apply
[2]Grandfather Existing Users
[3]Grandfather Existing Users with Seizure Diagnosis
[4] Step Therapy Edit Applies
[5] Electronic Step Edit

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

- **Rivaroxaban (Xarelto®):** Prior authorization is required for rivaroxaban (Xarelto®). Payment will be considered for patients under the following conditions:
  1. Patient is 18 years of age or older; and
  2. Patient does not have a mechanical prosthetic heart valve; and
  3. Patient does not have active bleeding; and
  4. Patient is not pregnant; and
  5. Patient does not have severe renal impairment (CrCl < 15mL/min).

  Atrial Fibrillation
  - Patient has a diagnosis of non-valvular atrial fibrillation; and
  - Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial); and
  - Presence of at least one additional risk factor for stroke, with as $CHADS_2$ score ≥1.
  - For a CrCl > 50mL/min a dose of 20mg once daily will be considered; or
  - For a CrCl 15 to 50mL/min a dose of 15mg once daily will be considered.

Treatment and Prevention of DVT or PE

- Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum six month trial); and
- Patient does not have a CrCl < 30mL/min; and
- Patient does not have significant liver disease (hepatitis or cirrhosis)
- For treatment of acute DVT or PE a dose of 15mg twice daily for 21 days followed by 20mg once daily for remaining treatment will be considered; or
- For prevention of DVT or PE a dose of 20mg once daily will be considered.

Prophylaxis of DVT following Hip or Knee Replacement

- Patient does not have a CrCl < 30mL/min; and
- Patient does not have significant liver disease (hepatitis or cirrhosis); and
- For patients undergoing hip replacement, patient is not undergoing staged bilateral total hip replacement
- Requests will be approved for the following dosing:
  - Hip replacement: 10mg once daily for up to 35 days following hip replacement; or
  - Knee replacement; 10mg daily for up to 12 days following knee replacement.

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

- **Testosterone Products:** Prior authorization is required for testosterone products. Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for symptoms of sexual dysfunction, erectile dysfunction and infertility will not be considered. Payment for a diagnosis of hypogonadism (testosterone deficiency) will be considered under the following conditions:
  1. Patient is male and 18 years of age or older (or 12 years of age or older for testosterone cypionate); and
  2. Patient has two (2) morning pre-treatment testosterone levels below the lower limit if the normal testosterone reference range of the individual laboratory used (attach lab results); and
  3. Patient has at least one of the signs and symptoms specific to androgen deficiency
     a. Incomplete or delayed sexual development
     b. Breast discomfort, gynecomastia
     c. Loss of body hair, reduction in shaving frequency
     d. Very small (<5mL) or shrinking testes
     e. Hot flushes, sweats
     f. Height loss, low trauma fracture, low bone mineral density; and

4. Patient does not have:
    a. Breast of prostate cancer
    b. Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL
    c. Hematocrit > 50 percent
    d. Untreated severe obstructive sleep apnea
    e. Severe lower urinary tract symptoms
    f. Uncontrolled or poorly controlled heart failure

If criteria for coverage are met, initial authorization will be given for 3 months. Requests for continuation of therapy will require the following:

1. An updated testosterone level (attach lab result); and
2. Documentation of how the patient's specific symptoms have responded to therapy; and
3. Documentation the patient has not experienced a hematocrit > 54 percent or an increase in PSA > 1.4ng/mL in the past 12 months.

Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis.

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

3. 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.

- **Insulin, Pre-Filled Pens:** Prior authorization is required for pre-filled insulin pens. Prior authorization for non-preferred insulin pens will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Prior authorization is granted when documentation indicates:
  1. The patient's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin; and
  2. There is no caregiver available to provide assistance, and
  3. Patient does not reside in a long-term care facility.

4. Point of Sale (POS) Billing Issues:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *January 1, 2014*. 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
Glipizide ER 2.5mg	30	30
Glipizide ER 5mg	30	30
Glipizide ER 10mg	60	30
Latuda 60mg	30	30
Vimpat 50mg	60	30
Vimpat 100mg	60	30
Vimpat 150mg	60	30
Vimpat 200mg	60	30

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

c. **Removal of prescription acetaminophen combination products containing more than 325mg acetaminophen:** Due to a FDA notice, prescription acetaminophen combination products containing more than 325mg acetaminophen will be removed from coverage effective **January 14, 2014.**

d. **ProDUR age edits:** Removal of Dulera age edit.

5. **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.

6. **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.