The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Updated 1/01/2007

Actiq®. *Use Actiq® PA form*	Prior authorization is required for Actiq®. Payment will be authorized only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. This product carries a **Black Box Warning**. Actiq®: • Is indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain. • Is contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.
ADD/ADHD/ NARCOLEPSY AGENTS *Amphetamine Salt Combo* *Atomoxetine* *Dexmethylphenidate* *Dextroamphetamine Sulfate* *Methylphenidate* *Modafinil* *Pemoline* *Use ADD/ADHD/Narcolepsy Agents PA form*	Prior authorization is required for ADD/ADHD/Narcolepsy agents for recipients 21 years of age or older. The psychostimulant category includes amphetamine salt combos, atomoxetine, dexmethylphenidate HCl, dextroamphetamine, methamphetamine HCl, methylphenidate HCl, modafinil and pemoline. Prior approval shall be granted if there is documentation of one of the following: 1. Attention deficit disorder. 2. Attention deficit hyperactivity disorder. 3. Narcolepsy.
Alpha$_1$-Proteinase Inhibitor Enzymes *Use Miscellaneous PA form*	Prior authorization is required for Alpha$_1$-Proteinase Inhibitor enzymes. Payment will be authorized only for cases in which there is a diagnosis of congenital alpha$_1$-proteinase inhibitor (alpha$_1$ –PI; alpha1-antitrypsin) deficiency with clinically demonstrable panacinar emphysema. Payment for a non-preferred Alpha$_1$-Proteinase Inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.
Alpha-Blockers, Urospecific (Flomax®, Uroxatral®) *Use Alpha Blocker Urospecific PA Form*	Prior authorization is required for urospecific alpha-blockers. Payment will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred alpha1-adrenergic blocker or for patients who meet any of the following criteria: 1. History of postural hypotension or hypotension 2. Use of antihypertensive or other medication that may exacerbate hypotension
Amylino Mimetic (Symlin®) *Use Amylino Mimetic (Symlin®) form*	Prior authorization is required for amylino mimetics (Symlin®). Payment will be approved under the following conditions, 1) Diagnosis of Type 1 or Type 2 diabetes mellitus, 2) Concurrent use of mealtime insulin therapy, 3) Documented inadequate glycemic control with mealtime insulin therapy.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Updated 1/01/2007

Anti-Acne *Use Anti-Acne PA form*	Prior authorization is required for all prescription topical acne products for the treatment of mild to moderate acne vulgaris. Payment for non-preferred topical acne products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. An initial treatment failure of an over-the-counter benzoyl peroxide product, which is covered by the program, is required prior to the initiation of a prescription product, or evidence must be provided that use of these agents would be medically contraindicated. If the patient presents with a preponderance of comedonal acne, tretinoin products may be utilized as first line agents with prior authorization.
Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents Use *Antiemetic-5HT3 Receptor Antagonists/* Substance P Neurokinin Agents form	Prior authorization is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the following dosage limits per month. Payment for Antiemetic-5HT3 Receptor Agonists/ Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent in this class. Note: Aprepitant (Emend®) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy. Aprepitant (N)/Emend® (P): 4 – 125mg capsules 8 – 80mg capsules Dolasetron (N)/Anzemet® (N): 5 – 50mg/100mg tablets 4 vials (100mg/5mL) 8 ampules (12.5mg/0.625mL) Granisetron (N)/Kytril® (N): 8 – 1mg tablets 30mL – oral solution (1mg/5mL) 8 vials (1mg/mL) 2 vials (4mg/mL) Ondansetron (N)/Zofran® (P): 12 – 4mg tablets 12 – 8mg tablets 4 – 24mg tablets 50mL/month – oral solution (4mg/5mL) 4 – 20mL vials (2mg/mL) 8 – 2mL vials (2mg/mL) Ondansetron ODT (N)/Zofran® ODT (P): 12 – 4mg tablets 12 – 8mg tablets Palonosetron (N)/ Aloxi® (N): 4 vials (0.25mg/5mL)
Anti-Fungal *Use Anti-Fungal PA form*	Prior authorization is not required for preferred oral antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. Prior authorization will be required for all non-preferred oral antifungal therapy beginning the first day of therapy. Payment for a non-preferred oral antifungal will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment for any oral antifungal therapy beyond a cumulative 90 days of therapy per 12-month period per patient will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This prior authorization requirement does not apply to nystatin.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Updated 1/01/2007

Antihistamines *Use Antihistamine PA form*	Prior authorization is required for all non-preferred antihistamines and preferred 2nd generation legend antihistamines. Patients 21 years of age and older must have two unsuccessful trials with an antihistamine that does not require prior authorization, prior to the approval of a non-preferred 1st generation or preferred 2nd generation legend antihistamine. One of the trials must be loratadine. Prior to approval of a non-preferred 2nd generation antihistamine, in addition to the above criteria, there must be an unsuccessful trial with a preferred 2nd generation legend antihistamine. Patients 20 years of age and younger must have an unsuccessful trial of loratadine prior to the approval of a non-preferred 1st generation or preferred 2nd generation legend antihistamine. Prior to approval of a non-preferred 2nd generation antihistamine, in addition to the above criteria, there must be an unsuccessful trial with a preferred 2nd generation legend antihistamine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Anti-Thrombotics, Injectable *Use Anti-Thrombotic Injectable PA form*	Prior authorization is required for use of any preferred injectable anti-thrombotic agent longer than 10 consecutive days. Prior authorization will be required for all non-preferred injectable anti-thrombotic agents beginning the first day of therapy. Payment for non-preferred anti-thrombotic injectable agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment for usage of injectable anti-thrombotic agents beyond this limit will be authorized for cases in which there is a clinical diagnosis of: 1. Pregnancy or planned pregnancy 2. Cancer-associated thromboembolic disease 3. Anti-thrombin III deficiency 4. Warfarin allergy 5. History of thrombotic event while on therapeutic anticoagulant therapy. 6. Total hip arthroplasty.
Benzodiazepines *Use Benzodiazepine PA form*	Prior authorization is required for non-preferred benzodiazepines. Payment for non-preferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. Prior authorization will be approved for up to 12 months for documented: 1. Generalized anxiety disorder. 2. Panic attack with or without agoraphobia. 3. Seizure. 4. Non-progressive motor disorder. 5. Dystonia. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine. Prior authorization requests will be approved for up to a three-month period for all other diagnoses related to the use of benzodiazepines.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Updated 1/01/2007

Digestive Enzymes *Use Miscellaneous PA form*	Prior authorization is required for all digestive enzymes. Payment for preferred digestive enzymes will be authorized only for cases in which there is a clinical diagnosis of malabsorption due to pancreatic insufficiency. Payment for non-preferred digestive enzymes will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.
Ergotamine Derivatives *Use Ergotamine Derivative PA form*	Prior authorization is required for preferred ergotamine derivatives used for migraine headache treatment for quantities exceeding 18 unit doses of tablets, injections, or sprays per 30 days. Payment for ergotamine derivatives for migraine headache treatment beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred ergotamine derivatives beginning the first day of therapy. Payment for non-preferred Ergotamine agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. For consideration, the following information must be supplied: 1. The diagnosis requiring therapy. 2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.
Erythropoiesis Stimulating Agents *Use Erythropoesis Stimulating Agent PA form*	Prior authorization is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for non-preferred erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Patients who meet all of the following criteria may receive prior authorization for the use of erythropoiesis stimulating agents: 1. Hemoglobin/Hematocrit less than 10/30 percent respectively. If renewal of prior authorization is being requested, hemoglobin/hematocrit greater than 12/36 percent will require dosage reduction or discontinuation. Consideration will be given for continuing therapy for higher hemoglobin/hematocrit values on an individual basis after reviewing medical documentation submitted. Hemoglobin/hematocrit laboratory values must be dated within six weeks of the prior authorization request. 2. Transferrin saturation greater than or equal to 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron binding capacity), ferritin levels greater than or equal to 100 mg/ml, or on concurrent therapeutic iron therapy. Transferrin saturation or ferritin levels must be dated within three months of the prior authorization request. 3. For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy. 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.

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Updated 1/01/2007

Granulocyte Colony Stimulating Factor Agents *Use Granulocyte Colony Stimulating Factor PA form*	Prior authorization is required for therapy with granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Laboratory values for complete blood and platelet count must be contained as directed by the manufacturer's instructions. Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines. Payment shall be authorized for one of the following uses: 1. Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy. 2. Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant. 3. Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy. 4. Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.
Growth Hormone *Use Growth Hormone PA form*	Prior authorization is required for therapy with growth hormones. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. All of the following criteria must be met for approval for prescribing of growth hormones: 1. Standard deviation of 2.0 or more below mean height for chronological age. 2. No intracranial lesion or tumor diagnosed by MRI. 3. Growth rate below five centimeters per year. 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter. 5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males. 6. Epiphyses open. Prior authorization will be granted for 12-month periods per recipient as needed. If the request is for **Zorbtive**® [somatropin (rDNA origin) for injection] approval will be granted for the treatment of Short Bowel Syndrome in patients receiving specialized nutritional support. Zorbtive® therapy should be used in conjunction with optimal management of Short Bowel Syndrome.
Incretin Mimetic (Byetta®) *Use Incretin Mimetic form*	Prior authorization is required for incretin mimetics (Byetta®). Payment will be approved under the following conditions, 1) Diagnosis of Type 2 diabetes mellitus, 2) Documented inadequate glycemic control with or contraindication to metformin, sulfonylurea, and metformin/sulfonylurea combination therapy, 3) Concurrent therapy with metformin and/or sulfonylurea unless contraindicated.
Inspra® *Use Miscellaneous PA form*	Prior authorization is required for Inspra®. Payment will be authorized only in cases where there is documented trial and therapy failure on Aldactone® or documented cases of gynecomastia from Aldactone® therapy.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Updated 1/01/2007

Ketorolac – Oral *Use Ketorolac PA form*	Prior authorization is required for ketorolac tromethamine (oral), a nonsteroidal anti-inflammatory drug indicated for short-term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions. This product carries a **Black Box Warning**. Oral ketorolac tromethamine is indicated only as a continuation therapy to ketorolac tromethamine IV/IM, and the combined duration of use of ketorolac tromethamine IV/IM and oral ketorolac tromethamine is not to exceed five (5) days. Payment will be approved for the preferred product under the following conditions: 1. Documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given. 2. Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40mg/day. Maximum duration of therapy is 5 days per month. 3. Diagnosis indicating moderately severe, acute pain. Payment for a non-preferred product will be authorized only for cases in which there is documentation of trial and therapy failure with the preferred agent.
Lipase Inhibitor Drugs *Use Lipase Inhibitor PA form*	Prior authorization is required for lipase inhibitor drugs. Payment for lipase inhibitor drugs will be authorized for the clinical diagnosis of hyperlipidemia. Requests for lipase inhibitor drugs for weight loss must include documentation showing failure of other weight loss programs, a body mass index (BMI) equal to or greater than 30, one or more co-morbidity conditions, and a weight management plan including diet and exercise. Prior authorization may be given for up to six months. Additional prior authorizations may be given on an individual basis after review of medical necessity and documented significant weight loss (at least 10 percent) from the individual's weight at the beginning of the previous prior authorization period.
Muscle Relaxants *Use Muscle Relaxant PA form*	Prior authorization is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least two preferred muscle relaxants.
Narcotic Agonist-Antagonist Nasal Sprays *Use Narcotic Agonist/Antagonist Nasal Spray PA form*	Prior authorization is required for narcotic agonist-antagonist nasal sprays. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines. For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration. Payment for non-preferred narcotic agonist-antagonist nasal sprays will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Updated 1/01/2007

Nicotine Replacement Therapy *Use Nicotine Replacement Therapy form*	Prior Authorization is required for over-the-counter nicotine replacement patches and nicotine gum. Requests for authorization must include: 1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling. 2) Confirmation of enrollment in the Quitline Iowa counseling program is required for approval. 3) Approvals will only be granted for patients eighteen years of age and older. 4) The maximum allowed duration of therapy is twelve weeks within a twelve-month period. 5) A maximum quantity of 14 nicotine replacement patches and/or 110 pieces of nicotine gum may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a 4 week supply at one unit per day of nicotine replacement patches and /or 330 pieces of nicotine gum. Following the first 28 days of therapy, continuation is available only with documentation of ongoing participation in the Quitline Iowa program.
Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products *Use Non-Parenteral Vasopressin Deriv. of Posterior Pituitary Hormone Products PA form*	Prior authorization is required for non-parenteral vasopressin derivatives of posterior pituitary hormone products. Payment for preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses: 1. Diabetes Insipidus. 2. Hemophilia A. 3. Von Willebrand's disease. Payment for non-parenteral vasopressin derivatives of posterior pituitary hormone products used in the treatment of primary nocturnal enuresis will be authorized for patients who are six years of age or older for periods of six months. Approvals will be granted for subsequent six-month periods only after a drug-free interval to assess the need for continued therapy. Payment for non-preferred non-parenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial and therapy failure with the preferred agent.
Non-Preferred Drug *Use Non-Preferred Drug PA form*	Prior authorization is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-preferred medication will be authorized only for cases in which there is documentation of previous trial and therapy failure with the preferred agent, unless evidence is provided that use of these agents would be medically contraindicated.
Non-Steroidal Anti-inflammatory Drugs *Use Non-Steroidal Anti-inflammatory Drug PA form*	Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs and all preferred single source COX-2 inhibitors. Requests must document previous trials and therapy failure with at least two multi-source preferred nonsteroidal anti-inflammatory drugs. In addition to these two required trials, requests for a non-preferred COX-2 inhibitor must also include documentation of a previous trial and therapy failure with a preferred COX-2 inhibitor. Prior authorization is not required for prescriptions for preferred multi-source nonsteroidal anti-inflammatory drugs.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Updated 1/01/2007

Oral Isotretinoin *Use Oral Isotretinoin PA Form*	Prior authorization is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata. 2. Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (www.ipledgeprogram.com) risk management program. Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent
Oxycodone CR/ER (Oxycontin®) *Use Oxycodone CR/ER form or Select Brand Name PA form for Oxycontin®*	Oxycodone CR/ER should be dosed every 12 hours. Prior authorization is required for Oxycodone CR/ER for: 1. doses exceeding two tablets per day of the same strength or 2. for more than two strengths per month. Prior authorization for Oxycodone CR/ER at any dose twice daily for cancer pain will be approved. In order to receive approval for quantities or strengths of Oxycodone CR/ER that require prior authorization, the prescriber must provide information to document the need for the medication at the prescribed dosage or quantity.
Palivizumab (RSV Prophylaxis) *Use Palivizumab PA form*	Prior authorization is required for therapy with palivizumab. Payment for palivizumab shall be authorized for patients who meet one of the following criteria: 1. Patient is less than 24 months of age at start of therapy and has chronic lung disease requiring medication or oxygen within the last six months. 2. Patient is less than 12 months of age at start of therapy with a gestational age of less than or equal to 28 weeks. 3. Patient is less than 6 months of age at start of therapy with a gestational age between 28 weeks and 31 weeks. 4. Patient is less than 6 months of age at start of therapy with a gestational age of 32 weeks to 35 weeks and has at least one additional risk factor.
Pre-Filled Insulin Pens *Use Pre-filled Insulin Pen PA form*	Prior authorization is required for pre-filled insulin pens. Prior authorization is granted when documentation indicates: • The member's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin, and • There is no caregiver available to provide assistance. 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.

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Updated 1/01/2007

Proton Pump Inhibitors *Use Proton Pump Inhibitor PA form*	Prior authorization is not required for the preferred proton pump inhibitors (PPI) for a cumulative 60-days of therapy per 12-month period. Prior authorization will be required for all non-preferred proton pump inhibitors as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for a non-preferred proton pump inhibitor will be authorized only for cases in which there is documentation of previous trial and therapy failure with the preferred agent. Prior authorization is required for any PPI usage longer than 60 days or more frequently than one 60-day course per 12-month period. The 12-month period is patient specific and begins 12 months before the requested date of prior authorization. Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of: 1. Specific Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas). 2. Barrett's esophagus. 3. Erosive esophagitis 4. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses. 5. Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or a negative Helicobacter pylori test result. Prior authorization is NOT required for Prevacid granules for oral suspension or SoluTabs for children age 12 years old or younger for the first 60 days of therapy. Prior authorization is required for Prevacid granules for oral suspension and SoluTabs for patients over 12 years of age beginning day one of therapy. Authorization for Prevacid granules for oral suspension and SoluTabs will be considered for those patients who cannot tolerate a solid oral dosage form.
Pulmonary Arterial Hypertension Agents ***Use Pulmonary Arterial Hypertension Agents PA form***	Prior Authorization is required for agents used to treat pulmonary hypertension. Payment will be approved under the following conditions: 1. Diagnosis of pulmonary arterial hypertension
Pulmozyme® *Use Miscellaneous PA form*	Prior authorization is required for Pulmozyme®. Payment will be authorized only for cases in which there is a diagnosis of cystic fibrosis.
Regranex® *Use Regranex® PA Form*	Prior authorization is required for Regranex®. Payment for new prescriptions will be authorized for ten weeks for patients who meet the following criteria: 1. Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond 2. Inadequate response to 2 weeks of wound debridement and topical moist wound dressing Longer than 10 weeks will be authorized for patients who meet the following criteria: Wound has decreased in size by 30% after 10 weeks

The drug prior authorization unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Updated 1/01/2007

Sedative/Hypnotics-Non-Benzodiazepine *Use Sedative/Hypnotics-Non-Benzodiazepine PA form*	Prior authorization is required for preferred nonbenzodiazepine sedative/hypnotic medications for quantities exceeding 90 units per 12 months. Payment for nonbenzodiazepine sedative/hypnotics beyond this limit will be considered on an individual basis after review of submitted documentations. Prior authorization is required for all non-preferred nonbenzodiazepine sedative/hypnotics as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred nonbenzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s).
Selected Brand Name Drugs *Use Selected Brand Name PA form*	Prior authorization is required for selected brand-name drugs, as determined by the Department, for which there is available an "A" rated bioequivalent generic product as determined by the Federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List (PDL). For prior authorization to be considered, the prescriber must submit a completed Selected Brand Name PA form, certifying that the specific brand is medically necessary for the particular patient and providing evidence of an adverse reaction, contraindication, or treatment failure associated with the bioequivalent generic drug. The list of selected brand-name drugs includes the drugs on the Federal Upper Limit (FUL) list and the State Maximum Allowable Cost (SMAC) list at www.mslciowa.com
Serotonin 5-HT1-receptor Agonists *Use Serotonin 5-HT1-receptor Agonists PA form*	Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for quantities exceeding 18 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. For consideration, the following information must be supplied: 1. The diagnosis requiring therapy. 2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.
Tretinoin Products (topical) *Use Topical Tretinoin PA form*	Prior authorization is required for all tretinoin prescription products. Payment for non-preferred tretinoin products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Alternatives such as topical benzoyl peroxide (OTC), and topical or oral antibiotics must first be tried (unless evidence is provided that use of these agents would be medically contraindicated) for the following conditions: endocrinopathy, mild to moderate acne (non-inflammatory and inflammatory), and drug-induced acne. Trials and therapy failure will not be required for those patients presenting with a preponderance of comedonal acne. Upon treatment failure with the above-mentioned products or if medically contraindicated, tretinoin products will be approved for three months. If tretinoin therapy is effective after the three-month period, approval will be granted for a one-year period. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of tretinoin products.

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Updated 1/01/2007

Vitamins, Minerals and Multiple Vitamins *Use Vitamin/Mineral PA form*	Payment for vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease or for recipients aged 20 or under if there is a diagnosed disease which inhibits the nutrition absorption process as a secondary effect of the disease. (Prior approval is not required for a legend product primarily classified as a blood modifier, if that product does not contain more than three vitamins/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)
Xolair® *Use Xolair® PA form*	Prior authorization is required for Xolair®. Payment for Xolair® will be authorized for patients 12 and older when there is a diagnosis of moderate to severe persistent asthma and documentation of previous trial and therapy failure with therapeutic doses of inhaled steroids.
Zelnorm® *Use Miscellaneous PA form*	Prior authorization is required for Zelnorm®. Payment for Zelnorm® will be authorized only for short-term treatment of irritable bowel syndrome (IBS) with the primary bowel symptom of constipation and for patients less than 65 years of age with a clinical diagnosis of chronic idiopathic constipation with documented constipation treatment failures.
Zyvox® *Use Zyvox® PA Form*	Prior authorization is required for Zyvox®. Payment for Zyvox® will be authorized when there is documentation that: 1. Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable). 2. Patient is being treated for one of the following diagnoses: • Vancomycin-resistant Enterococcus (VRE) and no alternatice regimens with documented efficacy are available and VRE is not in lower urinary tract**. • Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin* • Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin* *Severe intolerance to vancomycin is defined as: – Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration – Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine) **VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.