Department of HUMAN SERVICES

INFORMATIONAL LETTER NO. 2161-MC-FFS

DATE: August 31, 2020

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, Nursing Facilities-Mental ILL, Federally Qualified Health Centers (FQHC), Indian Health Service, Maternal Health Centers, Certified Nurse Midwife, Community Mental Health, Family Planning, Residential Care Facilities, ICF/ID State and Community Based ICF/ID Providers, and Physician Assistants

APPLIES TO: Managed Care (MC), Fee-for-Service (FFS),

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

RE: October 2020 Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: October 1, 2020

1. **Changes to the Preferred Drug List (PDL) Effective October 1, 2020.** Refer to the PDL website[1] to review the complete PDL.

Preferred	Non-Preferred	Non-Recommended
Celecoxib	Aklief[1]	Ayvakit[1]
Farxiga	Amphetamine ER Susp[1]	Brukinsa[1]
Fluoxetine 40mg Caps	Amzeeq[1]	Koselugo[1]
Harvoni 45mg-200mg[1]	Annovera	Pemazyre[1]
Hemlibra	Arazlo[1]	Tabrecta[1]
Humalog KwikPen U-100	Azelastine / Fluticasone	Tazverik[1]
Humalog Mix KwikPen	Bevyxxa[1]	Tukysa[1]
Humalog Junior KwikPen	Bijuva	
Humalog Cartridge	Budesonide / Formoterol	
Jardiance	Bupropion XL 450mg	
Lokelma[1]	Bynfezia	
Mesalamine Rectal Supp	Canasa	
Mycobutin	Caplyta[2]	
Nayzilam	Ciprofloxacin /	

[1] http://www.iowamedicaidpdl.com/

Preferred	Non-Preferred	Non-Recommended
	Fluocinolone Otic	
Norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg	Dayvigo[1]	
Norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	Diazoxide	
Novolog Vial	Doxepin Tabs	
Novolog Mix Vial	Drizalma[1]	
Pentamidine	EluRyng	
Sovaldi 200mg[1]	Esperoct	
Synjardy	Estrostep FE	
Valtoco	Everolimus (Afinitor)[1]	
Veltassa[1]	Everolimus (Zortress)	
Xembify	Fasenra	
	Gloperba	
	Gvoke	
	Harvoni Oral Packet[1]	
	Hydrocodone ER Caps[1]	
	Insulin Aspart FlexPen[1]	
	Insulin Aspart PenFill[1]	
	Insulin Aspart Vial	
	Insulin Aspart Prot FlexPen[1]	
	Insulin Aspart 70/30 Vial	
	Insulin Lispro Jr KwikPen[1]	
	Insulin Lispro Protamine & Lispro Sus Pen[1]	
	Isturisa	
	Ivermectin Cream[1]	
	Jatenzo[1]	
	Levorphanol[1]	
	Methylphenidate Cap ER (XR)[1]	
	Moxifloxacin Ophth Sol	

[1]Clinical PA Criteria Apply
[2]Step 3

Preferred	Non-Preferred	Non-Recommended
	Naproxen / Esomeprazole[1]	
	Nebupent	
	Nexletol[1]	
	Nexlizet	
	Nitisinone	
	Nourianz	
	Nurtec[1]	
	Onzetra[1]	
	Orfadin 20mg Cap	
	Oxbryta[1]	
	Palforzia[1]	
	Posaconazole[1]	
	Pretomanid	
	ProAir Digihaler	
	Prolate[1]	
	Pyrimethamine	
	Reyvow[1]	
	Rybelsus[1]	
	Secuado[2]	
	Sovaldi Oral Packet[1]	
	Talicia	
	Teriparatide	
	Tramadol 100mg	
	Travoprost	
	Trijardy XR[1]	
	Trikafta[1]	
	Ubrelvy[1]	
	Vumerity[1]	
	Xenleta Tabs	
	Zerviate	
	Ziextenzo[1]	
	Ziprasidone Inj[2]	
	ZTlido[1]	

[1]Clinical PA Criteria Apply
[2]Step 3

2. Changes to Existing Prior Authorization Criteria- *Changes are italicized or stricken.* See complete prior authorization criteria under the Prior Authorization Criteria tab[2].

- **Anti-Diabetic Non-Insulin Agents:**
  Prior authorization (PA) is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions:
  1. *Patient has an FDA approved or compendia indicated diagnosis*, and
  2. Patient *meets the FDA approved or compendia indicated age*, and
  3. *For the treatment of Type 2 Diabetes Mellitus, the* patient has not achieved HgbA1C goals after a minimum three month trial with metformin at maximally tolerated dose.
  4. *Requests* for non-preferred anti-diabetic, non-insulin agents*,* subject to clinical criteria*,* will be authorized only for cases in which there is documentation of previous trials and therapy failures with *a preferred drug in the same class. Requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with* metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor Combination, a preferred Incretin Mimetic, and a preferred SGLT2 Inhibitor at maximally tolerated doses.

  Initial authorizations will be approved for six months. Additional PAs will be considered on an individual basis after review of medical necessity and documented continued improvement in *symptoms (such as* HgbA1C *for Type 2 Diabetes)*.

- **Biologicals for Axial Spondyloarthritis:**
  Prior authorization (PA) is required for biologicals used for *axial spondyloarthritis conditions*. Payment will be considered under the following conditions:
  1. *Patient has a diagnosis of:*
     a. ankylosing spondylitis *(AS) or*
     b. *nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and*
  2. *The requested dose does not exceed the maximum FDA labeled or compendia recommended dose for the submitted diagnosis; and*
  3. Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and
  4. Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and

[2] http://www.iowamedicaidpdl.com/pa_criteria

5. Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least ~~three~~ *one* month~~s~~ in duration; and
6. Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate*; and*~~.~~
7. ~~Payment~~ *Requests* for non-preferred biologicals for *axial spondyloarthritis conditions* ~~ankylosing spondylitis~~ will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents *that are FDA approved or compendia indicated for the submitted diagnosis, when applicable.*

- **Dupilumab (Dupixent):**
  1. *Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and*
     a. *Documentation dupilumab will be used as an add-on maintenance treatment; and*
     b. *Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:*
        i. *Nasal corticosteroid spray; and*
        ii. *Oral corticosteroid; and*

- **Ivabradine (Corlanor):**
  1. *Patient has a diagnosis of stable symptomatic heart failure (NYHA/Ross class II to IV) due to dilated cardiomyopathy, and*
     a. *Pediatric patient age 6 months and less than 18 years old; and*
     b. *Patient has documentation of a left ventricular ejection fraction ≤45%; and*
     c. *Patient is in sinus rhythm with a resting heart rate (HR) defined below;*
        i. *6 to 12 months - HR ≥ 105 bpm*
        ii. *1 to 3 years - HR ≥ 95 bpm*
        iii. *3 to 5 years - HR ≥ 75 bpm*
        iv. *5 to 18 years - HR ≥ 70 bpm; and*
  2. Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g. carvedilol 50mg daily, metoprolol succinate 200mg daily, or bisoprolol 10mg daily) *or weight appropriate dosing for pediatric patients*, or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and
  3. Patient has documentation of a trial and continued use with a preferred *angiotensin system blocker* at a maximally tolerated dose.

- **Linezolid:**
  Prior authorization (PA) is required for linezolid. Payment for linezolid will be authorized when there is documentation that:
  1. ~~Prescriber is an infectious disease (ID) physician or has consulted *an* ID physician (telephone consultation is acceptable.~~
  2. *The patient* has ~~an active infection and meets~~ one of the following diagnostic criteria:
     a. Vancomycin-resistant Enterococcus (VRE) ~~and no alternative regimens with documented efficacy are available and VRE is not in lower urinary tract**.~~*; or*
     b. Methicillin-resistant Staph aureus (MRSA) ~~and patient is intolerant to vancomycin*~~*; or*
     c. Methicillin-resistant Staph epidermis (MRSE) ~~and patient is intolerant to vancomycin*~~*; or*
     d. *Other multiply resistant gram positive infection (e.g. penicillin resistant Streptococcus spp); and*
  3. *Patient meets ONE of the following criteria:*
     a. Patient is severely intolerant to vancomycin with no alternative regimens with documented efficacy available, or*
     *b. VRE in a part of body other than lower urinary tract**, or*
     c. Patient discharged on linezolid and requires additional quantity (up to 10 days oral therapy will be allowed).
  4. *A current culture and sensitivity report is provided documenting sensitivity to linezolid.*

3. **Removal of Prior Authorization Criteria:** Clinical prior authorization criteria will be removed for Chronic Pain Syndromes and form 470-4551 Chronic Pain Syndromes will no longer be required. PA will continue to be required for non-preferred medications through the Preferred Drug List (PDL) using form 470-4108 Nonpreferred Drug[3].

4. **Point of Sale Billing Issues:**

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented. Short acting opioids are not listed on the quantity limit chart but are subject to a quantity limit of 6 units per day, unless otherwise indicated on the chart. A comprehensive list of all quantity limit edits appears on the Quantity Limit Chart[4].

[3] http://www.iowamedicaidpdl.com/sites/default/files/ghs-files/prior-authorization-forms/2011-06-16/non-preferred-drug-pa-form-npi-july-111.pdf
[4] http://www.iowamedicaidpdl.com/billing_quantity_limits

Drug Product	Quantity	Days Supply
Buprenorphine TD Patch Weekly 5 MCG/HR (Butrans)	4	28
Celecoxib 50MG & 200MG (Celebrex)	60	30
Farxiga 5MG & 10MG	30	30
Hydrocodone Bitartrate Cap ER 12HR Abuse-Deterrent 10MG, 15MG, 20MG, 30MG, 40MG, 50MG (Zohydro ER)	60	30
Hydrocodone Bitartrate Tab ER 24HR Deter 20MG, 30MG, 40MG, 60MG, 80MG, 100MG, 120MG (Hysingla)	30	30
Hydrocodone / Ibuprofen 5-200MG, 7.5-200MG, 10-200MG	150	30
Hydromorphone Supp 3MG	120	30
Hydromorphone HCL Tab ER 24HR Deter 8MG, 12MG, 16MG (Exalgo)	30	30
Jardiance 10MG & 25MG	30	30
Levorphanol Tartrate 2MG	120	30
Morphine Sulfate Tab ER 12HR Deter 15MG (Morphabond)	90	30
Morphine Sulfate Tab ER Abuse Deterrent 15MG (Arymo ER)	90	30
Oxycodone Cap ER 12HR Abuse-Deterrent 9MG, 13.5MG, 18MG, 27MG (Xtampza ER)	60	30
Oxycodone HCL Conc 100MG/5Ml (20MG/ML)	87 ML	30
Oxycodone HCL Soln 5MG/5ML	1770 ML	30
Oxycodone HCL Tab ER 12HR Deter 10MG, 15MG, 20MG (OxyContin)	60	30
Oxycodone / Ibuprofen Tab 5-400MG	120	30
Synjardy 5-500MG, 5-1000MG, 12.5-500MG & 12.5-1000MG	60	30
Tapentadol HCL Tab ER 12HR 50MG (Nucynta ER)	60	30

b. **Morphine Milligram Equivalents (MME):** Effective October 1, 2020, the MME per day limit will be reduced from 120 MME per day to 90 MME per day. Prior authorization will be required for use of high-dose opioids ≥ 90 morphine milligram equivalents (MME) per day. Patients undergoing active cancer treatment or end-of-life care will not be subject to prior authorization criteria.

5. **DUR Update:** The latest issue of the Drug Utilization Review (DUR) Digest is located at the Iowa DUR website[5] under the "Newsletters" link.

We encourage providers to go to the PDL website[6] 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.

[5] http://www.iadur.org/
[6] http://www.iowamedicaidpdl.com/