# Iowa Department of Human Services

**INFORMATIONAL LETTER NO.1966-MC-FFS**

**DATE:** November 28, 2018

**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

**APPLIES TO:** Managed Care, Fee-for-Service

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

**RE:** Iowa Medicaid Pharmacy Program Changes

**EFFECTIVE:** January 1, 2019

1. **Changes to the Preferred Drug List (PDL) Effective January 1, 2019.** Refer to the PDL website[1] to review the complete PDL.

| Preferred | Non-Preferred | Non-Recommended |
|---|---|---|
| Advate | Adapalene Solution[1] | Pifeltro |
| Amitiza[1] | Adzenys ER Oral Suspension[1] | Viracept Tablets |
| Ampyra[1] | Aimovig[1] | |
| Angeliq | Ajovy[1] | |
| Asmanex | Azopt | |
| Atazanavir | Bethkis | |
| Aubagio[1,2] | Blephamide Ophth Suspension | |
| Austedo[1] | Blephamide S.O.P. | |
| Brilinta | Combivent Respimat | |
| Buprenorphine-Naloxone SL Tablets[1] | Crotan | |
| Climara Pro | Dalfampridine ER[1] | |

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

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|---|---|---|
| Combipatch | Delstrigo | |
| Complete Natal DHA | Dexamethasone Therapy Pack | |
| Completenate Tablets | Diastat Rectal Gel | |
| Delzicol | Dorzolamide/Timolol PF | |
| Depo-SubQ Provera 104 | Durezol | |
| Diazepam Rectal Gel | Estradiol Weekly Patch | |
| Elidel[1] | Fulphila[1] | |
| Entresto[1] | Golytely Powder Pack | |
| Fiasp | Imiquimod 3.75% | |
| Fiasp FlexTouch | Ingrezza[1] | |
| Firazyr[3] | Kadian 20mg, 30mg, 50mg, 60mg, 80mg, 100mg & 200mg[1] | |
| Flovent Diskus | Kapspargo[1] | |
| FML Forte | Kitabis Pak | |
| Haegarda[3] | Kogenate FS | |
| Midazolam Injection | Kogenate FS Bio-Set | |
| Neomycin-Bacitracin-Poly-HC Ophth Ointment | Lamotrigine Kits | |
| Niva-Plus Tablets | Lexiva | |
| Odefsey | Lokelma[1] | |
| Ozempic[1] | Lopinavir-Ritonavir Oral Solution | |
| Pennsaid | Lotemax | |
| Perseris[4] | Luliconazole | |
| PNV 29-1 Tablets | Lupron Depot-Ped Syringe Kit[1] | |
| Praluent[1] | Menest | |
| Preplus Tablets | Methylphenidate ER Capsules (CD)[1] | |
| Pretab Tablets | Methylphenidate ER Capsules (LA)[1] | |
| Prezcobix | Mircera[1] | |
| ProAir Respiclick | Moxeza | |
| Protopic[1] | Mulpleta[1] | |
| Recombinate | Noctiva Nasal Emulsion | |
| Ruconest[3] | Olumiant[1] | |
| Sklice | Orilissa | |
| Suprep | Otovel | |
| Synarel | Plenvu | |
| Symfi | Plixda Pads[1] | |

| | | |
|---|---|---|
| Tecfidera[1, 2] | Reyataz | |
| Tetrabenazine[1] | RoxyBond[1] | |
| Thrivite RX Tablets | Siklos | |
| Tresiba FlexTouch | Stavudine Capsules | |
| Triveen-Duo DHA | Suboxone[1] | |
| Viberzi[1] | Symtuza | |
| Virt-Nate Tablets | Tadalafil[1] | |
| Vol-tab RX | Takhzyro | |
| Voltaren Gel | Tavalisse[1] | |
| Zemplar Capsules | Tegretol Tablets[5] | |
| Zyprexa Relprevv[4] | Vivelle-Dot | |
| | Zepatier[1] | |

[1]Clinical PA Criteria Apply
[2]Step Therapy
[3]PA required for diagnosis confirmation
[4] Step 2
[5]Grandfather existing users with seizure diagnosis

**2. Pharmacy Benefit Policy Changes-** Effective January 1, 2019, coverage for the drugs listed below will be removed under the pharmacy benefit. Coverage will continue, however, to be available through the medical benefit for Abraxane, Alimta, Amifostine Crystalline, Arranon, Avastin, Bleomycin Sulfate, Busulfex, Camptosar, Cisplatin, Cytarabine, Dexrazoxane, Doxil, Doxorubicin HCL, Erbitux, Faslodex, Fluorouracil, Folotyn, Gemcitabine HCL, Gemzar, Gliadel Wafer, Herceptin, Ifosfamide & Mesna, Intron-A, Irinotecan, Istodax, Mesna, Mesnex, Navelbine, Paclitaxel, Proleukin, Taxotere, Velcade, Vidaza, Vinblastine Sulfate, Vincristine Sulfate, Vinorelbine Tartrate, and Zinecard.

**3. New Drug Prior Authorization Criteria-** See complete prior authorization criteria under the Prior Authorization Criteria tab[2].

- **CGRP Inhibitors:**
  Prior authorization is required for CGRP Inhibitors. Payment will be considered for patients when the following is met:
  1. Patient has a diagnosis of migraine as defined by one of the following:
     a. Chronic Migraine
        i. ≥ 15 headache days per month for a minimum of 3 months; and
        ii. ≥ 8 migraine headache days per month for a minimum of 3 months; or
     b. Episodic Migraine
        i. 4 to 14 migraine days per month for a minimum of 3 months; and
  2. Patient meets the FDA approved age; and

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

3. Patient has been evaluated for and does not have medication overuse headache; and
4. Patient has documentation of three trials and therapy failures, of at least 3 months per agent, at a maximally tolerated dose with a minimum of two different migraine prophylaxis drug classes (i.e. anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadalol, propranolol, timolol], antidepressants, [amitriptyline, venlafaxine]); and
5. The requested dose does not exceed the maximum FDA labeled dose; and
6. Lost, stolen, or destroyed medication replacement requests will not be authorized.

Initial requests will be approved for 3 months. Additional prior authorizations will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days).

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

**4. Changes to Existing Prior Authorization Criteria-** *Changes are italicized or stricken.* See complete prior authorization criteria under the Prior Authorization Criteria tab[3].

- **Hepatitis C Treatments:**
  Prior authorization is required for hepatitis C treatments. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions:
  7. Patient has advanced liver disease corresponding to a Metavir score of *2* or greater fibrosis as confirmed by one of the following:
     - Liver biopsy confirming Metavir score ≥ *F2*; or
     - Transient elastography (FibroScan) score ≥ *7.5kPa*; or
     - FibroSURE (FibroTest) score ≥ *0.48*; or
     - APRI score > *0.7*; or
     - Radiological imaging consistent with cirrhosis (i.e. evidence of portal hypertension); or
     - Physical findings or clinical evidence consistent with cirrhosis; or
     - Patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), proteinuria, nephritic syndrome, or membranoproliferative glomerulonephritis.
  12. HCV treatment is prescribed by *or in consultation with* a digestive disease, liver disease, or infectious disease provider practice; and
  *21. Only one treatment attempt will be allowed per calendar year, regardless of compliance.*

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

- **Janus Kinase Inhibitors:**

  Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered *for an FDA approved or compendia indicated diagnosis* when the following conditions are met:

  2. Patient is not using or planning to use *a JAK inhibitor* in combination with *other JAK inhibitors,* biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and
  10. Patient has a diagnosis of:
      *c. Patient has a diagnosis of moderately to severely active ulcerative colitis, and*
      *i. Has a documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and*
      *ii. Has a documented trial and inadequate response with a preferred biological DMARD; and*
      *iii. If requested dose is for 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit.*

- **Multiple Sclerosis Agents:**

  For patients initiating therapy with *a preferred oral agent*, a manual prior authorization is not required if a preferred injectable interferon or non-interferon agent is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided:

  2. *Patient meets the FDA approved age; and*

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

**ProDUR Quantity Limits:** The following quantity limit edits will be implemented effective *January 1, 2019*. A comprehensive list of all quantity limit edits appears on the Quantity Limit Chart[4].

| Drug Product | Quantity | Days Supply |
|---|---|---|
| Aubagio 7mg & 14mg | 30 | 30 |
| Brilinta 60mg & 90mg | 60 | 30 |
| Midazolam Injection | 10 mL | 30 |
| Odefsey | 30 | 30 |
| Pennsaid 2% | 112 gms | 28 |
| Perseris 90mg & 120mg | 1 syringe | 30 |
| Prezcobix 800-150mg | 30 | 30 |
| ProAir Respiclick | 3 inhalers | 30 |
| Sklice | 117 gms | 30 |
| Symfi | 30 | 30 |

[4] http://www.iowamedicaidpdl.com/billing_quantity_limits

| | | |
|---|---|---|
| Tecfidera 120mg & 240mg | 60 | 30 |
| Voltaren Gel 1% | 900 gms | 30 |
| Xarelto 2.5mg | 60 | 30 |
| Zyprexa Relprevv 210mg& 300mg | 2 vials | 28 |
| Zyprexa Relprevv 405mg | 1 vial | 28 |

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[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/