Iowa Department of Human Services

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Director

INFORMATIONAL LETTER NO.1457

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/ID State and Community Based ICF/ID Providers

FROM: Iowa Department of Human Services, Iowa Medicaid Enterprise

DATE: December 1, 2014

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: January 1, 2015

1. **Changes to the Preferred Drug List (PDL) Effective January 1, 2015.** Please refer to the complete PDL located at www.iowamedicaidpdl.com.

Preferred	Non-Preferred	Non-Recommended
Butalbital-Apap-Caff w/Codeine 50-325-40-30 Capsules	Acyclovir Oral Suspension	Eloctate
Calcipotriene	Albuterol IR Tablets	Triumeq
Cephalexin 750mg Capsules	Alphagan P 0.1%	Zydelig
Enoxaparin Syringes	Amoxicillin 775mg ER Tab	
Fenofibrate Tablets	Avinza[1,2]	
Gabapentin 600mg & 800mg Tablets	Butalbital-Apap-Caff w/Codeine 50-300-40-30 Capsules[1]	
Gilenya[3]	Cefaclor 250mg/mL Susp	
Hypercare Solution	Cephalexin Tablets	
Kadian	Cerdelga	
Methadose Oral Concentrate	Clobetasol Propionate Cream, Gel & Ointment	
MS Contin	Coly-Mycin S	
Nutropin AQ[1]	Cortisporin-TC	
ProAir HFA	Depo Testosterone[1]	
Reno Caps[1]	Diclofenac 1.5% Solution[1]	
	Dovonex Cream	
Suprax 100mg/5mL & 200mg/5mL Oral Suspension	Econazole	

Temovate	Entecavir	
Triphrocaps[1]	Fondaparinux	
Ultravate	Genotropin[1]	
Virt-Caps[1]	Grastek[1]	
	Halobetasol Propionate	
	Harvoni[1]	
	Hydromorphone Injection[1]	
	Invokamet[1]	
	Jardiance[1]	
	Jublia	
	Lovenox Syringes	
	Megace ES	
	Metaproterenol	
	Methoxsalen	
	Niacin 50mg, 100mg, 250mg & 500mg Tablets[1]	
	Niaspan[2]	
	Omnitrope[1]	
	Opana ER[1,2]	
	Qudexy XR[1]	
	Ragwitek[1]	
	Rebif[2]	
	Revatio Suspension[1]	
	Simcor[2]	
	Sitavig[1]	
	Sivextro	
	Striverdi Respimat	
	Tanzeum[1]	
	Testosterone Gel[1]	
	Topiramate ER[1]	
	Tricor	
	Valsartan[1]	
	Vogelxo[1]	
	Zavesca	
	Zontivity[1]	
	Zubsolv[1]	

[1]Clinical PA Criteria Apply
[2]Grandfather Existing Users
[3]Electronic Step Edit

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

- **Apremilast (Otezla®):**
  Prior authorization is required for apremilast (Otezla®). Payment will be considered under the following conditions:
  1. Patient is 18 years of age or older; and
  2. Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints); and
  3. Prescribed by a rheumatologist or a dermatologist; and
  4. Patient does not have severe renal impairment (CrCl < 30 mL/min); and
  5. Patient has documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
  6. Patient has documentation of trials and therapy failures with two preferred biological agents used for psoriatic arthritis.

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

- **Methotrexate Injection**
  Prior authorization is required for non-preferred methotrexate injection. Payment will be considered under the following conditions:
  1. Diagnosis of severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (PJIA) and ALL of the following:
     a. Prescribed by a rheumatologist; and
     b. Patient has a documented trial and intolerance with oral methotrexate; and
     c. Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD (hydroxychloroquine, leflunomide, minocycline or sulfasalazine); and
     d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and
     e. Patient does not reside in a long-term care facility.
  2. Diagnosis of severe, recalcitrant disabling psoriasis and ALL of the following:
     a. Patient is 18 years of age or older; and
     b. Prescribed by a dermatologist; and
     c. Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy).

d. Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and
e. Patient does not reside in a long-term care facility.

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

- **Oral Immunotherapy**

Prior authorization is required for sublingual allergen immunotherapy. Payment will be considered under the following conditions:

1. Medication is prescribed by or in consultation with an allergist; and
2. Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and
3. Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines); and
4. Patient has a documented intolerance to immunotherapy injections; and
5. The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration).
6. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved.

Short Ragweed Pollen (Ragwitek®) In addition to the above criteria being met:

- Patient is 18 through 65 years of age; and
- Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen.
- If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen season and continued throughout the season.

Grass Pollen (Grastek®) In addition to the above criteria being met:

- Patient is 5 through 65 years of age; and
- Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, pereniial rye, Kentucky blue/June, meadow fescue, and redtop).
- If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected season onset of each grass pollen season.

- **Tasimelteon (Hetlioz®)**
  Prior authorization is required for tasimelteon (Hetlioz®). Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered under the following conditions:
  1. Patient has a diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as confirmed by a sleep specialist; and
  2. Patient is 18 years of age or older; and
  3. Documentation the patient is totally blind with no perception of light is provided; and
  4. Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and
  5. Patient has a documented trial and therapy failure with ramelteon (Rozerem®). If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation therapy will be considered when the patient has received 3 months of continuous therapy and patient has achieved adequate results with tasimelteon (Hetlioz®), such as entrainment, significant increases in nighttime sleep, and/or significant decreases in daytime sleep.

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

- **Chronic Pain Syndromes:**
  A prior authorization is required for duloxetine (Cymbalta®), pregabalin (Lyrica®), and milnacipran (Savella™). *For patients with a chronic pain diagnosis who are currently taking opioids, as seen in pharmacy claims, a plan to decrease and/or discontinue the opioid(s) must be provided with the initial request. Initial authorization will be given for three (3) months. There must be a significant decrease in opioid use or discontinuation of opioids after the initial three (3) month authorization for further approval consideration. Additional prior authorizations will be considered with documentation of a continued decrease in opioid utilization.* Payment will be considered under the following conditions:
  1. A diagnosis of fibromyalgia (Cymbalta®, Lyrica®, and Savella™)
     a. A trial and therapy at a therapeutic dose with *gabapentin plus one of* the following: tricyclic antidepressant, SSRI, or SNRI
  2. A diagnosis of postherpetic neuralgia (Lyrica®)
     A trial and therapy failure at a therapeutic dose with *gabapentin plus one* of the following: tricyclic antidepressant, topical lidocaine, valproate, or carbamazepine.
  3. A diagnosis of diabetic peripheral neuropathy (Cymbalta® and Lyrica®)
     A trial and therapy failure at a therapeutic dose *with gabapentin plus one* of the following: tricyclic antidepressant or topical idocaine.
  6. A diagnosis of chronic musculoskeletal pain (Cymbalta®)

A trial and therapy failure at a therapeutic dose with at least *two* drugs from *two* distinct therapeutic classes from the following: NSAIDs, opioids, tramadol, or tricyclic antidepressants.

Requests for dosing above the manufacturer recommended dosing will not be considered.

4. Point of Sale Billing Issues:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *January 1, 2015*. 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
Kadian 10mg	60	30
Kadian 20mg	60	30
Kadian 30mg	60	30
Kadian 40mg	60	30
Kadian 50mg	60	30
Kadian 60mg	60	30
Kadian 80mg	60	30
Kadian 100mg	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. Fifteen (15) Day Initial Prescription Supply Limit List: Effective **January 1, 2015,** there will be additions to the initial fifteen (15) day prescription limit list. In addition, several drugs previously on the list will be removed. Please refer to the updated list located at www.iowamedicaidpdl.com under the Preferred Drug Lists link.

d. Overrides for Lost, Stolen and Destroyed Medications:
Non-controlled medications that are lost, stolen, or destroyed **after delivery to the member** are limited to a one time override allowance per 12 month period. Overrides for the first occurrence of a lost, stolen, or destroyed medication can be obtained by contacting the POS Helpdesk at 877-463-7671 or locally at 256-4608.

Requests exceeding the one time override allowance for non-controlled medication that are lost, stolen, or destroyed **after delivery to the member** may be considered with additional documentation. Such requests involving stolen medications must include a copy of a police report.

Replacement of lost, stolen, or destroyed controlled substances and tramadol containing products will not be approved. In addition, no allowances will be provided for patients residing in a long term care (LTC) facility.

Prescription drugs that are not received by the member because they are lost or stolen in transit, prior to actual delivery to the member, or that are received in damaged or unusable condition will not be replaced through override of refill too soon. The original claim for the drug that was not properly delivered to the member should be reversed and a new claim for a replacement can then be submitted.

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.