



Iowa Department of Human Services

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INFORMATIONAL LETTER NO.1283

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: August 29, 2013

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: October 1, 2013

1. Changes to the Preferred Drug List (PDL)¹ Effective October 1, 2013

<u>Preferred</u>	<u>Non-Preferred</u>	<u>Non-Recommended</u>
Benzaclin Gel Pump ¹	Abilify Maintena	Iclusig
Betamethasone Dipropionate Cream	Acyclovir Ointment	Pomalyst
Clobex Lotion & Shampoo	Alendronate Oral Solution	
Duac ¹	Amcinonide Cream & Lotion	
Fluticasone Propionate Lotion	Betamethasone Valerate Foam	
Ilevro	Cephalexin 750mg Capsules	
Olux	Clobetasol Emollient Foam	
Olux-E	Clobetasol Propionate Foam, Lotion & Shampoo	
Quillivant XR ¹	Colazal	
Renagel 800mg	Cystaran	
Simbrinza	Delzicol	
Zostavax ²	Desoximetasone	
	Desvenlafaxine ¹	
	Dexedrine ¹	

	Dextroamphetamine 5mg & 10mg Tablets ¹	
	Eliquis	
	Fulyzaq	
	Gattex	
	Invokana	
	Ipratropium Bromide 0.06% Nasal Solution	
	Juxtapid	
	Kazano ¹	
	Kynamro	
	Liptruzet	
	Methylphenidate IR Tablets ¹	
	Namenda XR ¹	
	Nesina ¹	
	Oseni ¹	
	Oxtellar XR ¹	
	Paregoric Tincture	
	Prolensa	
	Signifor	
	Tecfidera	
	TOBI Podhaler	
	Travoprost	
	Tretinoin Microsphere ¹	
	Triamcinolone Lotion	
	Vascepa	

¹Clinical PA Criteria Apply

²PA Required < 50 years of age

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

- **Dabigatran (Pradaxa[®]):** Prior authorization is required for dabigatran (Pradaxa[®]). Payment will be considered for patients under the following conditions:
 1. Patient has a diagnosis of non-valvular atrial fibrillation; and
 2. 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
 3. Presence of at least one additional risk factor for stroke, with a CHADS₂ score ≥1; and
 4. Patient does not have a mechanical prosthetic heart valve; and
 5. Patient does not have active pathological bleeding; and
 6. Patient does not have severe renal impairment (CrCl < 15mL/min) or is not on dialysis.

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

- **Janus Kinase Inhibitors:** Prior authorization is required for Janus kinase inhibitors. Payment will be considered when the following conditions are met:
 1. The patient is 18 years of age or older; and
 2. Has a diagnosis of moderate to severe rheumatoid arthritis; and
 3. Has a documented trial and inadequate response to two preferred oral disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline); and
 4. Has a documented trial and inadequate response to two preferred biological DMARDs; and
 5. The patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and
 6. Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and
 7. Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to manufacturer labeling; and
 8. Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and
 9. Patient is not at an increased risk of gastrointestinal perforation.The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

- **Oral Constipation Agents (Lubiprostone and Linaclotide):** Prior authorization is required for lubiprostone (Amitiza[®]) and linaclotide (Linzess[™]). Payment will be considered under the following conditions:
 1. Patient is 18 years of age or older; and
 2. Patient must have documentation of adequate trials and therapy failures with at least one medication from each of the following categories:
 - a. Saline laxative (milk of magnesia); and
 - b. Osmotic laxative (polyethylene glycol or lactulose); and
 - c. Stimulant laxative (senna); and
 3. Patient does not have a known or suspected mechanical gastrointestinal obstruction; and
 4. Patient has one of the following diagnoses:
 - a. A diagnosis of chronic idiopathic constipation (Amitiza[®] or Linzess[™])
 - i. Patient has less than 3 spontaneous bowel movements (SBMs) per week; and

- ii. Patient has two or more of the following symptoms within the last 3 months:
 1. Straining during at least 25% of the bowel movements;
 2. Lumpy or hard stools for at least 25% of bowel movements; and/or
 3. Sensation of incomplete evacuation for at least 25% of bowel movements; and
- iii. Documentation the patient is not currently taking constipation causing therapies.
- b. A diagnosis of irritable bowel syndrome with constipation (Amitiza[®] or Linzess[™])
 - i. Patient is female (Amitiza[®] only); and
 - ii. Patient has abdominal pain or discomfort at least 3 days per month in last 3 months associated with two (2) or more of the following:
 1. Improvement with defecation;
 2. Onset associated with a change in stool frequency; and/or
 3. Onset associated with a change in stool form
- c. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza[®])
 - i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and
 - ii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
 1. Hard to very hard stool consistency;
 2. Moderate to very severe straining; and/or
 3. Having a sensation of incomplete evacuation

If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation of therapy may be provided if prescriber documents adequate response to treatment.

- **Repository Corticotropin Injection (H.P. Acthar Gel):** Prior authorization is required for repository corticotropin injection. Payment will be considered under the following conditions:
 1. Patient is under two years of age and
 2. Patient has a diagnosis of infantile spasms.

Treatment of compendia indicated steroid-responsive conditions will only be considered upon documented contraindications or intolerance to corticosteroids not expected to occur with the use of repository corticotropin injection.

If criteria for coverage are met, authorization will be provided for up to 30 days of treatment for all indications.

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.

- **Long-Acting Narcotics (replaces Oxycodone CR/ER criteria):** Prior authorization is required for *all non-preferred long-acting narcotics*. Payment will be considered under the following conditions:
 1. There is documentation of previous trials and therapy failure with two (2) chemically distinct preferred long-acting narcotics (such as extended-release morphine sulfate, Opana ER and methadone) at therapeutic doses, and
 2. A trial and therapy failure with fentanyl patch at a maximum tolerated dose, and
 3. A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization, and
 4. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at <https://pmp.iowa.gov/IAPMPWebCenter> prior to requesting prior authorization.
 5. *Requests for long-acting narcotics will only be considered for FDA approved dosing.*

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

- **Multiple Sclerosis- Oral Agents:** Prior authorization is required for fingolimod (Gilenya™), teriflunomide (Aubagio®), or *dimethyl fumarate (Tecfidera™)*.

For patients initiating therapy with dimethyl fumarate (Tecfidera™), documentation of the following must be provided:

1. *Patient does not have a low lymphocyte count as documented by a recent (within 6 months) CBC prior to initiating therapy.*
2. *Upon renewal, documentation of an updated CBC.*

- **Thrombopoietin Receptor Agonists:** *Payment for eltrombopag (Promacta®) for the treatment of chronic hepatitis C associated thrombocytopenia will only be considered to allow for initiation and/or maintenance of interferon-based therapy with ribavirin when the patient has a baseline platelet count less than $75 \times 10^9/L$. Requests will not be considered under the following conditions:*
 1. *Patients taking direct acting antiviral agents for the treatment of chronic hepatitis C genotype 1 infection in addition to interferon-based therapy with ribavirin.*
 2. *Patients with decompensated liver disease with a Child-Pugh score > 6 (Class B & C).*
 3. *Patients with a history of ascites.*
 4. *Patients with hepatic encephalopathy.*

4. Point of Sale (POS) Billing Issues:

- a. ProDUR Quantity Limits:** The following quantity limit edits will be implemented effective *October 1, 2013*. 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
Pradaxa	60	30

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

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.