



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

INFORMATIONAL LETTER NO.1110

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: March 15, 2012

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: April 9, 2012

1. Changes to the Preferred Drug List (PDL)¹ Effective April 9, 2012

<u>Preferred</u>	<u>Non-Preferred</u>	<u>Recommended</u>	<u>Non-Recommended</u>
Actos [®] 30mg & 45mg	Atorvastatin	Caprelsa [®]	Lamivudine
Desogen [®]	Atovaquone/Proguanil		Xalkori [®]
DuoNeb [®]	Bupropion 75mg & 100mg		
Fluocinolone Oil	Carafate [®] Suspension		
Gablofen	Ciloxan [®]		
Medrol [®] 4mg Tablets	Clonazepam ODT ¹		
Nordette [®]	ConZip [™] 1		
Rilutek [®] 1	Duexis [®] 1		
Wellbutrin [®] 75mg & 100mg	Eprosartan ¹		
	Felbamate		
	Feriprox [®]		
	Firazyr [®]		
	Flucytosine ¹		
	Fondaparinux ¹		
	Gabapentin Oral Solution		
	Hectorol [®] 1mcg		
	Imipenem/Cilastatin		
	Juvisync [™] 1		
	Levetiracetam ER ¹		

	Morphine Sulfate ER Capsules		
	Olanzapine		
	Onfi™ ¹		
	Oxandrin®		
	PhosLo®		
	Pyridoxine 100mg/ml Injection		
	Simvastatin 80mg ²		
	Sumavel™ DosePro™ ¹		
	Zirgan®		

¹Clinical PA Criteria Apply

² Grandfather Existing Users

2. **New Drug Prior Authorization Criteria-** The prior authorization criteria will be implemented effective April 9, 2012. See prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

- **Nebivolol (Bystolic®):** Prior authorization is required for Bystolic®. Payment will be considered in cases where there are documented trials and therapy failures with two preferred cardio-selective beta-blockers of a different chemical entity at a therapeutic dose. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
- **Vilazodone (Viibryd™):** Prior authorization is required for Viibryd™. Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered for patients when the following criteria are met:
 1. The patient has a diagnosis of Major Depressive Disorder (MDD) and is 18 years of age or older; and
 2. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SSRI; and
 3. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and
 4. Documentation of a previous trial and therapy failure at a therapeutic dose with one additional generic antidepressant from any class.

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

3. Point of Sale (POS) Billing Issues:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective April 9, 2012. 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	Comments
Adderall 5mg	90	30	
Adderall 7.5mg	90	30	
Adderall 10mg	90	30	
Adderall 15mg	90	30	
Dexedrine 15mg SR	120	30	
Dextromethorphan-guaifenesin 10-100mg/5ml	240ml	30	Allowed for a cumulative 90 days per 12 month period
Onfi 5mg	60	30	
Onfi 10mg	60	30	
Onfi 20mg	60	30	
Pseudoephedrine 30mg	72	30	Allowed for a cumulative 90 days per 12 month period
Pseudoephedrine 60mg	72	30	Allowed for a cumulative 90 days per 12 month period
Pseudoephedrine 30mg/5ml	240	30	Allowed for a cumulative 90 days per 12 month period
Sucralfate 1gm	120	30	Allowed for a cumulative 60 days per 12 month period, thereafter a limit of 60 tablets per 30 days is enforced

b. Proper Billing of Synagis® and flu vaccines: As a reminder, Synagis® 5mg Injection and all flu vaccine injections should be billed as 0.5ml.

- 4. Synagis® Coverage 2011-2012 RSV Season:** Members that have not received the maximum three or five doses based on gestational age may be considered for April dosing if RSV prevalence is still at epidemic levels, provided 30 days has elapsed since their previous dose. Requests will not be considered for doses greater than 14 days in advance of the previous dose. No allowances will be made for a sixth dose.
- 5. Specialty Drug List:** Several additions to the Specialty Drug List will be effective April 9, 2012. Please refer to the complete Specialty Drug List located at www.iowamedicaidpdl.com under the heading Specialty Drug List.

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.