



Iowa Department of Human Services

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For Human Services use only:

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Employees' Manual, Title 8
Medicaid Appendix

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PRESCRIBED DRUGS MANUAL TRANSMITTAL NO. 14-1

ISSUED BY: Division of Medical Services

SUBJECT: **PRESCRIBED DRUGS**, Chapter III, *Provider-Specific Policies*, Contents (pages 2, 3, and 4), revised; Contents (page 5), new; pages 1, 8, 9, 10, 14, 18, 19, 20, 31 through 60, 62, 69, 70, 71, 73, 79 through 88, 91, 94, 97, 107, 108, 109, and 113, revised; pages 60a, 60b, and 88a through 88d, new; and the following forms:

- 470-4116 *Request for Prior Authorization: ADD/ADHD/Narcolepsy Agents*, revised
- 470-4593 *Request for Prior Authorization: Angiotensin Receptor Blocker Before ACE Inhibitor*, revised
- 470-4093 *Request for Prior Authorization: Anti-Acne Products - Topical*, revised
- 470-4094 *Request for Prior Authorization: Antifungal Drugs*, revised
- 470-4095 *Request for Prior Authorization: Antihistamines – Oral*, revised
- 470-4521 *Request for Prior Authorization: Biologicals for Ankylosing Spondylitis*, revised
- 470-4522 *Request for Prior Authorization: Biologicals for Arthritis*, revised
- 470-4523 *Request for Prior Authorization: Biologicals for Inflammatory Bowel Disease*, revised
- 470-5136 *Request for Prior Authorization: BRAF Inhibitors*, revised
- 470-5142 *Request for Prior Authorization: Buprenorphine/Naloxone*, revised
- 470-5171 *Request for Prior Authorization: Dabigatran (Pradaxa®)*, new
- 470-4897 *Request for Prior Authorization: DPP-4 Inhibitors*, revised
- 470-4550 *Request for Prior Authorization: Extended Release Formulations*, revised
- 470-4100 *Request for Prior Authorization: Growth Hormones*, revised
- 470-4407 *Request for Prior Authorization: Incretin Mimetic*, revised
- 470-4111 *Request for Prior Authorization: Insulin, Pre-Filled Pens*, revised

470-5175	<i>Request for Prior Authorization: Janus Kinase (JAK) Inhibitors, new</i>
470-4409	<i>Request for Prior Authorization: Long-Acting Narcotics, revised</i>
470-4705	<i>Request for Prior Authorization: Modified Formulations, revised</i>
470-5060	<i>Request for Prior Authorization: Multiple Sclerosis Agents – Oral, revised</i>
470-5174	<i>Request for Prior Authorization: Oral Constipation Agents, new</i>
470-4112	<i>Request for Prior Authorization: Proton Pump Inhibitors, revised</i>
470-4327	<i>Request for Prior Authorization: Pulmonary Arterial Hypertension Agents, revised</i>
470-5172	<i>Request for Prior Authorization: Repository Corticotropin Injection (H.P. Acthar Gel), new</i>
470-5187	<i>Request for Prior Authorization: Rivaroxaban (Xarelto®), new</i>
470-4899	<i>Request for Prior Authorization: Short Acting Narcotics, revised</i>
470-5016	<i>Request for Prior Authorization: Sodium Oxybate (Xyrem®), revised</i>
470-5188	<i>Request for Prior Authorization: Testosterone Products, new</i>
470-4850	<i>Request for Prior Authorization: Thrombopoietin Receptor Agonists, revised</i>
470-4114	<i>Request for Prior Authorization: Topical Retinoids for Acne, revised</i>

Summary

The Prescribed Drug manual is revised to:

- ◆ Revise 24 forms for requesting drug prior authorization.
- ◆ Add six forms for requesting drug prior authorization.
- ◆ Obsolete one form for requesting drug prior authorization.
- ◆ Update the quantity limit chart.
- ◆ Update the non-drug product list.
- ◆ Update the refill too soon policy for lost, stolen or destroyed medications.
- ◆ Update policy regarding new drug entities.
- ◆ Update billing for pregnant members.
- ◆ Update links.

Date Effective

Upon receipt.

Material Superseded

This material replaces the following pages from Chapter III of the *Prescribed Drugs Manual*:

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87, 88, 91, 94, 97, 107-109, 113	August 1, 2013

Additional Information

The updated provider manual containing the revised pages can be found at:
www.ime.state.ia.us/providers

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.



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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. GENERAL PHARMACY GUIDELINES

This manual gives general information about Medicaid drug coverage and billing policies. For more detailed information, see the following web sites:

www.iadur.org	Drug Utilization Review (DUR) Commission
www.ime.state.ia.us	Iowa Medicaid Enterprise (IME)
www.iowamedicaidpdl.com	Pharmaceutical and Therapeutics (P&T) Committee and Preferred Drug List (PDL)
www.mslc.com/iowa	Pharmacy Reimbursement
www.iowamedicaidpos.com	Point of Sale (POS) system for pharmacy claims

1. Definitions

340B Program means the federal 340B Drug Pricing program managed by Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). The program allows certain designated facilities to purchase prescription medications at discounts, so these facilities can offer some medications to their patients at reduced prices.

340B Actual acquisition cost (340B AAC) means the net cost of a drug paid by a pharmacy for drugs purchased through the 340B drug pricing program. A drug's 340B AAC includes discounts, rebates, chargebacks and other adjustments to the price of the drug, but excludes dispensing fees.

Average actual acquisition cost (average AAC) means the average prices that retail pharmacies paid to acquire drug products.

Compendium of drug information means one of the following:

- ◆ The American Hospital Formulary Service Drug Information (AHFS);
- ◆ The United States Pharmacopeia Drug Information (USP-DI); or
- ◆ DRUGDEX Information System.

Contract pharmacy means a pharmacy under contract with a covered entity that lacks its own pharmacy whereby the contract pharmacy is authorized to dispense 340B-discounted drugs on behalf of the covered entity.



4. Pharmacist Responsibilities

a. Prospective Drug Utilization Review

Pharmacists shall review patient drug therapy at the point of sale to screen for potential drug therapy problems due to:

- ◆ Therapeutic duplication
- ◆ Drug-disease contraindications
- ◆ Drug-drug interactions
- ◆ Incorrect drug dosage or duration
- ◆ Drug-allergy interactions
- ◆ Clinical abuse or misuse

b. Dispensing Requirements

Pharmacists are required to:

- ◆ Dispense drugs in accordance with cost and quantity requirements established by state law.
- ◆ Dispense the **least costly item** in stock that meets the order of the doctor or other practitioner, as shown on the prescription.

c. Patient Counseling

Pharmacists must offer to discuss with each Medicaid member or the member's caregiver presenting a prescription those matters that, in the pharmacist's professional judgment, will enhance or optimize drug therapy. Appropriate elements of patient counseling may include:

- ◆ The name and description of the drug
- ◆ The dosage form, dose, administration route and duration of therapy
- ◆ The intended use of the drug, if known and expected action
- ◆ Directions and precautions for preparation, administration, and use
- ◆ Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance and the action required if they occur
- ◆ Techniques for self-monitoring drug therapy
- ◆ Proper storage
- ◆ Prescription refill information, including the approximate date when refill will be allowed (generally, 90% of the prescription is used)



- ◆ Actions to be taken in the event of a missed dose
- ◆ Comments relevant to the patient's drug therapy, including any other information peculiar to the specific patient or drug

Patient counseling is required in accordance with federal law at 42 USC Section 1396r(g)(2)(A)(ii)(I) and state rules at 657 Iowa Administrative Code 8.20(1)-(2).

d. Reason for Denial

The pharmacist should explain the reason for any **denial** of a requested drug or item to the member or caregiver. For example, denial could be due to one of the following:

- ◆ **Noncovered drug or item.** Explain why the drug or item is not covered and suggest alternatives to the member, caregiver, or practitioner.
- ◆ **Prior authorization requirement.** Explain the prior authorization process and requirements to the member or caregiver.

When a patient presents a prescription for nonpreferred drug at a pharmacy and it is denied, contact the prescriber and ask if the prescriber wishes to choose a preferred drug.

If the prescriber wishes to change to a preferred drug, the prescriber may dictate the new prescription order.

If the prescriber views that the nonpreferred drug is medically necessary, the prescriber must obtain prior authorization.

- ◆ **Refill too soon.** Inform the member or caregiver of an approximate date the prescription can be refilled (after 90% of the previous supply is used).

In special circumstances, such as a change in dose, travel, or lost, stolen or destroyed medication, that result in an early refill, contact the IME Pharmacy Point of Sale (POS) Unit at (515) 256-4608 (local calls) or 877-463-7671 with the information. This information will be reviewed to determine if an override can be given to allow payment.

Non-controlled medications that are lost, stolen or destroyed are limited to a one time override allowance per 12 month period. Overrides for the first occurrence of a lost, stolen or destroyed medication can be obtained by contacting the IME Pharmacy Point of Sale (POS) Unit at (515) 256-4608 (local calls) or 877-463-7671.



Replacement of lost, stolen or destroyed controlled substances and tramadol containing products will not be allowed. In addition, no allowances will be provided for patients residing in a long term care (LTC) facility.

Requests exceeding the one time override allowance for non-controlled lost, stolen or destroyed medications may be considered with additional documentation. Requests for stolen medications must include a copy of a police report.

- ◆ **Plan limits exceeded.** Refer to the limits list posted on the web site, www.iowamedicaidpdl.com, under "Billing/Quantity Limits." The number of doses should be reduced to meet the quantity limit.

If there are special circumstances where adherence to the quantity limit is not possible, the prescriber should complete form 470-4556, *Quantity Limit Override*, or form 470-5038, *Request for Fifteen Day Initial Prescription Supply Override*, and fax it to 1-800-574-2515. The clinical staff will review the information submitted and determine if an override can be given to allow payment.

If the member or caregiver is not satisfied with the explanation of the reason for a denial, refer the person to the member's DHS worker for assistance in filing an appeal or requesting an exception to policy. Appeal and exception requests may be filed on line through the following web site: <http://www.dhs.state.ia.us/dhs/appeals/>.

5. Drug Use Review

The drug use review (DUR) process was established to fulfill a federal requirement established by the federal Omnibus Budget Reconciliation Act of 1990. Iowa Medicaid has implemented both of the required DUR types:

- ◆ **Prospective drug utilization review** occurs when the pharmacist does the review of patient drug therapy at the point of sale. See [Pharmacist Responsibilities](#).
- ◆ **Retrospective drug utilization review** occurs when the review takes place after the point of sale.

The retrospective DUR program provides ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and members, or associated with specific drugs.



A **preferred drug with conditions** has “preferred” agents but must meet certain medical criteria and guidelines that coincide with current prior authorization guidelines.

5. Nonpreferred Drugs

Drug products designated “N” (nonpreferred) on the Preferred Drug List require prior authorization, with the primary criteria being failure on the preferred agents rather than clinical guidelines. See www.iowamedicaidpdl.com for the current designations.

Drug products within a therapeutic class that are not selected as preferred will be denied for payment unless the prescriber obtains prior authorization. Payment for drugs requiring a prior authorization will be made only when:

- ◆ The drugs are prescribed for treatment of one or more conditions set forth for each, and
- ◆ The Iowa Medicaid prior authorization criteria have been met, and
- ◆ Approval is obtained through the prior authorization process.

EXCEPTION: In the event of an emergency when the prescriber cannot submit a prior authorization request, the pharmacist may dispense a 72-hour supply of the drug and reimbursement will be made.

6. Newly Released Drugs

a. New Drug Entities

New drug entities (including new generic drugs) and new drug product dosage forms of existing drug entities will be identified weekly and immediately be coded as “Nonpreferred – Prior authorization required” until presented at the next quarterly scheduled P&T Committee meeting. If the drug category requires step therapy, the step therapy requirements must also be met, treating the new drug as a non-preferred step 3 drug.

These prior authorization restrictions will continue through the review process, including while committee recommendations are being made, and lasting until DHS makes a final determination.



Drug	√ = Prior Authorization Required
Senna tablets, 187 mg	
Sodium chloride hypertonic ophthalmic ointment, 5%	
Sodium chloride hypertonic ophthalmic solution, 5%	
Tolnaftate 1% cream	
Tolnaftate 1% powder	
Tolnaftate 1% solution	

Nonprescription multiple vitamins and minerals may also be payable under conditions specified under [PRIOR AUTHORIZATION REQUIREMENTS](#).

Oral solid forms of these items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription, except when dispensed via a unit-dose system.

8. Medical Supplies

Pharmacies that dispense medical equipment and supplies should follow the [MEDICAL EQUIPMENT AND SUPPLY DEALER PROVIDER MANUAL](#) and purchase a supply of [CMS-1500](#) claim forms from any supplier.

C. PRIOR AUTHORIZATION REQUIREMENTS

Prior approval is required for the following:

- ◆ [ADD/ADHD/narcolepsy agents](#)
- ◆ [Alpha₂ agonists, extended release](#)
- ◆ [Alpha₁-proteinase inhibitor enzymes](#)
- ◆ [Amylino mimetic \(Symlin[®]\)](#)
- ◆ [Angiotensin receptor blockers](#)
- ◆ [Anti-acne](#)
- ◆ [Antiemetic-5HT3 receptor antagonists/substance P neurokinin products](#)
- ◆ [Antifungal](#)
- ◆ [Antihistamines](#)
- ◆ [Becaplermin \(Regranex[®]\)](#)
- ◆ [Benzodiazepines](#)
- ◆ [Biologicals for ankylosing spondylitis](#)
- ◆ [Biologicals for arthritis](#)
- ◆ [Biologicals for inflammatory bowel disease](#)
- ◆ [Biologicals for plaque psoriasis](#)
- ◆ [Buprenorphine \(Butrans[™]\) transdermal system](#)
- ◆ [Buprenorphine/Naloxone \(Suboxone[®]\)](#)



- ◆ [Chronic pain syndrome agents](#)
- ◆ [Colchicine \(Colcrys[®]\)](#)
- ◆ [Concurrent IM/PO antipsychotic use](#)
- ◆ [Crizotinib \(Xalkori[®]\)](#)
- ◆ [Dabigatran \(Pradaxa\)](#)
- ◆ [Dalfampridine \(Ampyra[™]\)](#)
- ◆ [Dextromethorphan and Quinidine \(Nuedexta[™]\)](#)
- ◆ [Dipeptidyl peptidase-4 \(DPP-4\) inhibitors](#)
- ◆ [Dornase alfa \(Pulmozyme[®]\)](#)
- ◆ [Eplerenone \(Inspra[®]\)](#)
- ◆ [Erythropoiesis stimulating agents](#)
- ◆ [Extended release formulations](#)
- ◆ [Febuxostat \(Uloric[®]\)](#)
- ◆ [Fentanyl, short-acting oral products](#)
- ◆ [Granulocyte colony stimulating factor agents](#)
- ◆ [Growth hormones](#)
- ◆ [Hepatitis C Protease Inhibitors-Oral](#)
- ◆ [Immunomodulators, topical](#)
- ◆ [Incretin mimetic](#)
- ◆ [Insulin, pre-filled pens](#)
- ◆ [Isotretinoin \(oral\)](#)
- ◆ [Ivacaftor \(Kalydeco[™]\)](#)
- ◆ [Janus Kinase Inhibitors](#)
- ◆ [Ketorolac tromethamine \(Toradol[®]\)](#)
- ◆ [Lidocaine patch \(Lidoderm[®]\)](#)
- ◆ [Linezolid \(Zyvox[®]\)](#)
- ◆ [Long Acting Narcotics](#)
- ◆ [Mifepristone \(Korlym[®]\)](#)
- ◆ [Modified formulations](#)
- ◆ [Multiple Sclerosis-Oral Agents](#)
- ◆ [Muscle relaxants](#)
- ◆ [Narcotic agonist-antagonist nasal sprays](#)
- ◆ [Nebivolol \(Bystolic[®]\)](#)
- ◆ [Nicotine replacement products](#)
- ◆ [Nonparenteral vasopressin derivatives of posterior pituitary hormone products](#)
- ◆ [Nonpreferred drugs](#)
- ◆ [Nonsteroidal anti-inflammatory drugs](#)
- ◆ [Omalizumab \(Xolair[®]\)](#)
- ◆ [Oral Constipation Agents](#)
- ◆ [Palivizumab \(Synagis[®]\)](#)
- ◆ [Proton pump inhibitors](#)
- ◆ [Pulmonary arterial hypertension agents](#)



- ◆ [Quantity limit override](#)
- ◆ [Repository Corticotropin Injection \(H.P. Acthar Gel\)](#)
- ◆ [Rivaroxaban \(Xarelto[®]\)](#)
- ◆ [Roflumilast \(Daliresp[™]\)](#)
- ◆ [Sedative/hypnotics-non-benzodiazepine](#)
- ◆ [Selected brand name drugs](#)
- ◆ [Serotonin 5-HT₁ receptor agonists](#)
- ◆ [Short-acting narcotics](#)
- ◆ [Smoking cessation therapy \(oral\)](#)
- ◆ [Sodium oxybate \(Xyrem[®]\)](#)
- ◆ [Testosterone Products](#)
- ◆ [Thrombopoietin receptor agonists](#)
- ◆ [Topical Retinoids for Acne](#)
- ◆ [Vemurafenib \(Zelboraf[™]\)](#)
- ◆ [Vilazodone \(Viibryd[™]\)](#)
- ◆ [Vitamins, minerals and multiple vitamins](#)
- ◆ [Vusion[™] ointment](#)

The prescriber requests prior authorizations, not the pharmacy. The process is a **prescriber fax-only system** using the forms provided by the Iowa Medicaid Enterprise. The prescriber must request prior authorization by faxing the designated *Request for Prior Authorization* form to **800-574-2515**.

The specific criteria for approval of a prior authorization request are defined in the subsections that follow. The prior authorization criteria are also available in chart format on the web site www.iowamedicaidpdl.com.

Requests require the information on the applicable *Request for Prior Authorization* form, as noted in each subsection. Prior authorization forms may be obtained:

- ◆ From the web site https://www.iowamedicaidpdl.com/pa_forms or
- ◆ By calling the drug prior authorization help desk at (515) 256-4607 (local calls) or 877-776-1567. (Requests for prior authorizations will **not** be taken at this number.)

The IME 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.



Request for Prior Authorization
ADD/ADHD/NARCOLEPSY AGENTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Prior Authorization (PA) is required for ADD/ADHD/Narcolepsy Agents for patients 21 years of age or older under the following conditions: 1) Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-IV criteria...

Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. * If a non-preferred long-acting medication is requested, a trial of the preferred immediate release and extended release product of the same chemical entity is required.

Preferred

- Adderall
Daytrana
Focalin
Focalin XR
Metadate CD
Methylphenidate IR Tablets
Methylphenidate ER Tabs (10, 18, 27, 36, 54mg)

- Provigil
Quillivant XR
Ritalin
Ritalin SR
Strattera
Vyvanse

Non-Preferred

- Adderall XR
Amphetamine ER
Amphetamine Salt Combo
Concerta
Desoxyn
Dexedrine*
Dextroamphetamine Tab
Dextroamphetamine ER Cap*
Dexmethylphenidate

- Methylin Chew
Methylin Solution
Methylphenidate ER (Caps and 20mg Tabs)
Modafinil
Nuvigil
Procentra
Ritalin LA*

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

- Attention Deficit Disorder (ADD)
Attention Deficit Hyperactivity Disorder (ADHD)

Age of patient at onset of symptoms:

Date of most recent mental status exam:

Rating scale used to determine diagnosis:

Documentation of clinically significant impairment in two or more current environments (social, academic, or occupational).

Environment 1 & description:

Environment 2 & description:

**Request for Prior Authorization
ADD/ADHD/NARCOLEPSY AGENTS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)

Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS)

Have non-pharmacological treatments been tried? No Yes *If Yes, please indicate below:*

Weight Loss

Position therapy

CPAP Date: _____

Maximum titration? Yes No

BiPAP Date: _____

Maximum titration? Yes No

Surgery Date: _____

Specifics: _____

Diagnosis confirmed by a sleep specialist? Yes No

Other (specify) _____

Please document prior psychostimulant trial(s) and failures(s) including drug name(s) strength, dose, exact date ranges and failure reasons: _____

Other - Please provide all pertinent medication trial(s) relating to the diagnosis including drug name(s) strength, dose and exact date ranges:

Reason for use of Non-Preferred drug requiring approval: _____

Prescriber signature (Must match prescriber listed above.)	Date of submission
--	--------------------

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*



Request for Prior Authorization
ANGIOTENSIN RECEPTOR BLOCKER BEFORE ACE INHIBITOR

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prescriber must fill all information above. It must be legible, correct, and complete or form will be returned.

Payment for Angiotensin Receptor Blockers (ARB) and Angiotensin Receptor Blocker Combinations will only be considered for cases in which there is a contraindication or therapy failure with at least one ACE-I or ACE-I Combination.

Preferred

- Avapro, Benicar, Benicar HCT, Diovan, Diovan HCT, Exforge, Exforge HCT, Irbesartan-HCT, Losartan, Losartan HCT, Micardis, Micardis HCT

Non-Preferred

- Atacand, Atacand HCT, Avalide, Azor, Cozaar, Edarbi, Edarbyclor, Eprosartan, Hyzaar, Irbesartan, Teveten, Teveten HCT, Tribenzor, Twynsta, Valtorna, Valsartan/HCT

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

Preferred ACE Inhibitor Trial: Drug Name Strength

Dosage Instructions Trial date from: Trial date to:

Failure reason with ACE Inhibitor:

Medical or contraindication reason to override ACE Inhibitor trial requirements:

Reason for use of Non-Preferred drug requiring prior approval:

Other relevant information:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only.



Request for Prior Authorization
ANTI-ACNE PRODUCTS-TOPICAL

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for all prescription topical acne products. Payment for the treatment of mild to moderate acne vulgaris will be considered under the following conditions: 1) Previous trial and therapy failure with a preferred over-the-counter benzoyl peroxide product...

Preferred

- Azelex
BenzaClin Pump
Benzoyl Peroxide Lotion (3%, 6%, 9%)
BPO Gel/Cloths
Clindamycin
Duac

- Erythromycin
Erythromycin/BPO
MetroCream
MetroGel
MetroLotion

Non-Preferred

- Aczone
Akne-Mycin
Benzac AC
BenzaClin
Benzamycin
Benzamycin Pak
Brevoxyl
Cleocin T
Clindagel
Clindamycin/BPO
Finacea
Klaron

- Metronidazole
Noritate
Rosanil Cleanser
Sodium Sulfa/Sulf
Sulfacet-R
Triaz Cloths

Other (specify) _____

Table with 5 columns: Strength, Dosage Form, Dosage Instructions, Quantity, Days Supply

Diagnosis: _____

Benzoyl peroxide trial: Drug Name & Strength: _____ Dosing Instructions: _____

Trial date from: _____ Trial date to: _____

Medical or contraindication reason to override trial requirements: _____

Document treatment failures with two preferred topical agents including drug names, strength, exact date ranges and failure reasons :

Pertinent Lab data: _____

Other relevant information: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Form with fields for Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.



Request for Prior Authorization
ANTIFUNGAL DRUGS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

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 is required for all non-preferred oral antifungal therapy as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy.

Preferred (PA required after 90 days)

- Clotrimazole Troche
Fluconazole
Gris-Peg
Griseofulvin Suspension
Terbinafine
Voriconazole

Non-Preferred (PA required from Day 1)

- Diflucan
Grifulvin V
Griseofulvin Tablets
Ketoconazole Tablets
Lamisil
Noxafil
Onmel
Oravig
Sporanox
Vfend

Table with 4 columns: Strength, Dosage Instructions, Quantity, Days Supply

Diagnosis:

Does the patient have an immunocompromised condition? Yes No

If yes, diagnosis:

Does the patient have a systemic fungal infection? Yes No

If yes, date of diagnosis: Type of infection:

Previous trial(s) with preferred drug(s): Drug Name Strength

Trial Date from Trial Date to:

Medical or contraindication reason to override trial requirements:

Reason for use of Non-Preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

Form with fields for Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.



Request for Prior Authorization
ANTIHISTAMINES-ORAL

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for all non-preferred oral antihistamines. Patients 21 years of age and older must have three unsuccessful trials with oral antihistamines that do not require prior authorization, prior to the approval of a non-preferred oral antihistamine. Two of the trials must be with cetirizine and loratadine. Patients 20 years of age and younger must have an unsuccessful trial with cetirizine and loratadine prior to the approval of a non-preferred oral antihistamine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred 1st Generation Antihistamines (no PA required) required)

- Chlorpheniramine Maleate (OTC)
Cyproheptadine
Diphenhydramine (OTC)
Other preferred as listed on PDL

Non- Preferred 1st Generation Antihistamines (PA

- Carbinoxamine Maleate
Clemastine Fumarate
Dexchlorpheniramine Maleate

Preferred 2nd Generation OTC Antihistamines (no PA required)

- Loratadine Tab (OTC)
Loratadine Syrup (OTC)
Cetirizine Tab (OTC)
Cetirizine Syrup (OTC)

Non-Preferred 2nd Generation Antihistamines (PA required)

- Clarinet/Clarinet D
Desloratadine
Levocetirizine
Xyzal

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Document antihistamine treatment failure(s) including drug names, strength, exact date ranges and failure reasons:

Medical or contraindication reason to override trial requirements:

Reason for use of Non-Preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



13. **Becaplermin (Regranex[®])**

Prior authorization is required for Regranex[®]. Payment for new prescriptions will be authorized for ten weeks for patients who meet the following criteria:

- ◆ Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond.
- ◆ Inadequate response to two weeks of wound debridement and topical moist wound dressing.

Authorization will be approved beyond ten weeks for patients whose wound has decreased in size by 30% after ten weeks.

Use form 470-4276, *Request for Prior Authorization: Becaplermin (Regranex[®])*, to request prior authorization. Click [here](#) to see a sample of the form.

14. **Benzodiazepines**

Prior authorization is required for nonpreferred benzodiazepines. Payment for nonpreferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. Requests for clobazam (Onfi) will be considered for a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) in patients two years of age and older when used as an adjunctive treatment. If a long-acting medication is requested, one of the therapeutic trials must include the immediate-release form of the requested benzodiazepine.

Prior authorization will be approved for up to 12 months for documented:

- ◆ Generalized anxiety disorder
- ◆ Panic attack with or without agoraphobia
- ◆ Seizure
- ◆ Nonprogressive motor disorder
- ◆ Dystonia

Prior authorization requests will be approved for up to a three-month period for all other diagnoses related to the use of benzodiazepines.

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

Use form 470-4117, *Request for Prior Authorization: Benzodiazepines*, to request prior authorization. Click [here](#) to see a sample of the form.



15. **Biologicals for Ankylosing Spondylitis**

Prior authorization is required for biologicals used for ankylosing spondylitis. Payment will be considered following inadequate responses to two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses unless there are documented adverse responses or contraindications to NSAID use. Trials should be at least three months in duration.

Patients with symptoms of peripheral arthritis must also have failed a 30-day 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.

Payment for nonpreferred biologicals for ankylosing spondylitis will be considered only for cases in which there is documentation of a previous trials and therapy failures with two preferred biological agents.

Use form 470-4521, *Request for Prior Authorization: Biologicals for Ankylosing Spondylitis*, to request prior authorization. Click [here](#) to see a sample of the form.

16. **Biologicals for Arthritis**

Prior authorization is required for biologicals used for arthritis. Patients initiating therapy with a biological agent must:

- ◆ Be screened for hepatitis B and C. Patients with active hepatitis B will not be considered for coverage.
- ◆ Not have been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last five years of starting or resuming treatment with a biological agent.
- ◆ Not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV with an ejection fraction of 50% or less.
- ◆ Be screened for latent TB infection. Patients with latent TB infection will only be considered after one month of TB treatment. Patients with active TB will only be considered upon completion of TB treatment.



Request for Prior Authorization
BIOLOGICALS FOR ANKYLOSING SPONDYLITIS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for biologicals used for ankylosing spondylitis. Payment will be considered following inadequate responses to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses...

Preferred

- Enbrel
Humira

Non-Preferred

- Cimzia
Remicade
Simponi

Strength Dosage Instructions Quantity Days Supply

NSAID Trial #1 Name/Dose: Trial start date: Trial end date:

Reason for Failure:

NSAID Trial #2 Name/Dose: Trial start date: Trial end date:

Reason for Failure:

DMARD Trial (for peripheral arthritis diagnosis) Name/Dose:

Trial start date: Trial end date: Reason for Failure:

Reason for use of Non-Preferred drug requiring prior approval:

Other medical conditions to consider:

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only.



Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for biologicals used for arthritis. Patients initiating therapy with a biological agent must 1) be screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; 2) have not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; 3) not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less; and 4) be 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.

Preferred

- Enbrel
Humira

Non-Preferred

- Actemra, Cimzia (prefilled syringe), Kineret, Orencia, Remicade, Simponi, Stelara

Strength Dosage Instructions Quantity Days Supply

Screening for Hepatitis B: Date: Active Disease: Yes No

Screening for Hepatitis C: Date: Active Disease: Yes No

Screening for Latent TB infection: Date: Results:

Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last 5 years of starting or resuming treatment with a biologic agent? Yes No

Does patient have a diagnosis of NYHA class III or IV CHF diagnosis with ejection fraction of 50% or less: Yes No

**Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS**
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Rheumatoid arthritis (RA) (Humira, Enbrel, Actemra, Cimzia, Kineret, Orencia, Remicade, Simponi)-
Payment will be considered upon a trial and inadequate response to two preferred disease modifying
antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another
preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline). Upon an unsuccessful
methotrexate trial in patients with established RA, the combination trial with a second DMARD may be
overridden if there is evidence of severe disease documented by radiographic erosions.

Methotrexate trial: Dose: _____ Trial dates: _____

Failure reason: _____

Plus preferred oral DMARD trial: Drug Name & Dose: _____ Trial dates: _____

Failure reason: _____

Radiographic evidence indicating erosions: Yes No

Psoriatic arthritis, moderate to severe (Cimzia, Enbrel, Humira, Remicade, Simponi, Stelara)-
Payment will be considered upon a trial and inadequate response to the preferred oral DMARD, methotrexate
(leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Methotrexate or preferred oral DMARD trial: Drug Name & Dose: _____

Trial dates: _____ Failure reason: _____

Methotrexate contraindication if applicable: _____

Juvenile idiopathic arthritis, moderate to severe (Enbrel, Humira, Actemra, Orencia)-
Payment will be considered upon a trial and inadequate response to intraarticular glucocorticoid injections and
the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is
contraindicated).

Intraarticular Glucocorticoid Injections: Drug Name & Dose: _____ Trial dates: _____

Failure reason: _____

Plus methotrexate or preferred oral DMARD trial: Drug Name & Dose: _____

Trial dates: _____ Failure reason: _____

Methotrexate contraindication if applicable: _____

Reason for use of Non-Preferred drug requiring prior approval: _____

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
--	--------------------

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of
medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for
Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the
member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member
continues to be eligible for Medicaid.



Request for Prior Authorization
BIOLOGICALS FOR INFLAMMATORY BOWEL DISEASE

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for biologicals used for inflammatory bowel disease. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

Preferred

Humira []
Humira Starter Kit []

Strength

Non-Preferred

Cimzia (prefilled syringe) []
Remicade []

Simponi []

Dosage Instructions

Quantity

Days Supply

[] Crohn's Disease - Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate.

Trial Drug Name/Dose: Trial dates:

Reason for failure:

Trial Drug Name/Dose: Trial dates:

Reason for failure:

Reason for use of Non-Preferred drug requiring prior approval:

[] Ulcerative colitis (moderate to severe) - Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine.

Trial Drug Name/Dose: Trial dates:

Reason for failure:

Trial Drug Name/Dose: Trial dates:

Reason for failure:

Reason for use of Non-Preferred drug requiring prior approval:

Possible drug interactions/conflicting drug therapies/other medical conditions to consider:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



Payment will be considered under the following conditions:

- ◆ A diagnosis of rheumatoid arthritis (RA). A trial and inadequate response to two preferred disease-modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline). Upon an unsuccessful methotrexate trial in patients with established RA, the combination trial with a second DMARD may be overridden if there is evidence of severe disease documented by radiographic erosions.
- ◆ A diagnosis of moderate to severe psoriatic arthritis. A trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).
- ◆ A diagnosis of moderate to severe juvenile idiopathic arthritis. A trial and inadequate response to intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

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

Payment for nonpreferred biologicals for arthritis will be considered only for cases in which there is documentation of a previous trials and therapy failures with two preferred biological agents.

Use form 470-4522, *Request for Prior Authorization: Biologicals for Arthritis*, to request prior authorization. Click [here](#) to see a sample of the form.

17. Biologicals for Inflammatory Bowel Disease

Prior authorization is required for biologicals used for inflammatory bowel disease.

Payment for nonpreferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

- ◆ Crohn's disease. Payment will be considered following an inadequate response to two preferred conventional therapies, such as aminosalicylates (mesalamine, sulfasalazine), corticosteroids, azathioprine/6-mercaptopurine, or methotrexate.



- ◆ Ulcerative colitis (moderate to severe). Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine.

Use form 470-4523, *Request for Prior Authorization: Biologicals for Inflammatory Bowel Disease*, to request prior authorization. Click [here](#) to see a sample of the form.

18. **Biologicals for Plaque Psoriasis**

Prior authorization is required for biologicals used for plaque psoriasis. Payment will be considered following an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine.

Payment for nonpreferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents.

Use form 470-4524, *Request for Prior Authorization: Biologicals for Plaque Psoriasis*, to request prior authorization. Click [here](#) to see a sample of the form.

19. **Buprenorphine (Butrans™) Transdermal System**

Prior authorization is required for Butrans™. Payment will be considered when the following criteria are met:

- ◆ Previous trials and therapy failures at a therapeutic dose with two preferred long-acting opioids. The preferred trials must allow for adequate dose titration and show use of a short-acting narcotic for breakthrough pain.
- ◆ A trial and therapy failure with fentanyl patch at maximum tolerated dose.

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

Use form 470-5017, *Request for Prior Authorization: Buprenorphine (Butrans™) Transdermal System*, to request prior authorization. Click [here](#) to see a sample of the form.



Request for Prior Authorization
Buprenorphine/Naloxone

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Prescriber must fill all information above, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for buprenorphine or buprenorphine/naloxone. Requests for doses above 24 mg per day or greater than once daily dosing will not be considered. Initial requests will be considered for up to 3 months. Requests for maintenance doses above 16 mg per day will not be considered on a long-term basis. Concomitant use with opioids, tramadol and hypnotics will be prohibited. Benzodiazepines will be allowed up to a cumulative 30 days per 12 month period. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Payment will be considered when the following is met:

- 1) Patient has a diagnosis of opioid dependence and is 16 years of age or older; AND
2) Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has an "X" DEA number; AND
3) Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy; AND
4) A projected treatment plan is provided with initial request (see below requirements).
5) Requests for renewal must include updated treatment plan and additional documentation as indicated below.
6) Requests for buprenorphine will only be considered for pregnant patients.

Preferred

- Suboxone SL Film
Zubsolv

Non-Preferred

- Buprenorphine (Please verify patient is pregnant) No Yes
Buprenorphine/Naloxone SL Tabs

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

Prescriber meets qualifications to prescribe and treat opioid dependence and possess "X" DEA number: No Yes

Patient participates in and is compliant with counseling: No Yes

Date of most recent counseling session:

Initial Requests: Include projected treatment plan. May attach treatment plan or provide at a minimum the below information:

- Anticipated induction/stabilization dose: _____
- Anticipated maintenance dose: _____
- Expected frequency of office visits: _____
- Expected frequency of counseling/psychosocial therapy visits: _____

Renewal Requests: Please provide the below information:

- Updated treatment plan, including consideration of a medical taper to the lowest effective dose based on a self assessment scale. Date of most recent taper attempt: _____
- Documentation the Iowa Prescription Monitoring Program (PMP) website has been reviewed for the patient's use of controlled substances since the last prior authorization request. No Yes
Date reviewed: _____
- Documentation of a current, negative drug screen. Date of most recent drug screen: _____
- Documentation the patient has been compliant with office visits and counseling/psychosocial therapy visits. Compliant with office visits? No Yes
Date of most recent office visit: _____

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



20. Buprenorphine/Naloxone (Suboxone®)

Prior authorization is required for buprenorphine or buprenorphine/naloxone (Suboxone®). Requests for doses above 24mg per day or greater than once daily dosing will not be considered. Initial requests will be considered for up to three months. Requests for maintenance doses above 16mg per day will not be considered on a long-term basis.

Concomitant use with opioids, tramadol, and hypnotics will be prohibited. Benzodiazepines will be allowed up to a cumulative 30 days per 12 month period. Payment will be considered for patients when the following is met:

- ◆ Patient has a diagnosis of opioid dependence and is 16 years of age or older; AND
- ◆ Prescriber meets qualification criteria to prescribe buprenorphine/naloxone (Suboxone®) for opioid dependence and has an "X" DEA number; AND
- ◆ Patient is participating in and compliant with formal substance abuse counseling or psychosocial therapy; AND
- ◆ A projected treatment plan is provided, including:
 - Anticipated induction and stabilization dose,
 - Anticipated maintenance dose,
 - Expected frequency of office visits, and
 - Expected frequency of counseling or psychosocial therapy visits
- ◆ Requests for renewal must include:
 - An updated treatment plan, including consideration of a medical taper to the lowest effective dose based on a self-assessment scale,
 - Documentation the Iowa Prescription Monitoring Program website has been reviewed for the patient's use of controlled substances since the last prior authorization request,
 - Documentation of a current, negative drug screen,
 - Documentation the patient has been compliant with office visits and counseling or psychosocial therapy visits.

Requests for buprenorphine will only be considered for pregnant patients.

Use form 470-5142, *Request for Prior Authorization: Buprenorphine/Naloxone (Suboxone®)*, to request prior authorization. Click [here](#) to see a sample of the form.



21. Chronic Pain Syndrome Agents

Prior authorization is required for duloxetine (Cymbalta[®]), pregabalin (Lyrica[®]), and milnacipran (Savella[™]). Payment will be considered under the following conditions:

- ◆ A diagnosis of **fibromyalgia** (Cymbalta[®], Lyrica[®], and Savella[™]) with:
 - A trial and therapy failure at a therapeutic dose with three drugs from three distinct therapeutic classes from the following: tricyclic antidepressant, muscle relaxant, SSRI/SNRI, tramadol, or gabapentin, **and**
 - Documented non-pharmacologic therapies (cognitive behavior therapies, exercise, etc.), **and**
 - Documentation of a previous trial and therapy failure at a therapeutic dose with Savella[™] when Cymbalta[®] and Lyrica[®] are requested.
- ◆ A diagnosis of **postherpetic neuralgia** (Lyrica[®]) with a trial and therapy failure at a therapeutic dose with at least two drugs from two distinct therapeutic classes from the following: tricyclic antidepressant, topical lidocaine, valproate, carbamazepine, or gabapentin
- ◆ A diagnosis of **diabetic peripheral neuropathy** (Cymbalta[®] and Lyrica[®]) with a trial and therapy failure at a therapeutic dose with at least two drugs from two distinct therapeutic classes from the following: tricyclic antidepressant, topical lidocaine, tramadol, or gabapentin
- ◆ A diagnosis of **partial onset seizures**, as adjunct therapy (Lyrica[®])
- ◆ A diagnosis of major depressive disorder or generalized anxiety disorder (Cymbalta[®])
- ◆ A diagnosis of **chronic musculoskeletal pain** (Cymbalta[®]) with a trial and therapy failure at a therapeutic dose with at least three drugs from three distinct therapeutic classes from the following: NSAIDs, opioids, tramadol, or tricyclic antidepressants.

Requests for concomitant use of these agents for an indicated chronic pain diagnosis may only be considered once each agent has been tried at maximum tolerated dose separately. Duplicate use of drugs from the same therapeutic category will not be considered.

Use form 470-4551, *Request for Prior Authorization: Chronic Pain Syndrome*, to request prior authorization. Click [here](#) to see a sample of the form.



22. Colchicine (Colcrys®)

Prior authorization is not required for colchicine (Colcrys®) for the treatment of acute gout for 3 tablets per 60-day period. Prior authorization is required for colchicine (Colcrys®) for the treatment of chronic hyperuricemia/gout prophylaxis or Familial Mediterranean fever. Payment will be considered under the following conditions:

- ◆ Chronic hyperuricemia/gout prophylaxis following a trial and therapy failure at a therapeutic dose with allopurinol or probenecid. A quantity limit of 60 tablets per 30 days will be applied, when criteria for coverage are met.
- ◆ Familial Mediterranean fever. A maximum quantity limit of 120 tablets per 30 days will be applied for this diagnosis.

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

Use form 470-5059, *Request for Prior Authorization: Colchicine (Colcrys®)*, to request prior authorization. Click [here](#) to see a sample of the form.

23. Concurrent IM/PO Antipsychotic Use

Prior authorization is required for concurrent long-acting injectable and oral antipsychotic medications after 12 weeks (84 days) of concomitant treatment. Consideration of concomitant therapy beyond 12 weeks (84 days) will require documentation of medical necessity.

Prior authorization is required for all nonpreferred antipsychotics as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for nonpreferred antipsychotics will be considered only for cases in which there is documentation of previous trials and therapy failures with a preferred agent.

Use form 470-4594, *Request for Prior Authorization: Concurrent IM/PO Antipsychotic Utilization*, to request prior authorization. Click [here](#) to see a sample of the form.



24. Crizotinib (Xalkori®)

Prior authorization is required for Xalkori® (Crizotinib). Payment will be considered for patients when the following is met:

- ◆ Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test (attach copy of results); and
- ◆ Is prescribed by an oncologist.

Use form 470-5118, *Request for Prior Authorization: Crizotinib (Xalkori®)*, to request prior authorization. Click [here](#) to see a sample of the form.

25. Dabigatran (Pradaxa®)

Prior authorization is required for dabigatran (Pradaxa®). Payment will be considered for patients under the following conditions:

- ◆ Patient has a diagnosis of non-valvular atrial fibrillation; and
- ◆ Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum six month trial); and
- ◆ Presence of at least one additional risk factor for stroke, with a CHADS₂ score ≥ 1 ; and
- ◆ Patient does not have a mechanical prosthetic heart valve; and
- ◆ Patient does not have active pathological bleeding; and
- ◆ 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.

Use form 470-5171, *Request for Prior Authorization: Dabigatran (Pradaxa®)*, to request prior authorization. Click [here](#) to see a sample of the form.



Request for Prior Authorization
DABIGATRAN (PRADAXA®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for dabigatran (Pradaxa®). Payment will be considered 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.

Non-Preferred

Pradaxa®

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Treatment failure with warfarin:

Trial dose: Trial dates:

Reason for failure:

Possible drug interactions/conflicting drug therapies:

Does patient have mechanical prosthetic heart valve? Yes No

Does patient have active pathological bleeding? Yes No

Does patient have severe renal impairment (CrCl < 15mL/min)? Yes No

Is patient on dialysis? Yes No

**Request for Prior Authorization
DABIGATRAN (PRADAXA®)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Documentation of additional risk factors and CHADS₂ score:

Risk factor based CHADS ₂ Score	
Risk Factors	Score
<input type="checkbox"/> Congestive heart failure	1
<input type="checkbox"/> Hypertension (systolic > 160mmHg)	1
<input type="checkbox"/> Age ≥ 75 years	1
<input type="checkbox"/> Diabetes mellitus	1
<input type="checkbox"/> Stroke / TIA / thrombo-embolism	2
Total	

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



26. Dalfampridine (Ampyra™)

Prior authorization is required for dalfampridine (Ampyra™). Payment will be considered under the following conditions:

- ◆ For patients that have a gait disorder associated with MS.
- ◆ Initial authorizations will be approved for 12 weeks with a baseline timed 25-foot walk (T25FW) assessment.
- ◆ Additional prior authorizations will be considered at six-month intervals after assessing the benefit to the patient as measured by a 20% improvement in T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained.
- ◆ Prior authorizations will not be considered for patients with a seizure diagnosis or in patients with moderate or severe renal impairment.

Use form 470-5015, *Request for Prior Authorization: Dalfampridine (Ampyra™)*, to request prior authorization. Click [here](#) to see a sample of the form.

27. Dextromethorphan and Quinidine (Nuedexta™)

Prior authorization is required for Nuedexta™. Payment will be considered under the following conditions:

- ◆ Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS).
- ◆ A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI.
- ◆ Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire.
- ◆ Subsequent prior authorizations will be considered at six month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire.

Use form 470-5084, *Request for Prior Authorization: Dextromethorphan and Quinidine (Nuedexta™)*, to request prior authorization. Click [here](#) to see a sample of the form.



28. Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

Prior authorization is required for dipeptidyl peptidase-4 (DPP-4) inhibitors and DPP-4 inhibitor combinations. Payment will be considered under the following conditions:

- ◆ The patient has a diagnosis of Type 2 diabetes mellitus;
- ◆ The patient is 18 years of age or older; and
- ◆ The patient has not achieved HbA1C goals using a combination of two or more antidiabetic medications (metformin, sulfonylurea, thiazolidinedione, or insulin) at maximum tolerated doses unless otherwise contraindicated.

Payment for a nonpreferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated.

Use form 470-4897, *Request for Prior Authorization: DPP-4 Inhibitors*, to request prior authorization. Click [here](#) to see a sample of the form.

29. Dornase Alfa (Pulmozyme®)

Prior authorization is required for Pulmozyme®. Payment will be authorized only for cases in which there is a diagnosis of cystic fibrosis.

Use form 470-4104, *Request for Prior Authorization: Miscellaneous*, to request prior authorization. Click [here](#) to see a sample of the form.

30. Eplerenone (Inspra®)

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.

Use form 470-4104, *Request for Prior Authorization: Miscellaneous*, to request prior authorization. Click [here](#) to see a sample of the form.

31. Erythropoiesis Stimulating Agents

Prior authorization is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia.

Payment for **nonpreferred** erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.



Request for Prior Authorization
DPP-4 INHIBITORS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for dipeptidyl peptidase-4 (DPP-4) inhibitors and DPP-4 Inhibitor Combinations. Payment will be considered under the following conditions: 1) A diagnosis of Type 2 Diabetes Mellitus 2) Patient is 18 years of age or older 3) The patient has not achieved HbgA1C goals using a combination of two or more antidiabetic medications...

Preferred

- Janumet
Januvia

- Kombiglyze XR
Onglyza

Non-Preferred

- Janumet XR
Jentadueto
Kazano

- Nesina
Oseni
Tradjenta

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Trial Drug #1 Name/Dose:

Trial start date: Trial end date:

Reason for Failure:

Trial Drug #2 Name/Dose:

Trial start date: Trial end date:

Reason for Failure:

Most recent HgbA1C Level: Date this level was obtained:

Reason for non-preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.



Request for Prior Authorization
EXTENDED RELEASE FORMULATIONS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Payment for a non-preferred extended release formulation will be considered when the following criteria for coverage are met: 1) Previous trial and therapy failure with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2) Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis.

Prior Authorization is required for the following extended release formulations: Adoxa, Augmentin XR, Cardura XL, Cipro XR, ConZip ER, Coreg CR, Doryx, Flagyl ER, Fortamet, Gralise, Keppra XR, Lamictal XR, Luvox CR, metronidazole sr, Mirapex ER, Moxatag, Namenda XR, Nexiclon XR, Oleptro, Oxtellar XR, Paxil CR, Prozac Weekly, Rayos, Requip XL, Rythmol SR, Ryzolt, Sanctura XR, Seroquel XR, Solodyn ER, tramadol sr, Ultram ER.

Drug Name: Strength:

Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Previous therapy with immediate release product of same chemical entity (include strength, exact date ranges, and reason for failure):

Previous therapy with a preferred drug of a different chemical entity (include strength, exact date ranges, and reason for failure):

Contraindication(s) to using immediate release product and/or a preferred drug of a different chemical entity:

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

Form with fields for Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.



Patients who meet all of the following criteria may receive prior authorization for the use of erythropoiesis stimulating agents:

- ◆ Hemoglobin less than 10g/dL. If renewal of prior authorization is being requested, a hemoglobin less than 11g/dL (or less than 10g/dL for patients with Chronic Kidney Disease (CKD) not on dialysis) will be required for continued treatment. Hemoglobin laboratory values must be dated within four weeks of the prior authorization request.
- ◆ 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.

- ◆ For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy.
- ◆ No evidence of untreated GI bleeding, hemolysis, or vitamin B-12, iron or folate deficiency.

Use form 470-4098, *Request for Prior Authorization: Erythropoiesis Stimulating Agents*, to request prior authorization. Click [here](#) to see a sample of the form.

32. Extended-Release Formulations

Payment for a nonpreferred extended-release formulation will be considered when both of the following criteria are met:

- ◆ Previous trial with the preferred immediate-release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance, and
- ◆ Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity that is indicated to treat the submitted diagnosis.

Use form 470-4550, *Request for Prior Authorization: Extended Release Formulations*, to request prior authorization. Click [here](#) to see a sample of the form.



33. **Febuxostat (Uloric®)**

Prior authorization is required for febuxostat (Uloric®). Payment for febuxostat (Uloric®) will only be considered for cases in which there is a diagnosis of gout still persistent while currently using 300 mg per day of a preferred allopurinol product unless documentation is provided that such as trial would be medically contraindicated.

Use form 470-4849, *Request for Prior Authorization: Febuxostat (Uloric®)*, to request prior authorization. Click [here](#) to see a sample of the form.

34. **Fentanyl, Short-Acting Oral Products**

Prior authorization is required for short-acting oral fentanyl products. 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®, Fentora®, and Onsolis™ are indicated only for the management of breakthrough cancer pain in patients with malignancies who are already receiving and tolerant to opioid therapy for their underlying persistent cancer pain.

Actiq®, Fentora®, and Onsolis™ are 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 these products for patients who are not opioid-tolerant.

Use form 470-4092, *Request for Prior Authorization: Fentanyl, Short Acting Oral Products*, to request prior authorization. Click [here](#) to see a sample of the form.

35. **Granulocyte Colony Stimulating Factor Agents**

Prior authorization is required for therapy with granulocyte colony stimulating factor agents.

Payment for **nonpreferred** 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 obtained as directed by the manufacturer's instructions.



Request for Prior Authorization
GROWTH HORMONES

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

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(s) and therapy failure with a preferred agent(s).

Preferred

- Genotropin, Norditropin, Genotropin MiniQuick, Omnitrope

Non- Preferred

- Humatrope, Saizen, Nutropin, Tev-Tropin, Nutropin AQ Pen, Zorbtive, Nutropin AQ NuSpin

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Previous Growth Hormone Therapy (include drug name(s), strength, and exact date ranges):

Number of vials per month: Estimate length of therapy:

Bone Age: Date of Bone Age Test: Epiphyses open? Yes No

Height: Weight: Height percentile at time of diagnosis: Weight percentile:

Is standard deviation 2.0 or more below mean height for chronological age or less than fifth percentile? Yes No

MRI diagnosis: Date:

Growth rate per year

Pertinent Medical History including growth pattern, diagnostic test, treatment plan, and response so far:

Please provide 2 stimuli tests and results:

Reason for use of Non-Preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only.



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:

- ◆ Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
- ◆ Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant.
- ◆ Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy.
- ◆ Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.

Use form 470-4099, *Request for Prior Authorization: Granulocyte Colony Stimulating Factor*, to request prior authorization. Click [here](#) to see a sample of the form.

36. Growth Hormones

Prior authorization is required for therapy with growth hormones. Payment for **nonpreferred** 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:

- ◆ Standard deviation of 2.0 or more below mean height for chronological age.
- ◆ No intracranial lesion or tumor diagnosed by MRI.
- ◆ Growth rate below five centimeters per year.
- ◆ Annual bone age testing is required for the diagnosis of growth hormone deficiency. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required.
- ◆ Epiphyses open.
- ◆ Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter.

Prior authorization will be granted for 12-month periods as needed.



Idiopathic short stature (ISS) is an FDA approved indication for growth hormone therapy but treatment is not considered medically necessary. Requests on this basis will be denied.

A request for Zorbtive[®] [somatropin (rDNA origin) for injection], will be approved 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.

Use form 470-4100, *Request for Prior Authorization: Growth Hormones*, to request prior authorization. Click [here](#) to see a sample of the form.

37. **Hepatitis C Protease Inhibitors-Oral (Incivek[™] and Victrelis[™])**

Prior authorization is required for all oral hepatitis C protease inhibitors. Payment will be considered under the following conditions:

- ◆ A diagnosis of hepatitis C genotype 1.
- ◆ Patient is 18 years of age or older.
- ◆ Administered in combination with peginterferon alfa and ribavirin.
- ◆ HCV-RNA results are required at treatment week four for telaprevir (Incivek[™]). Additional prior authorization will be considered with documentation of response to treatment, measured by HCV-RNA levels. A maximum of 12 weeks of therapy will be allowed for telaprevir (Incivek[™]).
- ◆ HCV-RNA results are required at treatment week 8, 12, and 24 (including lead in period) for boceprevir (Victrelis[™]). Additional prior authorizations will be considered with documentation of response to treatment, measured by HCV-RNA levels. Prior authorizations will be approved for a maximum of 24, 32, or 40 weeks of therapy with boceprevir (Victrelis[™]) based on response.

Use form 470-5066, *Request for Prior Authorization: Hepatitis C Protease Inhibitors*, to request prior authorization. Click [here](#) to see a sample of the form.



Request for Prior Authorization
INCRETIN MIMETIC

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for incretin mimetics. Payment will be considered under the following conditions: 1) Diagnosis of Type 2 diabetes mellitus, 2) Unless otherwise contraindicated, the patient has not achieved HbgA1C goals using a combination of two or more antidiabetic medications (metformin, sulfonylurea, or thiazolidinedione) at maximum therapeutic doses.

Preferred

Byetta

Non-Preferred

Bydureon

Victoza

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

Trial Drug #1 Name/Dose:

Trial start date: Trial end date:

Reason for Failure:

Trial Drug #2 Name/Dose:

Trial start date: Trial end date:

Reason for Failure:

Most recent HgbA1C Level: Date this level was obtained:

Other relevant information:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.



38. Immunomodulators – Topical

Prior authorization is required for topical immunomodulators. When there is an adequate trial and therapy failure with two preferred topical corticosteroids, payment will be considered:

- ◆ For pimecrolimus (Elidel[®]) or tacrolimus (Protopic[®]) 0.03% for non-immunocompromised patients two years of age and older; and
- ◆ For tacrolimus (Protopic[®]) 0.1% for patients 16 years of age and older

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

Use form 470-5040, *Request for Prior Authorization: Immunomodulators – Topical*, to request prior authorization. Click [here](#) to see a sample of the form.

If criteria for coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 grams or 100 grams for all other areas.

39. Incretin Mimetic (Byetta[®] and Victoza[®])

Prior authorization is required for incretin mimetics (Byetta[®] and Victoza[®]). Payment will be considered under the following conditions:

- ◆ The member has a diagnosis of type 2 diabetes mellitus.
- ◆ The member has not achieved glycemic goals using a combination of two or more antidiabetic medications (metformin, sulfonylurea, or thiazolidinedione) at maximum tolerated doses unless otherwise contraindicated.

An initial authorization will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in glycemic control since the initial prior authorization.

Use form 470-4407, *Request for Prior Authorization: Incretin Mimetic (Byetta[®] and Victoza[®])*, to request prior authorization. Click [here](#) to see a sample of the form.



40. Insulin Pens, Pre-filled

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 the member cannot accurately draw up the insulin, and
- ◆ There is no caregiver available to provide assistance.
- ◆ Patient does not reside in a long-term care facility.

Prior authorization for **nonpreferred** insulin pens will be granted only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

Use form 470-4111, *Request for Prior Authorization: Insulin, Pre-Filled Pens*, to request prior authorization. Click [here](#) to see a sample of the form.

41. Isotretinoin (Oral)

Prior authorization is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne under the following conditions:

- ◆ There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Trials and failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata.
- ◆ Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (<https://www.ipledgeprogram.com/>) risk management program.

Payment for nonpreferred oral isotretinoin products will be authorized only for cases in which there is documentation of trials and therapy failure with a preferred agent. Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

Use form 470-4101, *Request for Prior Authorization: Isotretinoin (Oral)*, to request prior authorization. Click [here](#) to see a sample of the form.



Request for Prior Authorization
INSULIN, PRE-FILLED PENS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for pre-filled insulin pens. Prior authorization is granted when documentation indicates: 1) The patient's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin, and 2) There is no caregiver available to provide assistance, and 3) Patient does not reside in a long-term care facility.

Preferred

- Lantus SoloSTAR
Levemir Flexpen
Novolog Flexpen
Novolog PenFill
NovoLog Mix 70/30 Cartridge
NovoLog Mix 70/30

Non-Preferred

- Apidra SoloSTAR
Humalog KWP
Humalog Mix 75/25 Pen
Humalog Mix 50/50 Pen
Humulin N Pen
Humulin R Pen
Humulin 70/30 Pen

Number of Units

How Often

Number of Cartridges/Pens/PenFills (circle requested item)

Diagnosis:

What visual or physical conditions limit the patient's ability to prepare their own syringes?

Does the patient lack capable assistance residing with them? Yes No

Does the patient reside in a long-term care facility? Yes No

Other medical conditions to consider:

Reason for use of Non-Preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.



Request for Prior Authorization
JANUS KINASE (JAK) INHIBITORS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for Janus kinase (JAK) 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.
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 the manufacturer labeling; and
8) Patient does not have a history of malignancy, except 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 use of these agents would be medically contraindicated.

Non-Preferred

Xeljanz

Diagnosis: _____

Strength _____ Dosage Instructions _____ Quantity _____ Days Supply _____

Trial Information:

Methotrexate trial: Dose: _____ Trial dates: _____

Failure reason: _____

Plus preferred oral DMARD trial: Drug Name & Dose: _____ Trial dates: _____

Failure reason: _____

Preferred Biological DMARD Trial #1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Preferred Biological DMARD Trial #2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

**Request for Prior Authorization
JANUS KINASE (JAK) INHIBITORS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Will tofacitinib be used in combination with biologic DMARDs or potent immunosuppressants?

Yes No

Screening for Latent TB infection: Date: _____ Results: _____

Will patient be monitored for active tuberculosis during treatment? Yes No

Does patient have a history of malignancy, except successfully treated non-melanoma skin cancer (NMSC)? Yes No

Does patient have an increased risk of gastrointestinal perforation? Yes No

Recommended laboratory monitoring will be conducted according to manufacturer labeling (lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids)?

Yes No Date of most recent labs: _____

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



42. Ivacaftor (Kalydeco™)

Prior authorization is required for Kalydeco™ (Ivacaftor). Payment will be considered for patients when the following criteria are met:

- ◆ Patient is six years of age or older; and
- ◆ Has a diagnosis of cystic fibrosis with a G551D mutation in the CFTR gene as detected by an FDA-cleared cystic fibrosis mutation test; and
- ◆ Prescriber is a cystic fibrosis specialist or pulmonologist; and
- ◆ Patient does not have one of the following infections: *Burkholderia cenecepacia*, *dolosa*, or *Mycobacterium abcessus*.

Use form 470-5117, *Request for Prior Authorization: Ivacaftor (Kalydeco™)*, to request prior authorization. Click [here](#) to see a sample of the form.

43. Janus Kinase Inhibitors

Prior authorization is required for Janus kinase inhibitors. Payment will be considered when the following conditions are met:

- ◆ Patient is 18 years of age or older; and
- ◆ Has a diagnosis of moderate to severe rheumatoid arthritis; and
- ◆ 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
- ◆ Has a documented trial and inadequate response to two preferred biological DMARDs; and
- ◆ The patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and
- ◆ Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and
- ◆ Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to manufacturer labeling; and



- ◆ Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and
- ◆ 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.

Use form 470-5175, *Request for Prior Authorization: Janus Kinase Inhibitors*, to request prior authorization. Click [here](#) to see a sample of the form.

44. **Ketorolac Tromethamine (Toradol®)**

Prior authorization is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short-term management of moderately severe, acute pain (up to five days). It is **not** indicated for minor or chronic conditions. This product carries a Black Box Warning.

Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five days. Payment will be approved for the preferred product under the following conditions:

- ◆ For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given.
- ◆ Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40 mg/day. Maximum IV/IM dose is 120 mg/day. Maximum intranasal dose is 126 mg/day. Maximum duration of therapy is 5 days per month.
- ◆ Diagnosis indicating moderately severe, acute pain.

Requests for IV/IM and intranasal ketorolac must document previous trials and therapy failures with at least two preferred nonsteroidal anti-inflammatory drugs at therapeutic doses.

Use form 470-4102, *Request for Prior Authorization: Ketorolac Tromethamine (Toradol®)*, to request prior authorization. Click [here](#) to see a sample of the form.



45. Lidocaine Patch (Lidoderm®)

Prior authorization is required for topical lidocaine patches (Lidoderm®). Payment will be considered for a diagnosis of pain associated with post-herpetic neuralgia following a previous treatment failure with a preferred agent at therapeutic dose from two of the following: tricyclic antidepressant, opioid, gabapentin, carbamazepine, or valproic acid.

A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.

Use form 470-4898, *Request for Prior Authorization: Lidocaine Patch (Lidoderm®)*, to request prior authorization. Click [here](#) to see a sample of the form.

46. Linezolid (Zyvox®)

Prior authorization is required for linezolid (Zyvox®). Payment for Zyvox® will be authorized when there is documentation that:

- ◆ The prescriber is an infectious disease physician or has consulted an infectious disease physician. (Telephone consultation is acceptable.)
- ◆ The member has an active infection that meets one of the following diagnostic criteria:

Vancomycin-resistant enterococcus (VRE) when no alternative regimens with documented efficacy are available and VRE is not in lower urinary tract.

VRE in the lower urinary tract if severe renal insufficiency exists or the patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.

Methicillin-resistant staphylococcus aureus (MRSA) when the patient is intolerant to vancomycin.*

Methicillin-resistant staphylococcus epidermis (MRSE) when the 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 countermeasures (e.g., prolonged IV infusion, premedicated with diphenhydramine).



Use form 470-4275, *Request for Prior Authorization: Linezolid (Zyvox®)*, to request prior authorization. Click [here](#) to see a sample of the form.

47. Long Acting Narcotics

Prior authorization is required for all non-preferred long-acting narcotics. Payment will be considered under the following conditions:

- ◆ There is documentation of previous trials and therapy failures with two chemically distinct preferred long-acting narcotics (such as morphine sulfate ER, Opana ER, and methadone) at therapeutic doses, and
- ◆ A trial and therapy failure with fentanyl patch at maximum tolerated dose, and
- ◆ A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization.
- ◆ 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 the prior authorization.
- ◆ 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 use of these agents would be medically contraindicated.

Use form 470-4409, *Request for Prior Authorization: Long-Acting Narcotics*, to request prior authorization. Click [here](#) to see a sample of the form.

48. Mifepristone (Korlym®)

Prior authorization is required for mifepristone (Korlym®). Payment will be considered for patients when the following is met:

- ◆ The patient is 18 years of age or older; and
- ◆ Has a diagnosis of endogenous Cushing's Syndrome with hyperglycemia secondary to hypercortisolism in patients with Type 2 Diabetes or glucose intolerance; and
- ◆ Patient must have failure surgery or is not a candidate for surgery; and



Request for Prior Authorization
LONG-ACTING NARCOTICS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

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 failures with two (2) chemically distinct preferred long-acting narcotics...

Drug Name: _____ Strength: _____

Dosage Instructions: _____ Quantity: _____ Days Supply: _____

Diagnosis: _____

Document 2 chemically distinct preferred long-acting narcotic treatment failure(s) including drug names, strength, exact date ranges and failure reasons:

Preferred Long-Acting Narcotic Trial #1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Preferred Long-Acting Narcotic Trial #2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

*Please refer to the methadone dosing guidelines located at www.iadur.org under the Report Archive tab.

Trial of fentanyl patch: Dose: _____ Trial Dates: _____ Failure Reason: _____

Medical or contraindication reason to override trial requirements: _____

Prescriber review of patient's controlled substances use on the Iowa PMP website: [] No [] Yes Date Reviewed: _____

Attach signed chronic opioid therapy management plan between the prescriber and patient.

Form with fields for Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.



Request for Prior Authorization
MODIFIED FORMULATIONS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Payment for a non-preferred isomer, prodrug or metabolite will be considered when the following criteria are met: 1) Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2) Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available.

- Checkboxes for Aplenzin, Invega, Pristiq / Desvenlafaxine, Trilipix, Xopenex Nebs, Xopenex HFA.

Payment for a non-preferred alternative delivery system will only be considered for cases in which the use of an alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available.

- Checkboxes for Abilify Discmelt, Aricept ODT, Binosto, Fazaclo, Metozolv ODT, Remeron SolTab, Risperdal M-Tab, Zyprexa Zydis.

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Trial with parent drug product: Drug Name & Dose : Trial dates:

Failure Reason:

Trial with drug of a different chemical entity: Drug Name & Dose: Trial dates:

Failure Reason:

Medical Necessity for alternative delivery system:

Failure Reason of preferred alternative delivery system:

Medical or contraindication reason to override trial requirements:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.



Request for Prior Authorization
MULTIPLE SCLEROSIS AGENTS-ORAL

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Prior authorization is required for fingolimod (Gilenya™), teriflunomide (Aubagio®), or dimethyl fumarate (Tecfidera™). Payment will be considered for patients 18 years of age or older under the following conditions: 1) A diagnosis of relapsing forms of multiple sclerosis, and 2) A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis. The required trial may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

- Checkboxes for Aubagio®, Gilenya™, and Tecfidera™.

Strength Dosage Instructions Quantity Days Supply

Diagnosis: _____

Treatment failure with interferon or non-interferon:

Trial Drug Name & Dose: _____ Trial Dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies: _____

For patients initiating therapy with fingolimod (Gilenya™), please document the following:

- Patient has a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure: [] Yes [] No
• Patient has a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome: [] Yes [] No If yes, patient has a pacemaker: [] Yes [] No
• Patient has a baseline QTc interval ≥ 500ms: [] Yes [] No
• Patient is being treated with Class Ia or Class III anti-arrhythmic drugs: [] Yes [] No

**Request for Prior Authorization
MULTIPLE SCLEROSIS AGENTS-ORAL**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

For patients initiating therapy with teriflunomide (Aubagio®), please document the following:

- Patient has severe hepatic impairment: Yes No
- Patient has a negative pregnancy test if female of childbearing age: Yes No
If yes, provide date of pregnancy test: _____
- If female of childbearing age, specify plan for contraception: _____
- Patient is taking leflunomide: Yes No

For patients initiating therapy with dimethyl fumarate (Tecfidera™), please document the following:

- Patient has a low lymphocyte count documented by a recent (within 6 months) CBC:
 Yes No Lab Date: _____
- For renewal, documentation of an updated CBC: Lab date: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
--	--------------------

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



- ◆ Prescriber is an endocrinologist.
- ◆ Female patients of reproductive age must have a negative pregnancy test confirmed within the last seven days and must use a non-hormonal method of contraception during treatment and for one month after stopping treatment.

Use form 470-5141, *Request for Prior Authorization: Mifepristone (Korlym®)*, to request prior authorization. Click [here](#) to see a sample of the form.

49. Modified Formulations

Payment for a nonpreferred isomer, pro-drug, or metabolite will be considered when the following criteria are met:

- ◆ Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and
- ◆ Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available.

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

Payment for a nonpreferred alternative delivery system will be considered only for cases in which the use of an alternative delivery system is deemed medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available.

Use form 470-4705, *Request for Prior Authorization: Modified Formulations*, to request prior authorization. Click [here](#) to see a sample of the form.

50. Multiple Sclerosis-Oral Agents

Prior authorization is required for fingolimod (Gilenya™), teriflunomide (Aubagio®), or dimethyl fumarate (Tecfidera™). Payment will be considered for patients 18 years of age or older under the following conditions:

- ◆ A diagnosis of relapsing forms of multiple sclerosis; and
- ◆ A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis.

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



For patients initiating therapy with fingolimod (Gilenya™), documentation of the following must be provided:

- ◆ Patient does not have a recent (within past six months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure.
- ◆ Patient does not have a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless the patient has a pacemaker.
- ◆ Patient does not have a baseline QTc interval ≥ 500 ms.
- ◆ Patient is not being treated with Class Ia or Class III anti-arrhythmic drugs.

For patients initiating therapy with teriflunomide (Aubagio®), documentation of the following must be provided:

- ◆ Patient does not have severe hepatic impairment.
- ◆ A negative pregnancy test for females of childbearing age.
- ◆ Use of a reliable form of contraception for females of childbearing age.
- ◆ Patient is not taking leflunomide.

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

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

Use form 470-5060, *Request for Prior Authorization: Multiple Sclerosis Agents-Oral*, to request prior authorization. Click [here](#) to see a sample of the form.

51. Muscle Relaxants

Prior authorization is required for nonpreferred muscle relaxants. Payment for **nonpreferred** muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failure with at least three preferred muscle relaxants.

Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum of 4 tablets per day when the criteria for coverage are met.



If a nonpreferred long-acting medication is requested, one trial must include the preferred immediate-release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.

Use form 470-4105, *Request for Prior Authorization: Muscle Relaxants*, to request prior authorization. Click [here](#) to see a sample of the form.

52. Narcotic Agonist-Antagonist Nasal Sprays

Prior authorization is required for narcotic agonist-antagonist nasal sprays. The member's diagnosis must be supplied for consideration.

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 nonpreferred 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.

Use form 470-4106, *Request for Prior Authorization: Narcotic Agonist/Antagonist Nasal Sprays*, to request prior authorization. Click [here](#) to see a sample of the form.

53. 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.



Use form 470-5099, *Request for Prior Authorization: Nebivolol (Bystolic®)*, to request prior authorization. Click [here](#) to see a sample of the form.

54. Nicotine Replacement Products

Prior authorization is required for over-the-counter nicotine replacement patches, gum or lozenges, and prescription nicotine nasal spray or inhaler. Requests for authorization must include:

- ◆ Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
- ◆ Confirmation of enrollment in the Quitline Iowa counseling program is required for approval. Continuation therapy is available only with documentation of ongoing participation in the Quitline Iowa program.
- ◆ Approvals will be granted only for patients 18 years of age and older.
- ◆ The maximum allowed duration of therapy is 12 weeks total combined therapy within a 12-month period.
- ◆ Patients may receive nicotine replacement patches in combination with an oral nicotine replacement product (gum or lozenges).
- ◆ A maximum quantity of 14 nicotine replacement patches and 110 pieces of nicotine gum or 144 nicotine lozenges may be dispensed with the initial prescription. Subsequent prescription refills will be allowed for a four-week supply at one unit per day of nicotine replacement patches and 330 pieces of nicotine gum or 288 nicotine lozenges.
- ◆ Requests for nonpreferred nicotine replacement products will be considered after documentation of previous trials and intolerance with a preferred oral and preferred topical nicotine replacement product. A maximum quantity of 168 nicotine inhalers or 40ml nicotine nasal spray may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a four-week supply at 336 nicotine inhalers or 80ml of nicotine nasal spray.
- ◆ The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation.

Use form 470-4421, *Request for Prior Authorization: Nicotine Replacement Therapy*, to request prior authorization. Click [here](#) to see a sample of the form.



55. Nonparenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products

Prior authorization is required for nonparenteral vasopressin derivatives of posterior pituitary hormone products. Payment for nonparenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses:

- ◆ Diabetes insipidus
- ◆ Hemophilia A
- ◆ Von Willebrand's Disease

Payment for oral 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 **nonpreferred** nonparenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial and therapy failure with a preferred agent.

Use form 470-4107, *Request for Prior Authorization: Nonparenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products*, to request prior authorization. Click [here](#) to see a sample of the form.

56. Nonpreferred Drugs

Prior authorization is required for nonpreferred drugs as specified on the Iowa Medicaid [Preferred Drug List](#).

Payment for a nonpreferred medication will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents is medically contraindicated.

Use form 470-4108, *Request for Prior Authorization: Non-Preferred Drug*, to request prior authorization. Click [here](#) to see a sample of the form.



57. Nonsteroidal Anti-Inflammatory Drugs

Prior authorization is required for all nonpreferred nonsteroidal anti-inflammatory drugs (NSAIDs) and COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs or COX-2 inhibitors.

- ◆ Requests for a nonpreferred NSAID must document previous trials and therapy failures with at least three preferred NSAIDs.
- ◆ Requests for a nonpreferred COX-2 inhibitor must document previous trials and therapy failures with three preferred NSAIDs, two of which must be a preferred COX-2 preferentially selective NSAID.
- ◆ Requests for a nonpreferred topical NSAID must document previous trials and therapy failures with three preferred NSAIDs. The trials must include two preferred COX-2 preferentially selective NSAIDs and the oral drug of the same chemical entity. In addition, the use of a topical delivery system must be deemed medically necessary.
- ◆ Requests for a nonpreferred extended release NSAID must document previous trials and therapy failures with three preferred NSAIDs, one of which must be the preferred.

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

Use form 470-4109, *Request for Prior Authorization: Nonsteroidal Anti-Inflammatory Drugs*, to request prior authorization. Click [here](#) to see a sample of the form.

58. Omalizumab (Xolair®)

Prior authorization is required for omalizumab (Xolair®). Payment for Xolair® will be authorized when the following criteria are met:

- ◆ Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and
- ◆ Patient is 12 years of age or older; and
- ◆ Pretreatment IgE level is between 30 IU/ml and 700 IU/ml; and
- ◆ Patient's weight is between 30 kg and 150 kg; and
- ◆ History of a positive skin or RAST test to a perennial aeroallergen; and
- ◆ Prescriber is an allergist, immunologist, or pulmonologist; and



Request for Prior Authorization
ORAL CONSTIPATION AGENTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

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:
- saline laxative (milk of magnesia),
- osmotic laxative (polyethylene glycol or lactulose), and
- stimulant laxative (senna); and
3) Patient does not have a known or suspected mechanical gastrointestinal obstruction.

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

Non-Preferred

[] Amitiza [] Linzess

Strength Dosage Instructions Quantity Days Supply

Treatment failures:

Saline Laxative (milk of magnesia) Trial: Name/Dose: Trial Dates:

Failure reason:

Osmotic Laxative (polyethylene glycol / lactulose) Trial: Name/Dose:

Trial Dates: Failure reason:

Stimulant Laxative (senna) Trial: Name/Dose: Trial Dates:

Failure reason:

Does patient have a known or suspected mechanical gastrointestinal obstruction: [] Yes [] No

**Request for Prior Authorization
ORAL CONSTIPATION AGENTS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

- Chronic Idiopathic Constipation:** (Amitiza or Linzess)
 - Patient has less than 3 spontaneous bowel movements (SBMs) per week:
 Yes No
 - Patient has two or more of the following symptoms within the last 3 months:
 - Straining during at least 25% of the bowel movements
 - Lumpy or hard stools for at least 25% of bowel movements
 - Sensation of incomplete evacuation for at least 25% of bowel movements
 - Documentation the patient is not currently taking constipation causing therapies:
Medication review completed: Yes No
Current constipation causing therapies:
 Yes (please list) _____ No

- Irritable Bowel Syndrome with Constipation:** (Amitiza or Linzess)
 - Patient is female (Amitiza requests only): Yes No
 - Patient has abdominal pain or discomfort at least 3 days per month in the last 3 months associated with two (2) or more of the following:
 - Improvement with defecation
 - Onset associated with a change in stool frequency
 - Onset associated with a change in stool form

- Opioid-Induced Constipation with chronic, non-cancer pain:** (Amitiza)
 - Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims: Yes No
 - Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
 - Hard to very hard stool consistency
 - Moderate to very severe straining
 - Sensation of incomplete evacuation

- Other Diagnosis:** _____

- Renewal Requests:** Provide documentation of adequate response to treatment:

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
--	--------------------

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



- ◆ Patient is currently using a high dose inhaled corticosteroid and long-acting beta-agonist, is compliant with therapy and asthma symptoms are not adequately controlled after at least three months of therapy.
- ◆ Patient must have access to an EpiPen to treat allergic reactions that may occur after administration of Xolair®.

If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to Xolair® therapy and for patients who do not continue concurrent use with a high dose inhaled corticosteroid and long-acting beta-agonist.

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

Use form 470-4279, *Request for Prior Authorization: Omalizumab (Xolair®)*, to request prior authorization. Click [here](#) to see a sample of the form.

59. Oral Constipation Agents (Lubiprostone and Linaclotide)

Prior authorization is required for lubiprostone (Amitiza®) and linaclotide (Linzess™). Payment will be considered under the following conditions:

- ◆ Patient is 18 years of age or older; and
- ◆ Patient must have documentation of adequate trials and therapy failures with at least one medication from each of the following categories:
 - Saline laxative (milk of magnesia); and
 - Osmotic laxative (polyethylene glycol or lactulose); and
 - Stimulant laxative (senna); and
- ◆ Patient does not have a known or suspected mechanical gastrointestinal obstruction; and
- ◆ Patient has one of the following diagnoses:
 - A diagnosis of chronic idiopathic constipation (Amitiza® or Linzess™).
 - Patient has less than three spontaneous bowel movements (SBMs) per week; and



- Patient has two or more of the following symptoms within the last three months:
 - Straining during at least 25% of the bowel movements;
 - Lumpy or hard stools for at least 25% of bowel movements; and/or
 - Sensation of incomplete evacuation for at least 25% of bowel movements; and
- Documentation the patient is not currently taking constipation causing therapies.

A diagnosis of irritable bowel syndrome with constipation (Amitiza[®] or Linzess[™]).

- Patient is female (Amitiza[®] only); and
- Patient has abdominal pain or discomfort at least three days per month in last three months associated with two or more of the following:
 - Improvement with defecation;
 - Onset associated with a change in stool frequency; and/or
 - Onset associated with a change in stool form.

A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza[®]).

- Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and
- Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
 - Hard to very hard stool consistency;
 - Moderate to very severe straining; and/or
 - 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.

Use form 470-5174, *Request for Prior Authorization: Oral Constipation Agents*, to request prior authorization. Click [here](#) to see a sample of the form.



60. Palivizumab (Synagis®)

Respiratory Syncytial Virus (RSV) season is defined by the centers for disease control and prevention of the United States Department of Health and Human Services and described in the RSV surveillance reports published annually in the Morbidity and Mortality Weekly Report (MMWR) and available at <http://www.cdc.gov/surveillance/nrevss/rsv/reports.html>.

- ◆ Medicaid will use virology data provided by the Iowa Department of Public Health (IDPH) to prospectively estimate the start of the RSV season and follow the virology data to the end of the season.
- ◆ Medicaid will provide coverage of prescription drugs that protect against RSV consistent with the American Academy of Pediatrics (AAP) Guidelines for Infants and Children at Risk for Severe Illness due to RSV Infection.
- ◆ The start date will begin two weeks before the expected season start date for the state of Iowa. The start date will be adjusted to an earlier date by Medicaid if indicated by the virological data. The expected season start date shall be derived from the median start date of the past five seasons using Iowa virological data.

Prior authorization is required for therapy with palivizumab. Prior authorizations will be approved for a maximum of five doses per patient. No allowances will be made for a sixth dose. Payment for palivizumab will be considered for patients who meet one of the following criteria:

- ◆ Chronic lung disease (CLD):

The patient is less than 24 months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia) requiring medication (bronchodilator, corticosteroid, or diuretic therapy) or oxygen within six months before the anticipated start of RSV season.

- ◆ Prematurity:

The patient is less than 12 months of age at start of therapy with a gestational age of less than 29 weeks.

The patient is less than 6 months of age at start of therapy with a gestational age between 29 weeks through 31 weeks.

The patient is less than 3 months of age at start of therapy or born during the RSV season with a gestational age of 32 weeks through 34 weeks and has one of two risk factors. Risk factors include: day care attendance or siblings less than five years of age in household. Doses will be limited to a maximum of 3 doses or until patient reaches 90 days of age, whichever comes first.



- ◆ Severe neuromuscular disease or congenital abnormalities:
Patient is 12 months of age or younger at the start of therapy and has either severe neuromuscular disease or congenital abnormalities of the airway that compromises handling of respiratory secretions.
- ◆ Congenital heart disease (CHD):
The patient is less than 24 months of age at start of therapy and has hemodynamically significant congenital heart disease further defined by any of the following:
 - Receiving medication to control congestive heart failure,
 - Moderate to severe pulmonary hypertension, or
 - Cyanotic congenital heart disease.
- ◆ Severe immunodeficiency:
The patient is less than 24 months of age at start of therapy and has severe immunodeficiencies (e.g., severe combined immunodeficiency or advanced acquired immunodeficiency syndrome).

Use form 470-4110, *Request for Prior Authorization: Palivizumab (Synagis®)*, to request prior authorization. Click [here](#) to see a sample of the form.

61. Proton Pump Inhibitors

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 beginning the first day of therapy for all **nonpreferred** proton pump inhibitors as indicated on the Iowa Medicaid [Preferred Drug List](#). Payment for a nonpreferred proton pump inhibitor will be authorized only for cases with documentation of previous trial and therapy failure with three preferred products.

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.



Request for Prior Authorization
PROTON PUMP INHIBITORS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is not required for the preferred proton pump inhibitors (PPI) for a cumulative 60-days of therapy per 12-months. Prior authorization will be required for all non-preferred medications beginning the first day of therapy.

Preferred (PA required after 60 days)

- Options for preferred PPIs: Dexilant, Omeprazole Caps (RX), Pantoprazole

Non-Preferred (PA required from Day 1)

- Options for non-preferred PPIs: Aciphex, Nexium, Prilosec (RX), Esomeprazole, Omeprazole/Sodium Bicarb (RX), Protonix, Lansoprazole, Prevacid, Vimovo

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

- Diagnosis options: Barrett's esophagus, Erosive esophagitis, Hypersecretory conditions, Recurrent peptic ulcer disease, Symptomatic gastroesophageal reflux, Other

Trial Medication: Trial Date From: To:

Medical or contraindication reason to override trial requirements:

Scope Performed? No Yes If yes, date of scope:

Reason for use of Non-Preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

Prescriber Signature: Date of Submission:

*MUST MATCH PRESCRIBER LISTED ABOVE

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only.



Request for Prior Authorization
PULMONARY ARTERIAL HYPERTENSION AGENTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for agents used to treat pulmonary hypertension.

Preferred

Non-Preferred

- Epoprostenol, Letairis, Sildenafil, Tracleer, Ventavis, Adcirca, Flolan, Revatio, Tyvaso, Veletri

Strength, Dosage Instructions, Quantity, Days Supply

Diagnosis:

- Pulmonary arterial hypertension, Other (please specify)

Reason for use of Non-Preferred drug requiring prior approval:

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only.



Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of:

- ◆ Specific hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas).
- ◆ Barrett's esophagus.
- ◆ Erosive esophagitis.
- ◆ Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least one histamine H₂-receptor antagonist at full therapeutic doses.

Requests for PPIs exceeding one unit per day will be considered after documentation of a therapeutic trial and therapy failure with concomitant use of once daily PPI dosing and a bedtime dose of a histamine H₂-receptor antagonist. Upon failure of the combination therapy, subsequent requests for PPIs exceeding one unit per day will be considered on a short term basis (up to three months).

After the three-month period, a retrial of the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day.

- ◆ 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**

Either failure of Helicobacter pylori treatment or a negative Helicobacter pylori test result.

Use form 470-4112, *Request for Prior Authorization: Proton Pump Inhibitors*, to request prior authorization. Click [here](#) to see a sample of the form.

62. Pulmonary Arterial Hypertension Agents

Prior authorization is required for agents used to treat pulmonary hypertension. Payment will be approved for the diagnosis of pulmonary arterial hypertension.

Use form 470-4327, *Request for Prior Authorization: Pulmonary Arterial Hypertension Agents*, to request prior authorization. Click [here](#) to see a sample of the form.

 Iowa Department of Human Services	Provider and Chapter	Page
	Prescribed Drugs Chapter III. Provider-Specific Policies	60b
		Date
		February 1, 2014

63. Quantity Limit Override

a. Initial 15-Day Limit

Drugs that have been identified with high side effect profiles, high discontinuations rates, or frequent dose adjustments are limited to a 15-day initial supply. The initial prescription supply limit ensures cost effectiveness without waste of unused medications.

These drugs are identified on the Fifteen Day Initial Prescription Supply Limit list located on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab and the Billing/Quantity Limits tab.

To request authorization for an initial supply longer than 15 days, submit form 470-5038, *Request for Fifteen Day Initial Prescription Supply Override*, for consideration. Click [here](#) for a sample of the form. The form is located at www.iowamedicaidpdl.com under PA Forms. Documentation of medical necessity, excluding patient convenience, is required for consideration of the 15-day initial supply override.

b. Monthly Limits

Designated drugs have specific quantity limitations. These drugs are identified on the Iowa Medicaid Quantity Limit Chart posted on the website www.iowamedicaidpdl.com under the Billing/Quantity Limits tab.

Medication doses that use multiple, lower-strength tablets should be consolidated to the higher-strength tablet. Quantity limits based on the compendia are also enforced. Please view the current list at www.iowamedicaidpdl.com under Quantity Limits.

Prior authorization is required if there is a reason the higher tablet strength cannot be used or a medical rationale for use of higher than recommended dosing.

Providers should submit a Prior Authorization request for override consideration. Use form 470-4556, *Request for Prior Authorization: Request for Quantity Limit Override*, to request prior authorization. Click [here](#) to see a sample of the form. The form is located at www.iowamedicaidpdl.com under PA Forms.



Drug Product	Quantity	Days' Supply	Comments
Adderall XR 10 mg (amphetamine combo)	30	30	
Adderall XR 15 mg (amphetamine combo)	30	30	
Adderall XR 20 mg (amphetamine ER)	60	30	
Adderall XR 25 mg (amphetamine ER)	60	30	
Adderall XR 30 mg (amphetamine ER)	60	30	
Advair 100/50 diskus (fluticasone/salmeterol)	60	30	
Advair 250/50 diskus (fluticasone/salmeterol)	60	30	
Advair 500/50 diskus (fluticasone/salmeterol)	60	30	
Advair HFA (fluticasone/salmeterol)	1 inhaler (12 gm)	30	
Aerobid (flunisolide)	21	30	
Aerobid-M (flunisolide)	21	30	
Afinitor 2.5 mg (everolimus)	30	30	
Afinitor 5 mg (everolimus)	30	30	
Afinitor 7.5 mg (everolimus)	30	30	
Afinitor 10 mg (everolimus)	30	30	
Aldara (imiquimod)	12 pkts	28	Max 48 pkts/16 weeks
Allegra 30 mg (fexofenadine)	60	30	
Allegra 60 mg (fexofenadine)	60	30	
Allegra 180 mg (fexofenadine)	30	30	
Alora (estradiol)	8	28	
Alphagan P (brimonidine tartrate)	15 ml	30	
Alprazolam intensol 1 mg/ml (alprazolam)	180 ml	30	
Altace 1.25 mg (ramipril)	30	30	
Altace 2.5 mg (ramipril)	30	30	
Altace 5 mg (ramipril)	30	30	
Altace 10 mg (ramipril)	60	30	
Amaryl 1 mg (glimepiride)	30	30	
Amaryl 2 mg (glimepiride)	30	30	
Amaryl 4 mg (glimepiride)	60	30	
Ambien 5 mg (zolpidem)	30	30	
Ambien 10 mg (zolpidem)	30	30	
Ambien CR 6.25 mg (zolpidem)	30	30	
Ambien CR 12.5 mg (zolpidem)	30	30	



Drug Product	Quantity	Days' Supply	Comments
Focalin XR 25 mg (dexmethylphenidate)	60	30	
Focalin XR 30 mg (dexmethylphenidate)	60	30	
Focalin XR 35 mg (dexmethylphenidate)	30	30	
Focalin XR 40 mg (dexmethylphenidate)	30	30	
Foradil aerolizer (formoterol)	60	30	
Fosamax 5 mg (alendronate)	30	30	
Fosamax 10 mg (alendronate)	30	30	
Fosamax 40 mg(alendronate)	30	30	
Fosamax 70 mg (alendronate)	4	30	
Geodon 20 mg (ziprasidone)	60	30	
Geodon 40 mg (ziprasidone)	60	30	
Geodon 60 mg (ziprasidone)	60	30	
Geodon 80 mg (ziprasidone)	60	30	
Glucagen emergency kit (glucagon)	5	30	
Glucagon emergency kit	5	30	
Glucotrol XL 2.5 mg (glipizide er)	30	30	
Glucotrol XL 5 mg (glipizide er)	30	30	
Glucotrol XL 10 mg (glipizide er)	60	30	
Haldol decanoate 50 mg/ml-1 ml vial (haloperidol decanoate)	1 ml	30	
Haldol decanoate 50 mg/ml-5 ml vial (haloperidol decanoate)	10 ml	30	
Haldol decanoate 100 mg/ml-1 ml vial (haloperidol decanoate)	1 ml	30	
Haldol decanoate 100 mg/ml-5 ml vial (haloperidol decanoate)	5 ml	30	
Hycet solution (hydrocodone/acetaminophen)	3600 ml	30	
Hytrin 1 mg (terazosin)	30	30	
Hytrin 2 mg (terazosin)	60	30	
Hytrin 5 mg (terazosin)	30	30	
Hytrin 10 mg (terazosin)	60	30	
Hyzaar 50-12.5 mg (HCTZ/losartan)	30	30	
Hyzaar 100-12.5 mg (HCTZ/losartan)	30	30	
Hyzaar 100-25 mg (HCTZ/losartan)	30	30	
Innopran XL 80 mg (propranolol ER)	30	30	
Intal inhaler (cromolyn sodium)	3 inhalers (42.6 gm)	30	



Drug Product	Quantity	Days' Supply	Comments
Intuniv 1 mg (guanfacine ER)	30	30	
Intuniv 2 mg (guanfacine ER)	30	30	
Intuniv 3 mg (guanfacine ER)	30	30	
Intuniv 4 mg (guanfacine ER)	30	30	
Invega 3 mg (paliperidone)	30	30	
Invega 6 mg (paliperidone)	60	30	
Invega 9 mg (paliperidone)	30	30	
Invega Sustenna 39 mg syringe (paliperidone palmitate)	1 syringe	30	
Invega Sustenna 78 mg syringe (paliperidone palmitate)	1 syringe	30	
Invega Sustenna 117 mg syringe (paliperidone palmitate)	1 syringe	30	
Invega Sustenna 156 mg syringe (paliperidone palmitate)	1 syringe	30	
Invega Sustenna 234 mg syringe (paliperidone palmitate)	1 syringe	30	
Kalydeco (ivacaftor)	60	30	
Korlym (mifepristone)	120	30	
Latuda 20 mg (lurasidone)	30	30	
Latuda 40 mg (lurasidone)	30	30	
Latuda 60 mg (lurasidone)	30	30	
Latuda 80 mg (lurasidone)	60	30	
Latuda 120 mg (lurasidone)	30	30	
Lescol 20 mg (fluvastatin)	30	30	
Lexapro 5 mg (escitalopram)	15	30	
Lexapro 10 mg (escitalopram)	15	30	
Lexapro 20 mg (escitalopram)	60	30	
Lidoderm patch (lidocaine)	90	30	Maximum of 30 patches allowed for initial fill
Lipitor 10 mg (atorvastatin)	30	30	
Lipitor 20 mg (atorvastatin)	30	30	
Lipitor 40 mg (atorvastatin)	45	30	
Liquicet (hydrocodone/acetaminophen)	2700 ml	30	
Lorazepam intensol 2 mg/ml (lorazepam)	150 ml	30	
Lorcet 10/650 mg (hydrocodone/acetaminophen)	180	30	
Lorcet Plus (hydrocodone/acetaminophen)	180	30	



Drug Product	Quantity	Days' Supply	Comments
Lortab elixir (hydrocodone/ acetaminophen)	2700 ml	30	
Lortab 5/500 mg (hydrocodone/ acetaminophen)	240	30	
Lortab 7.5/500 mg (hydrocodone/ acetaminophen)	180	30	
Lortab 10/500 mg (hydrocodone/ acetaminophen)	180	30	
Lunesta 1 mg (eszopiclone)	30	30	
Lunesta 2 mg (eszopiclone)	30	30	
Lunesta 3 mg (eszopiclone)	30	30	
Luvox 25 mg (fluvoxamine)	30	30	
Luvox 50 mg (fluvoxamine)	30	30	
Lyrica 25 mg (pregabalin)	90	30	
Lyrica 50 mg (pregabalin)	90	30	
Lyrica 75 mg (pregabalin)	90	30	
Lyrica 100 mg (pregabalin)	90	30	
Lyrica 150 mg (pregabalin)	90	30	
Lyrica 200 mg (pregabalin)	90	30	
Lyrica 225 mg (pregabalin)	60	30	
Lyrica 300 mg (pregabalin)	60	30	
Mavik 1 mg (trandolapril)	30	30	
Mavik 2 mg (trandolapril)	30	30	
Mavik 4 mg (trandolapril)	60	30	
Maxair autoinhaler 14 g (pirbuterol acetate)	2 inhalers (28 gm)	30	
Maxidone (hydrocodone/ acetaminophen)	150	30	
Metadate CD 10 mg (methylphenidate ER)	30	30	
Metadate CD 20 mg (methylphenidate ER)	30	30	
Metadate CD 30 mg (methylphenidate ER)	30	30	
Metadate CD 40 mg (methylphenidate ER)	30	30	
Metadate CD 50 mg (methylphenidate ER)	30	30	
Metadate CD 60 mg (methylphenidate ER)	30	30	
Metadate ER 10 mg (methylin ER)	90	30	
Metadate ER 20 mg (methylin ER)	90	30	



Drug Product	Quantity	Days' Supply	Comments
Norvasc 2.5 mg (amlodipine)	30	30	
Norvasc 5 mg (amlodipine)	30	30	
Nucynta 50 mg (tapentadol)	180	30	
Nucynta 75 mg (tapentadol)	180	30	
Nucynta 100 mg (tapentadol)	180	30	
Onfi 5 mg (clobazam)	60	30	
Onfi 10 mg (clobazam)	60	30	
Onfi 20 mg (clobazam)	60	30	
Opana ER 5 mg (oxymorphone)	60	30	
Opana ER 7.5 mg (oxymorphone)	60	30	
Opana ER 10 mg (oxymorphone)	60	30	
Opana ER 15 mg (oxymorphone)	60	30	
Opana ER 20 mg (oxymorphone)	60	30	
Opana ER 30 mg (oxymorphone)	60	30	
Panlor SS (acetaminophen- caffeine-dihydrocodeine)	150	30	
Paxil 10 mg (paroxetine)	30	30	
Paxil 20 mg (paroxetine)	30	30	
Paxil 30 mg (paroxetine)	30	30	
Paxil 40 mg (paroxetine)	45	30	
Paxil CR 12.5 mg (paroxetine ER)	30	30	
Paxil CR 25 mg (paroxetine ER)	60	30	
Paxil CR 37.5 mg (paroxetine ER)	60	30	
Pegasys kit (peginterferon alpha-2a)	1	28	
Pegasys syringe (peginterferon alpha-2a)	4 ml	28	
Percocet 5/325 mg (oxycodone/ acetaminophen)	360	30	
Percocet 7.5/325 mg (oxycodone/ acetaminophen)	240	30	
Percocet 7.5/500 mg (oxycodone/ acetaminophen)	240	30	
Percocet 10/325 mg (oxycodone/ acetaminophen)	180	30	
Percocet 10/650 mg (oxycodone/ acetaminophen)	180	30	
Pradaxa (dabigatran)	60	30	
Pravachol 10 mg (pravastatin)	30	30	
Pravachol 20 mg (pravastatin)	30	30	
Pravachol 40 mg (pravastatin)	30	30	
Pravachol 80 mg (pravastatin)	30	30	



Drug Product	Quantity	Days' Supply	Comments
Valium 2 mg (diazepam)	120	30	
Valium 5 mg (diazepam)	120	30	
Valium 10 mg (diazepam)	120	30	
Valturna 150-160 mg (aliskiren/ valsartan)	30	30	
Valturna 300-320 mg (aliskiren/ valsartan)	30	30	
Venlafaxine ER 37.5 mg tablet	30	30	
Venlafaxine ER 75 mg tablet	30	30	
Venlafaxine ER 150 mg tablet	60	30	
Venlafaxine ER 225 mg tablet	60	30	
Veregen (sinecatechins)	30 gm	28	Max 120 gm/16 weeks
Vicodin 5/500 mg (hydrocodone/ acetaminophen)	240	30	
Vicodin ES (hydrocodone/ acetaminophen)	150	30	
Vicodin HP (hydrocodone/ acetaminophen)	180	30	
Vigamox (moxifloxacin)	6 ml	30	
Viibryd 10 mg (vilazodone)	30	30	
Viibryd 20 mg (vilazodone)	30	30	
Viibryd 40 mg (vilazodone)	30	30	
Vimpat 50 mg (lacosamide)	60	30	
Vimpat 100 mg (lacosamide)	60	30	
Vimpat 150 mg (lacosamide)	60	30	
Vimpat 200 mg (lacosamide)	60	30	
Vivelle/Vivelle-DOT (estradiol)	8 patches	28	
Vyvanse 20 mg (lisdexamfetamine)	30	30	
Vyvanse 30 mg (lisdexamfetamine)	30	30	
Vyvanse 40 mg (lisdexamfetamine)	30	30	
Vyvanse 50 mg (lisdexamfetamine)	30	30	
Vyvanse 60 mg (lisdexamfetamine)	30	30	
Vyvanse 70 mg (lisdexamfetamine)	30	30	
Wellbutrin 75 mg (bupropion)	180	30	
Wellbutrin 100 mg (bupropion)	90	30	
Wellbutrin SR 100 mg (bupropion SR)	60	30	
Wellbutrin SR 150 mg (bupropion SR)	60	30	
Wellbutrin SR 200 mg (bupropion SR)	60	30	



Drug Product	Quantity	Days' Supply	Comments
Wellbutrin XL 150 mg(bupropion ER)	30	30	
Wellbutrin XL 300 mg (bupropion ER)	30	30	
Xalatan (latanoprost)	5 ml	30	
Xalkori 200 mg (crizotinib)	60	30	
Xalkori 250 mg (crizotinib)	60	30	
Xanax 0.25 mg (alprazolam)	150	30	
Xanax 0.5 mg (alprazolam)	150	30	
Xanax 1 mg (alprazolam)	150	30	
Xanax 2 mg (alprazolam)	150	30	
Xanax XR 0.5 mg (alprazolam ER)	30	30	
Xanax XR 1 mg (alprazolam ER)	30	30	
Xodol 5/300 mg (hydrocodone/ acetaminophen)	360	30	
Xodol 7.5/300 mg (hydrocodone/ acetaminophen)	180	30	
Xodol 10/300 mg (hydrocodone/ acetaminophen)	180	30	
Xolair sol 150 mg (omalizumab)	6	30	
Xyrem 500 mg/ml (sodium oxybate)	540 ml	30	
Zamicet (hydrocodone/ acetaminophen)	2700 ml	30	
Zavesca (miglustat)	90	30	
Zebeta 5 mg (bisoprolol)	30	30	
Zelboraf 250 mg (vemurafenib)	240	30	
Zetia 10 mg (ezetimibe)	30	30	
Zocor 5 mg (simvastatin)	30	30	
Zocor 10 mg (simvastatin)	30	30	
Zocor 20 mg (simvastatin)	30	30	
Zocor 40 mg(simvastatin)	30	30	
Zoloft 50 mg (sertraline)	45	30	
Zonalon 5% cream (doxepin)	45 m	30	
Zovirax 5% ointment (acyclovir)	30 gm	30	
Zydone 5/400 mg (hydrocodone/ acetaminophen)	240	30	
Zydone 7.5/400 mg (hydrocodone/ acetaminophen)	240	30	
Zydone 10/400 mg (hydrocodone/ acetaminophen)	180	30	
Zyprexa 2.5 mg (olanzapine)	30	30	
Zyprexa 5 mg (olanzapine)	30	30	
Zyprexa 7.5 mg (olanzapine)	30	30	



Request for Prior Authorization
REPOSITORY CORTICOTROPIN INJECTION
(H.P. ACTHAR GEL)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

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.

Acthar HP

Dosage instructions _____ Quantity _____ Days supply _____

Patient's current height and weight: height: _____ weight: _____

Diagnosis: _____

Contraindication or intolerance to corticosteroids (for diagnosis other than infantile spasms):

Trial drug name & dose: _____ Trial dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.



Request for Prior Authorization
RIVAROXABAN (XARELTO®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for rivaroxaban (Xarelto®). Payment will be considered under the following conditions: 1) Patient is 18 years of age or older; and 2) Patient does not have a mechanical prosthetic heart valve; and 3) Patient does not have active bleeding; and 4) Patient is not pregnant; and 5) Patient does not have severe renal impairment (CrCl < 15mL/min).

Preferred

Xarelto

Strength Dosage Instructions Quantity Days Supply

Diagnosis (see additional criteria below):

Does patient have mechanical prosthetic heart valve? Yes No

Does patient have active bleeding? Yes No

Does patient have severe renal impairment (CrCl < 15mL/min)? Yes No

Document CrCl: Date obtained:

Does patient have a negative pregnancy test if female of childbearing age? Yes No

If yes, provide date of pregnancy test:

Atrial Fibrillation

- Patient has a diagnosis of non-valvular atrial fibrillation: Yes No
Provide 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):
Trial Dose: Trial Dates:
Failure reason:
A dose of 20mg once daily will be considered for a CrCl > 50mL/min. A dose of 15mg once daily will be considered for a CrCl 15-50mL/min.

- Documentation of additional risk factors and CHADS₂ score:

Risk factor based CHADS ₂ Score	
Risk Factors	Score
<input type="checkbox"/> Congestive heart failure	1
<input type="checkbox"/> Hypertension (systolic > 160mmHg)	1
<input type="checkbox"/> Age ≥ 75 years	1
<input type="checkbox"/> Diabetes mellitus	1
<input type="checkbox"/> Stroke / TIA / thrombo-embolism	2
Total	

Treatment and Prevention of DVT or PE

- Provide 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):

Trial Dose: _____ Trial Dates: _____

Failure reason: _____

- Does patient have significant liver disease (hepatitis or cirrhosis)? Yes No
- Requests will not be considered for patients with CrCl < 30mL/min.
- Requests will be considered for the following dosing:
 - For treatment of acute DVT or PE: 15mg twice daily for 21 days followed by 20mg once daily for remaining treatment
 - For prevention of DVT or PE: 20mg once daily

Prophylaxis of DVT following Hip or Knee Replacement

- Does patient have significant liver disease (hepatitis or cirrhosis)? Yes No
- For patients undergoing hip replacement, is patient undergoing staged bilateral total hip replacement? Yes No
- Requests will not be considered for patients with CrCl < 30mL/min.
- Requests will be considered for the following dosing:
 - Hip replacement: 10mg daily for up to 35 days following hip replacement
 - Knee replacement: 10mg daily for up to 12 days following knee replacement

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



Drug Product	Quantity	Days' Supply	Comments
Zyprexa 10 mg (olanzapine)	30	30	
Zyprexa 15 mg (olanzapine)	60	30	
Zyprexa 20 mg (olanzapine)	60	30	
Zyprexa Zydis 5 mg (olanzapine)	30	30	
Zyprexa Zydis 10 mg (olanzapine)	30	30	
Zyprexa Zydis 15 mg (olanzapine)	60	30	
Zyprexa Zydis 20 mg (olanzapine)	60	30	
Zyrtec 1 mg/ml liquid OTC (cetirizine)	300	30	
Zyrtec 5 mg tablet OTC (cetirizine)	30	30	
Zyrtec 10 mg tablet OTC (cetirizine)	30	30	

64. Repository Corticotropin Injection (H.P. Acthar Gel)

Prior authorization is required for repository corticotrophin injection. Payment will be considered under the following conditions:

- ◆ Patient is under two years of age; and
- ◆ 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 corticotrophin injection.

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

Use form 470-5172, *Request for Prior Authorization: Repository Corticotropin Injection (H.P. Acthar Gel)*, to request prior authorization. Click [here](#) to see a sample of the form.

65. Rivaroxaban (Xarelto®)

Prior authorization is required for rivaroxavan (Xarelto®). Payment will be considered for patients under the following conditions:

- ◆ Patient is 18 years of age or older; and
- ◆ Patient does not have a mechanical prosthetic heart valve; and
- ◆ Patient does not have active bleeding; and
- ◆ Patient is not pregnant; and
- ◆ Patient does not have severe renal impairment (CrCl < 15mL/min).



Atrial Fibrillation

- ◆ Patient has a diagnosis of non-valvular atrial fibrillation; and
- ◆ Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum six month trial); and
- ◆ Presence of at least one additional risk factor for stroke, with a CHADS₂ score ≥ 1 ;
- ◆ For a CrCl > 50mL/min a dose of 20 mg once daily will be considered; or
- ◆ For a CrCl 15 to 50mL/min a dose of 15 mg once daily will be considered.

Treatment and Prevention of DVT or PE

- ◆ Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum six month trial); and
- ◆ Patient does not have a CrCl < 30mL/min; and
- ◆ Patient does not have significant liver disease (hepatitis or cirrhosis);
- ◆ For acute treatment of acute DVT or PE a dose of 15 mg twice daily for 21 days followed by 20 mg once daily for remaining treatment will be considered; or
- ◆ For prevention of DVT or PE a dose of 20 mg once daily will be considered.

Prophylaxis of DVT Following Hip or Knee Replacement

- ◆ Patient does not have a CrCl < 30mL/min; and
- ◆ Patient does not have significant liver disease (hepatitis or cirrhosis); and
- ◆ For patients undergoing hip replacement, patient is not undergoing staged bilateral total hip replacement;

Requests will be approved for the following dosing:

- ◆ Hip replacement: 10 mg once daily for up to 35 days following hip replacement; or
- ◆ Knee replacement: 10 mg once daily for up to 12 days following knee replacement.

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



Use form 470-5187, *Request for Prior Authorization: Rivaroxaban (Xarelto®)*, to request prior authorization. Click [here](#) to see a sample of the form.

66. Roflumilast (Daliresp™)

Prior authorization is required for roflumilast (Daliresp™). Payment will be considered for patients 18 years of age or older when the following is met:

- ◆ A diagnosis of severe COPD with chronic bronchitis as documented by spirometry results, and
- ◆ A smoking history of ≥ 20 pack-years, and
- ◆ Currently on a long-acting bronchodilator in combination with an inhaled corticosteroid with documentation of inadequate control of symptoms, and
- ◆ A history of at least one exacerbation in the past year requiring treatment with oral glucocorticosteroids.

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

Use form 470-5085, *Request for Prior Authorization: Roflumilast (Daliresp™)*, to request prior authorization. Click [here](#) to see a sample of the form.

67. Sedative/Hypnotics-Non-Benzodiazepine

Preferred agents are available without prior authorization (PA). Although intermittent therapy is recommended, quantity limits will allow for 30 tablets per 30 days supply without PA for preferred medications.

Prior authorization is required for all nonpreferred nonbenzodiazepine sedative/hypnotics. Payment for nonpreferred nonbenzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of a previous trial and therapy failure with the preferred agents. Payment for nonpreferred nonbenzodiazepine sedative/hypnotics will be considered when there is:

- ◆ A diagnosis of insomnia.
- ◆ Medications with a side effect of insomnia (i.e., stimulants) are decreased in dose, changed to a short-acting product, or discontinued.
- ◆ Enforcement of good sleep hygiene is documented.



- ◆ All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses.
- ◆ A documented trial and therapy failure with zaleplon.

Use form 470-4328, *Request for Prior Authorization: Sedative/Hypnotics-Non-Benzodiazepine*, to request prior authorization. Click [here](#) to see a sample of the form.

68. Selected Brand-Name Drugs

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](#).

The list of selected brand-name drugs includes the drugs on the Federal Upper Limit (FUL) list at <http://www.mslc.com/Iowa/AACList.aspx>.

For prior authorization to be considered, the prescriber must submit a completed Selected Brand Name Drugs PA form and Iowa Medicaid MedWatch form with:

- ◆ Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available.
- ◆ Documentation of the failure must include the specific adverse reaction as defined by the FDA. (See Section B of the MedWatch form).
Intolerances, such as nausea and vomiting, to the generic drugs will not be considered as a basis for approval.

Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.

Use forms 470-5039 and 470-4119, *Request for Prior Authorization: Selected Brand Name Drugs*, to request prior authorization. Click [here](#) to see a sample of form 470-5039. Click [here](#) to see a sample of form 470-4119.



Request for Prior Authorization
SHORT ACTING NARCOTICS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for all non-preferred short acting narcotics. Payment will be considered for cases in which there is documentation of previous trials and therapy failures with three (3) chemically distinct preferred short acting narcotics (based on narcotic ingredient only) at therapeutic doses, unless evidence is provided that the use of these products would be medically contraindicated.

Preferred (*Please refer to the PDL for a complete list of preferred alternatives)

- Acetaminophen/Codeine Oxycodone /APAP (5/325)
Hydrocodone/APAP
Hydromorphone Tab/Inj Oxycodone/ASA
Meperidine Tab Tramadol
Morphine Sulfate Tab
Oxycodone Cap/Tab

Non-Preferred

- Butalbital/APAP/Caff/Codeine
Butalbital/ASA/Caff/Codeine
Combunox
Hydrocodone/APAP (5/300, 7.5/300, 10/300)
Hydrocodone/Ibuprofen
Meperidine Syrup/Injection
Other (specify)
Nucynta
Opana
Oxycodone/APAP (7.5/325, 10/325)
Pentazocine/APAP
Roxicodone
Xodol

Table with 4 columns: Strength, Dosage Instructions, Quantity, Days Supply

Diagnosis:

Preferred Trial 1: Drug Name, Strength, Dosage Instructions

Trial start date: Trial end date:

Specify failure:

Preferred Trial 2: Drug Name, Strength, Dosage Instructions

Trial start date: Trial end date:

Specify failure:

Preferred Trial 3: Drug Name, Strength, Dosage Instructions

Trial start date: Trial end date:

Specify failure:

Reason for use of Non-Preferred drug requiring prior approval:

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

Form with fields for Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



69. Serotonin 5-HT1 Receptor Agonists

Prior authorization is required for serotonin 5-HT1 receptor agonists for quantities exceeding 12 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 is required for all **nonpreferred** serotonin 5-HT1 receptor agonists beginning the first day of therapy. Payment for nonpreferred serotonin 5-HT1 receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents.

Requests for nonpreferred combination products may be considered only after documented separate trials and therapy failures with the individual ingredients.

For consideration, the following information must be supplied:

- ◆ The diagnosis requiring therapy.
- ◆ Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

Use form 470-4113, *Request for Prior Authorization: Serotonin 5-HT1 Receptor Agonists*, to request prior authorization. Click [here](#) to see a sample of the form.

70. Short-Acting Narcotics

Prior authorization is required for all nonpreferred short-acting narcotics.

Payment will be considered for cases in which there is documentation of previous trial and therapy failures with three chemically distinct preferred short-acting narcotics (based on narcotic ingredient only) at therapeutic doses, unless evidence is provided that use of these products would be medically contraindicated.

Use form 470-4899, *Request for Prior Authorization: Short Acting Narcotics*, to request prior authorization. Click [here](#) to see a sample of the form.



71. Smoking Cessation Therapy-Oral

Prior authorization is required for varenicline (Chantix™) or bupropion SR that is FDA approved for smoking cessation. Requests for authorization must include:

- ◆ Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
- ◆ Confirmation of enrollment and ongoing participation in the Quitline Iowa counseling program is required for approval and continued coverage.

Approvals will be granted only for patients 18 years of age or older.

- ◆ The duration of therapy is initially limited to 12 weeks within a 12-month period.
- ◆ For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment will be considered with a prior authorization request. The maximum duration of approvable therapy is 24 weeks within a 12-month period.
- ◆ Requests for varenicline to be used in combination with bupropion SR that is FDA-indicated for smoking cessation or nicotine replacement therapy will not be approved.
- ◆ The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation.

Use form 470-4517, *Request for Prior Authorization: Smoking Cessation Therapy-Oral*, to request prior authorization. Click [here](#) to see a sample of the form.

72. Sodium Oxybate (Xyrem®)

Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered for patients 16 years of age or older under the following conditions:

- ◆ A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS0 and previous trial and therapy failure at a therapeutic dose with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline.
- ◆ Patient is enrolled in the Xyrem® Success Program.



Request for Prior Authorization
SODIUM OXYBATE (XYREM®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered for patients 16 years of age or older under the following conditions: 1) A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study... 7) The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website...

Non-Preferred

[] Xyrem® Strength Dosage Instructions Quantity Days Supply

[] Cataplexy associated with Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)

Trial of preferred tricyclic antidepressant drug: Drug Name & Dose: Trial Dates: Failure Reason:

[] Excessive Daytime Sleepiness associated with Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)

Trial of preferred amphetamine stimulant: Drug Name & Dose: Trial Dates: Failure Reason:

Trial of preferred non-amphetamine stimulant: Drug Name & Dose: Trial dates: Failure Reason:

Medical or contraindication reason to override trial requirements:

Patient is enrolled in the Xyrem® Success Program: [] Yes [] No

Patient has a history of substance abuse: [] Yes [] No

Patient has been counseled and will be closely monitored for signs of abuse: [] Yes [] No

Patient has a semialdehyde dehydrogenase deficiency: [] Yes [] No

Patient has been instructed to not drink alcohol when using Xyrem®: [] Yes [] No

Prescriber review of patient's controlled substances use on the Iowa PMP website: [] No [] Yes Date Reviewed:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.

Preferred

- Androderm
- Android
- Depo-Testosterone
- Testim
- Testosterone Cypionate
- Testosterone Enanthate
- Testred

Non-Preferred

- Androgel
- Axiron
- Fortesta
- Methitest
- Striant

Diagnosis: _____

Strength _____ **Dosage Instructions** _____ **Quantity** _____ **Days Supply** _____

Complete for diagnosis of hypogonadism (testosterone deficiency):

List & attach results of two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used:

Level 1: _____ Date: _____ Level 2: _____ Date: _____

Patient has at least one of the signs and symptoms specific to androgen deficiency:

- Incomplete or delayed sexual development
- Loss of body hair, reduction in shaving frequency
- Height loss, low trauma fracture, low bone mineral density
- Breast discomfort, gynecomastia
- Very small (<5mL) or shrinking testes
- Hot flushes, sweats

Does patient have any of the following:

- Breast or prostate cancer: Yes No
- Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL: Yes No
- Hematocrit > 50%: Yes No
- Untreated severe obstructive sleep apnea: Yes No
- Severe lower urinary tract symptoms: Yes No
- Uncontrolled or poorly controlled heart failure: Yes No

Renewal Requests:

List & attach updated testosterone level: Level: _____ Date: _____

Describe the patient's specific symptom response to therapy: _____

Has patient experienced the following in the past 12 months:

- Hematocrit > 54%: Yes No Most recent lab date: _____
- Increase in PSA > 1.4ng/mL: Yes No Most recent lab date: _____

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



- ◆ A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant.
- ◆ Patient has been instructed to not drink alcohol when using Xyrem®.

Requests for patients with a prior history of substance abuse, concurrent use with a sedative hypnotic, or a semialdehyde dehydrogenase deficiency will not be considered.

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

Use form 470-5016, *Request for Prior Authorization: Sodium Oxybate (Xyrem®)*, to request prior authorization. Click [here](#) to see a sample of the form.

73. Testosterone Products

Prior authorization is required for testosterone products.

Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for symptoms of sexual dysfunction, erectile dysfunction, and infertility will not be considered.

Payment for a diagnosis of hypogonadism (testosterone deficiency) will be considered under the following conditions:

- ◆ Patient is male and 18 years of age or older (or 12 years of age for testosterone cypionate); and
- ◆ Patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (attach lab results); and
- ◆ Patient has at least one of the signs and symptoms specific to androgen deficiency:

Incomplete or delayed sexual development

Breast discomfort, gynecomastia

Loss of body hair, reduction in shaving frequency

Very small (< 5mL) or shrinking testes

Hot flushes, sweats

Height loss, low trauma fracture, low bone mineral density; and



◆ Patient does not have:

- Breast or prostate cancer
- Palpable prostate nodules or prostate-specific antigen (PSA) > 4ng/mL
- Hematocrit > 50 percent
- Untreated severe obstructive sleep apnea
- Sever lower urinary tract symptoms
- Uncontrolled or poorly controlled heart failure

If criteria for coverage are met, initial authorization will be given for three months. Requests for continuation of therapy will require the following:

- ◆ An updated testosterone level (attach lab result); and
- ◆ Documentation of how the patient's specific symptoms have responded to therapy; and
- ◆ Documentation the patient has not experienced a hematocrit > 54 percent or an increase in PSA > 1.4ng/mL in the past 12 months.

Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis.

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

Use form 470-5188, *Request for Prior Authorization: Testosterone Products*, to request prior authorization. Click [here](#) to see a sample of the form.

74. Thrombopoietin Receptor Agonists

Payment for a preferred thrombopoietin receptor agonist will be considered only for cases in which there is a diagnosis of chronic immune thrombocytopenic purpura (ITP) including documentation of an insufficient response to a corticosteroid or an immunoglobulin, or the member has undergone splenectomy.



Request for Prior Authorization
TOPICAL RETINOIDS FOR ACNE

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, and Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for all prescription topical retinoid products. Payment for prescription topical retinoid products will be considered under the following conditions: 1) Previous trial and therapy failure with a preferred over-the-counter benzoyl peroxide product, and 2) Previous trials and therapy failures with two preferred topical and/or oral antibiotics for the treatment of mild to moderate acne (non-inflammatory and inflammatory), and drug-induced acne. 3) Payment for non-preferred topical retinoid products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. 4) Trials and therapy failure will not be required for those patients presenting with a preponderance of comedonal acne. 5) Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of topical retinoid products. 6) Requests for non-preferred combination products may only be considered after documentation of separate trials and therapy failures with the individual ingredients. 7) Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for Tazorac for a psoriasis diagnosis.

Preferred

- Atralin
Differin Cream & Gel
Retin-A
Tazorac
Tretinoin

Non-Preferred

- Adapalene
Differin Lotion
Epiduo
Fabiator
Retin-A Micro
Tretinoin Microsphere
Veltin
Ziana

Table with 5 columns: Strength, Dosage Form, Dosage Instructions, Quantity, Days Supply

Diagnosis: [checkbox] Acne Vulgaris* Date of Diagnosis:
[checkbox] Cystic Acne
[checkbox] Preponderance of Comedonal Acne
[checkbox] Skin Cancer
[checkbox] Other (please specify):

*If Acne Vulgaris, please document treatment failures with over-the-counter benzoyl peroxide and two preferred oral and/or topical antibiotics including drug names, strength, exact date ranges, and failure reasons:

Medical or contraindication reason to override trial requirements:
Reason for use of Non-Preferred drug requiring prior approval:
Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.



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:

- ◆ Patients taking direct acting antiviral agents for the treatment of chronic hepatitis C genotype 1 infection in addition to interferon-based therapy with ribavirin.
- ◆ Patients with decompensated liver disease with a Child-Pugh score > 6 (Class B & C).
- ◆ Patients with a history of ascites.
- ◆ Patients with hepatic encephalopathy.

Payment for a nonpreferred thrombopoietin receptor agonist will be considered following documentation of a recent trial and therapy failure with a preferred thrombopoietin receptor agonist unless such a trial would be medically contraindicated.

Use form 470-4850, *Request for Prior Authorization: Thrombopoietin Receptor Agonists*, to request prior authorization. Click [here](#) to see a sample of the form.

75. Topical Retinoids

Prior authorization is required for all prescription topical retinoid products.

Payment for prescription topical retinoid products will be considered under the following conditions:

- ◆ Patients with a diagnosis of skin cancer, lamellar ichthyosis, or Darier's disease will receive automatic approval for lifetime use of topical retinoid products.
- ◆ Payment will be authorized when the patient has had previous trial and therapy failure with:

A preferred over-the-counter benzoyl peroxide product, and
Two preferred topical or oral antibiotics for the treatment of mild to moderate acne (noninflammatory and inflammatory) or drug-induced acne.

EXCEPTION: Trials and therapy failure are not required for patients presenting with a preponderance of comedonal acne.



- ◆ Payment for nonpreferred topical retinoid products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.
- ◆ Requests for nonpreferred combination products will be considered only after documentation of separate trials and therapy failures with the individual ingredients.
- ◆ Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for tazorac for a psoriasis diagnosis.

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

Use form 470-4114, *Request for Prior Authorization: Topical Retinoids for Acne*, to request prior authorization. Click [here](#) to see a sample of the form.

76. Vemurafenib (Zelboraf™)

Prior authorization is required for vemurafenib (Zelboraf™). Payment will be considered for patients when the following criteria are met:

- ◆ Patient is 18 years of age or older; and
- ◆ Has a diagnosis of unresectable or metastatic melanoma with BRAFV600E mutation as detected by an FDA-approved test; and
- ◆ Prescriber is an oncologist.

If the criteria for coverage are met, authorizations will be given at three month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.

Use form 470-5136, *Request for Prior Authorization: BRAF Inhibitors*, to request prior authorization. Click [here](#) to see a sample of the form.



Iowa Department of Human Services

FAX Completed Form To

1 (800) 574-2515

Request for Prior Authorization
BRAf INHIBITORS

Provider Help Desk

1 (877) 776-1567

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for BRAf inhibitors. Payment will be considered for patients when the following criteria are met: 1) Patient is 18 years of age or older; and 2) Has a diagnosis of unresectable or metastatic melanoma with BRAfV600E mutation as detected by an FDA-approved test; and 3) Prescriber is an oncologist.

[] Tafinlar [] Zelboraf

Strength Dosage Instructions Quantity Days Supply

Diagnosis (Attach copy of test results):

Is Prescriber an Oncologist? [] Yes [] No

Disease Progression Noted (renewals only)? [] Yes [] No

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.



77. 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:

- ◆ The patient has a diagnosis of Major Depressive Disorder (MDD) and is 18 years of age and older; and
- ◆ Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SSRI; and
- ◆ Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and
- ◆ Documentation of a previous trial and therapy failure at a therapeutic dose with an 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.

Use form 470-5098, *Request for Prior Authorization: Vilazodone (Viibryd™)*, to request prior authorization. Click [here](#) to see a sample of the form.

78. Vitamins, Minerals and Multiple Vitamins

Payment for vitamins, minerals, and multiple vitamins for treatment of specific conditions will be approved when:

- ◆ A specific vitamin or mineral deficiency disease is diagnosed; or
- ◆ A member aged 20 or under has a diagnosed disease that inhibits the nutrition absorption process as a secondary effect of the disease.

Prior approval is not required for prescribed multi-vitamins with or without iron or vitamin D supplements for patients under 12 months of age or a prescription product primarily classified as a blood modifier if that product does not contain more than three vitamins and minerals, or for products principally marketed as prenatal vitamin-mineral supplements.

Prior authorization is **not** required for a vitamin and mineral product principally marketed for use as a dietary supplement during pregnancy and lactation.

Use form 470-4115, *Request for Prior Authorization: Vitamins & Minerals*, to request prior authorization. Click [here](#) to see a sample of the form.

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79. Vusion™ Ointment

Prior authorization is required for Vusion™ ointment. Payment will be considered only for cases in which there is documentation of previous trials and therapy failures with (1) over-the-counter miconazole 2% cream (payable with a prescription) **and** (2) nystatin cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated.

Use form 470-4655, *Request for Prior Authorization: Vusion™ Ointment*, to request prior authorization. Click [here](#) to see a sample of the form.



b. Reimbursement for FUL Drugs

For the drug groups on the [Preferred Drug List](#) where brand-name products are preferred over generic products, the FUL rate will continue to apply when the generic version of the drug is dispensed.

However, the payment for preferred brand name products (which no longer require prior authorization before dispensing) equals the lower of the average acquisition cost (average AAC) or the submitted charges, as opposed to the FUL/SMAC rate.

Nonpreferred brand products require prior authorization before dispensing. If authorized, payment equals the lower of the the average acquisition cost (average AAC) or the submitted charges, as opposed to the FUL rate with a prior authorization. The DAW=1 is no longer required for brand reimbursement.

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.

For prior authorization to be considered, evidence of a treatment failure with the bioequivalent generic drug must be provided. A copy of a completed form 470-4119, *Request for Prior Authorization: Selected Brand Name Drugs*, shall be considered as evidence of treatment failure.

The list of selected brand-name drugs includes the drugs on the Federal Upper Limit (FUL) list at <http://www.mslc.com/Iowa/AACList.aspx>. Prior authorization **is not required** for brand name drugs that have been designated by the Department as **preferred** (payable) under the Iowa Medicaid Preferred Drug List (PDL).

3. Reimbursement for Unit-Dose Packaging

Additional reimbursement of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist. Unit-dose reimbursements are permitted only for patients with Plan 300 eligibility.



E. BILLING SYSTEM

Iowa Medicaid Enterprise provides for on-line, real-time processing of Medicaid pharmacy claims. Through electronic submission, you are able to submit claims more accurately. You also receive your Medicaid payments sooner than if you submitted paper claims.

Point-of-sale (POS) transactions are handled by the Iowa Medicaid Enterprise Pharmacy Point of Sale (POS) Unit. POS will handle the overrides for prospective drug utilization review edits such as high dose, therapeutic duplication, refill too soon, excessive days supply, dose consolidation, duplicate claim, or immunosuppressant drugs.

Providers that wish to exercise the point of sale billing option must complete the Iowa DHS Point of Sale Agreement. Please visit www.iowamedicaidpos.com to complete this agreement. You may call the (Point of Sale) POS Helpdesk at 877-463-7671 or locally at 515-256-4608.

1. Point of Sale Claim Submission

For point-of-sale (POS) submitters, refer to your POS Payer Sheet for claim submission instructions explanation of the data fields for the electronic billing format. (To view the instruction on line, click [here](#).)

The Iowa Medicaid Enterprise eliminated the procedure of paying pharmacy claims and then billing the primary insurance company on behalf of the members ("pay and chase") effective January 16, 2007, except for children under age 21 and pregnant women.

- ◆ **For members under age 21**, pharmacy claims may be processed through Pharmacy Point of Sale System with Iowa Medicaid as the primary insurer.
- ◆ **For members who are pregnant**, bill claims through the Pharmacy Point of Sale System with Iowa Medicaid as the primary insurer. To get a \$0.00 copayment, enter code "2" in the pregnancy indicator code field (NCPDP field 335-2C).



For medications payable on Iowa Medicaid, the POS staff will put an override on the point-of-sale system for the pharmacy to rebill the claims for reimbursement.

3. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ Complete form 470-3969, *Claim Attachment Control*. To view a sample of this form on line, click [here](#).

Complete the “attachment control number” with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.

- ◆ **Staple** the additional information to form 470-3969. Do **not** attach a paper claim.
- ◆ Mail the *Claim Attachment Control* with attachments to:

Medicaid Claims
PO Box 150001
Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

4. Paper Claim Submission

Traditional Universal Claim forms are no longer accepted. The new universal claim forms PUCF-D01PT (VER 1.2) can be ordered by calling CommuniForm at 800-564-8140, or online at <https://www.ncpdp.org/Products/Universal-Claim-Forms>.

The following table contains information that will aid in the completion of the pharmacy claim form. The table follows the form by field name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional, or conditional on the individual member’s situation.



Medication	Correct Unit for Billing	Quantity	Days' Supply
Stadol nasal spray 10 mg/ml (butorphanol)	MI (Submit in decimal format; do not round)	Varies; claims should be divisible by 2.5 ml	Varies
Synagis 50 mg (palivizumab)	MI (Submit in decimal format; do not round)	0.5 ml	30
Synagis 100 mg (palivizumab)	MI	1 ml	30
Ventolin HFA (albuterol)	Grams	18 grams	30
Xopenex HFA (levalbuterol)	Grams	Varies; claims should be divisible by 15 grams	Varies

3. Compounded Prescriptions

Iowa Medicaid will process claims for compounded prescriptions in the NCPDP D.Ø format using the multiple ingredient functionality. All applicable edits, including [Preferred Drug List](#) (PDL) rules, apply to each NDC submitted. Providers must submit the NDCs for the active ingredients dispensed to create the compound.

A dispensing fee will be added to the claim when a drug within the compound is reimbursed at EAC. There will be no additional fee paid to prepare the compounded prescription. Providers need to submit the quantity of the active ingredients used in the compound for reimbursement, not the quantity of the total amount of the compound made.

4. Coverage of Non-Drug Products

Products not approved as prescription drugs by the Food and Drug Administration do not meet the definition of "covered outpatient drugs" and cannot be covered by Medicaid pharmacy program. Coverage of these products is allowed in other coverage areas, such as medical supplies.

Medicaid will continue to cover certain non-drug products as listed below. Pharmacies shall continue to provide these products and bill Medicaid through the point of sale system. Prior authorizations (PA) will be submitted through the Pharmacy PA system.



Product	√ Indicates PA Required
Ammonium lactate lotion 12%	
AquADEKs capsules	√
AquADEKs tabs	√
AquADEKs solution	√
Bacterostatic sodium chloride injection 0.9%	
Bacterostatic water for injection	
Bacterostatic parabens water for injection	
Calcium carbonate 500 mg chewable tablets	√
Calcium carbonate 750 mg chewable tablets	√
Calcium carbonate 1000 mg chewable tablets	√
Calcium carbonate 1250 mg chewable tablets	√
Calcium carbonate 1250 mg/5 ml suspension	√
Calcium carbonate 600 mg tablets	√
Calcium carbonate-vitamin D 500 mg/200 unit	√
Calcium carbonate-vitamin D 600 mg/200 unit tablets	√
Calcium carbonate-vitamin D 600/400 unit tablets	√
Calcium citrate 950 mg tablets	√
Calcium gluconate 1.8 gm/5mL	√
Calcium gluconate 650 mg tablets	√
Calcium lactate 650 mg tablets	√
Calvite P&D tablets	√
Cerovite Jr chewable tablets	√
Cerovite liquid	√
Cholecalciferol 400 Unit tablets	√
Epoprostenolol diluents (Flolan) 0.5 mg	
Epoprostenolol diluents (Flolan) 1.5 mg	
Ferrous fumarate 325 mg tablets	
Ferrous gluconate 324 mg tablets	
Ferrous gluconate 325 mg tablets	
Ferrous sulfate 75 mg/0.6 ml drops	
Ferrous sulfate 75 mg/ml drops	
Ferrous sulfate 220 mg/5 ml elixir	
Ferrous sulfate 325 mg tablets	
Magnesium chloride er tablet 535 (64 mg) MG	√
Magnesium gluconate 1000 mg/5mL	√
Magnesium oxide 400 mg tablets	√
Maximum D3 capsules	√
Metronidazole powder	
Multiple vitamins tablets	√
Nephro-Vite tablets	√



Product	√ Indicates PA Required
Niacin 50 mg tablets	
Niacin 100 mg tablets	
Niacin 250 mg tablets	
Niacin 500 mg tablets	
Pediatric oral electrolyte solution	
Phos-Nak powder concentrate	√
Polysaccharide Iron Complex 150 mg capsules	√
Poly-Vi-Sol drops	√
Poly-Vi-Sol w/iron drops	√
Progesterone powder	
Progesterone micronized powder	
Pyridoxine 100 mg tablets	√
Pyridoxine 25 mg tablets	√
Pyridoxine 50 mg tablets	√
Slow-mag tablets	√
Sodium bicarbonate 325 mg tablets	√
Sodium bicarbonate 650 mg tablets	√
Sodium chloride injection 0.9%	
Sodium chloride solution 0.9% for inhalation	
Thera-M enhanced tablets	√
Tri-Vi-Sol drops	√
Tri-Vi-Sol w/iron drops	√
Vitamin A 10000 IU capsules	√
Vitamin B-1 100 mg tablets	√
Vitamin B-1 50 mg tablets	√
Vitamin B-12 1000 mcg CR tablets	√
Vitamin B-12 1000 mcg tablets	√
Vitamin C 500 mg chewable tablets	√
Vitamin C 500 mg tablets	√
Vitamin C 1000 mg tablets	√
Vitamin D 400 unit drops	√
Vitamin D 1000 unit tablets	√
Vitamin D 2000 unit tablets	√
Vitamin D 400 unit tablets	√
Vitamin E 400 unit capsules	√

5. Date of Birth Verification

Point of sale edits for the exact date of birth from the eligibility file for Iowa Medicaid members. Field # 304-C4 (Date of Birth) on The National Counsel for Prescription Drug Programs (NCPDP) Payer Sheet is mandatory. The NCPDP rejection message will state "09-Missing/Invalid Date of Birth." Claims should be resubmitted with the correct date of birth for the member.



a. Age Edits

Certain medications are payable only for specific age groups:

Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
Drugs FDA indicated for the treatment of Alzheimer's dementia (donepezil, galantamine, memantine, and rivastigmine)	Payable for members 40 years of age and older	PA is required for members under 40 years of age.
Aldara (imiquimod)	Payable for members 12 years of age and older	PA is required for members under 12 years of age.
Asmanex 110 mcg	Payable for members less than 12 years of age.	PA is required for members 12 years of age and older.
Brovana	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Clorazepate	Payable for members 9 years of age and older.	PA is required for members under 9 years of age.
Complera	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Edurant	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Eligard	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Erivedge	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.