



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. 15-1

ISSUED BY: Division of Medical Services

SUBJECT: **PRESCRIBED DRUGS**, Chapter III, *Provider-Specific Policies*, Contents (pages 1 through 4), revised; pages 8, 9, 10, 18, 19, 20, 29 through 60, 60a, 60b, 65, 69, 71, 72, 77, 78, 81, 83 through 87, 88a, 88b, 88c, 109, and 110, revised; pages 10a, 32a through 32d, 60c, and 60d, 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
- 470-5259 *Request for Prior Authorization: Anti-Diabetic Non-Insulin Agents*, revised
- 470-5098 *Request for Prior Authorization: Antidepressants*, revised
- 470-5207 *Request for Prior Authorization: Apixaban (Eliquis[®])*, revised
- 470-5171 *Request for Prior Authorization: Dabigatran (Pradaxa[®])*, revised
- 470-4550 *Request for Prior Authorization: Extended Release Formulations*, revised
- 470-4099 *Request for Prior Authorization: Granulocyte Colony Stimulating Factor*, revised
- 470-5066 *Request for Prior Authorization: Hepatitis C Antiviral Agents-Protease Inhibitors*, revised
- 470-5270 *Request for Prior Authorization: Hepatitis C Antiviral Agents-Sofosbuvir Containing Regimens*, new
- 470-5117 *Request for Prior Authorization: Ivacaftor (Kalydeco)*, revised
- 470-4279 *Request for Prior Authorization: Omalizumab (Xolair[®])*, revised
- 470-4110 *Request for Prior Authorization: Pavilizumab (Synagis[®])*, revised
- 470-4327 *Request for Prior Authorization: Pulmonary Arterial Hypertension Agents*, revised
- 470-4328 *Request for Prior Authorization: Sedative/Hypnotics-Non-Benzodiazepine*, revised

- 470-4113 *Request for Prior Authorization: Serotonin 5-HT1 Receptor Agonists*, revised
- 470-5188 *Request for Prior Authorization: Testosterone Products*, revised

Summary

The Prescribed Drug manual is revised to:

- ◆ Revise 15 forms for requesting drug prior authorization.
- ◆ Add form 470-5270, *Request for Prior Authorization: Hepatitis C Antiviral Agents-Sofosbuvir Containing Regimens*.
- ◆ Rename form 470-5098 from *Request for Prior Authorization: Vilazodone (Viibryd™)* to *Request for Prior Authorization: Antidepressants*.
- ◆ Update the quantity limit chart.
- ◆ Update the Non-Drug Product list.
- ◆ Update dispensing requirements.
- ◆ Update the refill too soon policy on lost, stolen, and destroyed medications.

Date Effective

Upon receipt.

Material Superseded

This material replaces the following pages from the ***PRESCRIBED DRUGS MANUAL***:

<u>Page</u>	<u>Date</u>
Chapter III	
Contents (page 1)	August 1, 2013
Contents (pages 2 and 3)	July 1, 2014
Contents (page 4)	February 1, 2014
8-10	February 1, 2014
18-20	July 1, 2014
470-4116	6/14
470-4593	6/14
470-5259	6/14
29, 30	July 1, 2014
470-5207	4/14
31-40	July 1, 2014
470-5171	10/13
41, 42	July 1, 2014
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43, 44	July 1, 2014
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45, 46	July 1, 2014
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47-56	July 1, 2014
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57	July 1, 2014
58	February 1, 2014
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59, 60	July 1, 2014
470-4327	6/14
60a, 60b	July 1, 2014
65	July 1, 2014
69, 71	February 1, 2014
72	August 1, 2013
77, 78, 81, 83, 84	July 1, 2014
470-4328	7/12
470-4113	5/13
85-87	July 1, 2014
470-5188	6/14
88a, 88b	July 1, 2014
470-5098	4/12
88c, 88d	July 1, 2014
109	February 1, 2014
110	August 1, 2013

Additional Information

The updated provider manual containing the revised pages can be found at:

<http://dhs.iowa.gov/sites/default/files/Drugs.pdf>

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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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.
- ◆ Develop and implement policies and procedures for delivery of prescriptions in accordance with state law, including:
 - Establishment of effective controls against diversion of prescription drugs, as required by Iowa Code § 155A.15(2)(i); and
 - Policies and procedures regarding shipment or other delivery to ensure accountability, safe delivery, and compliance with temperature requirements, as required by Iowa Administrative Code 657—8.15(2).



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 after delivery to the member 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.
- Requests exceeding the one time override allowance for non-controlled medications that are lost, stolen or destroyed after delivery to the member may be considered with additional documentation. Such requests involving stolen medications must include a copy of a police report.
- Override of refill too soon will not be allowed for controlled substances and/or tramadol containing products that are lost, stolen, or destroyed after delivery to the member.
- Override of refill limits will not be allowed for members residing in a long term care (LTC) facility.



- Prescription drugs that are not received by the member because they are lost or stolen in transit, before actual delivery to the member, or that are received in damaged or unusable condition will not be replaced through override of refill too soon. The original claim for the drug that was not properly delivered to the member should be reversed and a new claim for a replacement can then be submitted.

- ◆ **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://dhs.iowa.gov/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.



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](#)
- ◆ [Anti-diabetic, non-insulin agents](#)
- ◆ [Antidepressants](#)
- ◆ [Antiemetic-5HT3 receptor antagonists/substance P neurokinin products](#)
- ◆ [Antifungal](#)
- ◆ [Antihistamines](#)
- ◆ [Apixaban \(Eliquis[®]\)](#)
- ◆ [Becaplermin \(Regranex[®]\)](#)
- ◆ [Benzodiazepines](#)
- ◆ [Biologicals for ankylosing spondylitis](#)
- ◆ [Biologicals for arthritis](#)
- ◆ [Biologicals for inflammatory bowel disease](#)



- ◆ [Biologicals for plaque psoriasis](#)
- ◆ [BRAF inhibitors](#)
- ◆ [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 \(Nuedexta™\)](#)
- ◆ [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 Antiviral Agents, oral](#)
- ◆ [Immunomodulators, topical](#)
- ◆ [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 \(Lubiprostone and Linaclotide\)](#)



- ◆ [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](#)
- ◆ [Trametinib \(Mekinist™\)](#)
- ◆ [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 http://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

- Amphetamine Salt Combo, Daytrana, Focalin, Focalin XR, Metadate CD, Methylphenidate IR Tablets, Methylphenidate ER Tabs (10, 18, 20, 27, 36, 54mg), Provigil, Quillivant XR, Strattera, Vyvanse

Non-Preferred

- Adderall, Adderall XR, Amphetamine ER, Concerta, Desoxyn, Dexedrine*, Dextroamphetamine Tab, Dextroamphetamine ER Cap*, Dexmethylphenidate, Dexmethylphenidate ER, Methylin Chew, Methylin Solution, Methylphenidate ER Capsules, Modafinil, Nuvigil, Procentra, Ritalin, Ritalin SR, 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, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

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

- Diovan, Exforge, Exforge HCT, Irbesartan, Irbesartan HCT, Losartan, Losartan HCT, Micardis, Micardis HCT, Valsartan, Valsartan HCT

Non-Preferred

- Atacand, Atacand HCT, Avalide, Avapro, Azor, Benicar, Benicar HCT, Cozaar, Diovan HCT, Edarbi, Edarbyclor, Eprosartan, Hyzaar, Telmisartan, Telmisartan/Amlodipine, Telmisartan/HCT, Teveten, Teveten HCT, Tribenzor, Twynsta, Valsartan, Valturna

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-DIABETIC NON-INSULIN 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 preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions: 1) A diagnosis of Type 2 Diabetes Mellitus, and 2) Patient is 18 years of age or older; and 3) The patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated.

Preferred DPP-4 Inhibitors and Combinations

- Janumet
Januvia
Kombiglyze XR
Onglyza

Non- Preferred DPP-4 Inhibitors and Combinations

- Janumet XR
Jentadueto
Kazano
Nesina
Oseni
Tradjenta

Preferred Incretin Mimetics

- Byetta

Non-Preferred Incretin Mimetics

- Bydureon
Tanzeum
Victoza

Non-Preferred SGLT2 Inhibitors and Combinations

- Farxiga
Invokamet
Invokana
Jardiance

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Metformin Trial: Trial start date: Trial end date: Trial dose:

Reason for Failure:

Medical or contraindication reason to override trial requirements:

Most recent HgbA1C Level: Date this level was obtained:

Request for Prior Authorization
ANTI-DIABETICS NON-INSULIN AGENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Requests for Non-Preferred Drugs:

DPP-4 Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Incretin Mimetic Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

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
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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.



Request for Prior Authorization
ANTIDEPRESSANTS

(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 non-preferred antidepressants subject to clinical criteria. Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered for patients when the following criteria are met: 1) The patient has a diagnosis of Major Depressive Disorder (MDD) and is 18 years of age or older; and 2) Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; and 3) Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and 4) Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant . 5) If the request is for an isomer, prodrug or metabolite of a medication indicated for MDD, one of the trials must be with the preferred parent drug of the same chemical entity that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

- Checkboxes for Aplenzin, Brintellix, Fetzima, Khedezla, Pristiq, Viibryd

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Preferred Generic SSRI Trial 1: Drug Name& Dose Trial Dates:

Failure Reason

Preferred Generic SSRI Trial 2: Drug Name& Dose Trial Dates:

Failure Reason

Preferred Generic SNRI Trial: Drug Name& Dose Trial Dates:

Failure Reason

Preferred Non-SSRI/SNRI Generic Antidepressant Trial: Drug Name& Dose

Trial Dates: Failure Reason

Medical or contraindication reason to override trial requirements:

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.



Payment for a non-preferred anti-diabetic, non-insulin agent subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with Metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor combination and a preferred Incretin Mimetic at maximally tolerated doses, unless evidence is provided that use of these agents would be medically contraindicated.

Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented continued improvement in HgbA1C.

Use form 470-5259, *Request for Prior Authorization: Anti-Diabetic, Non-Insulin Agents*, to request prior authorization. Click [here](#) to see a sample of the form.

11. Antidepressants

Prior authorization is required for non-preferred antidepressants subject to clinical criteria. 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 or older; and
- ◆ Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; 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 one non-SSRI/SNRI generic antidepressant; and
- ◆ If the request is for an isomer, prodrug or metabolite of a medication indicated for MDD, one of the trials must be with the preferred parent drug of the same chemical entity that resulted in a partial response with a documented intolerance.

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: Antidepressants*, to request prior authorization. Click [here](#) to see a sample of the form.



12. Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products

Prior authorization is required for **preferred** antiemetic-5HT3 receptor antagonists/substance P neurokinin medications for quantities exceeding the following dosage limits per month.

- ◆ Aprepitant/Emend[®]:
 - Four 125 mg capsules
 - Eight 80 mg capsules
- ◆ Dolasetron/Anzemet[®]:
 - Five 50 mg tablets
 - Five 100 mg tablets
- ◆ Granisetron/Kytril[®]:
 - Eight 1 mg tablets
 - 30 ml oral solution (1 mg/5 ml)
 - Eight vials (1 mg/ml)
 - Two vials (4 mg/ml)
- ◆ Ondansetron ODT/Zofran ODT[®]:
 - Twelve 4 mg tablets
 - Twelve 8 mg tablets
- ◆ Ondansetron/Zofran[®]:
 - Twelve 4 mg tablets
 - Twelve 8 mg tablets
 - Four 24 mg tablets
 - 50 ml/month oral solution (4 mg/5 ml)
 - Four 20 ml vials (2 mg/ml)
 - Eight 2 ml vials (2 mg/ml)
- ◆ Palonosetron/Aloxi[®]: Four vials (0.25 mg/ml)

Payment for antiemetic-5HT3 receptor antagonists/substance P neurokinin agents beyond these limits will be considered on an individual basis after review of submitted documentation.

NOTE: Aprepitant (Emend[®]) is payable only when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.



Prior authorization is required for all **nonpreferred** antiemetic-5HT3 receptor antagonists/substance P neurokinin medications beginning the first day of therapy.

Payment for nonpreferred medications will be authorized only for cases in which there is documentation of previous trials and therapy failure with a preferred agent in this class.

Use form 470-4410, *Request for Prior Authorization: Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products*, to request prior authorization. Click [here](#) to see a sample of the form.

13. Antifungal Therapy

Prior authorization is not required for **preferred** oral antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient.

Payment for any oral antifungal therapy beyond this limit will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This prior authorization requirement does not apply to nystatin.

Prior authorization is required for all **nonpreferred** oral antifungal therapy beginning the first day of therapy. Payment for a nonpreferred oral antifungal agent will be authorized only for cases with documentation of previous trial and therapy failure with a preferred agent.

Use form 470-4094, *Request for Prior Authorization: Antifungal Drugs*, to request prior authorization. Click [here](#) to see a sample of the form.

14. Antihistamines

Prior authorization is required for all **nonpreferred** antihistamines and preferred second-generation prescription antihistamines.

- ◆ Members aged 21 or older must have three unsuccessful trials with oral antihistamines that do not require prior authorization prior to the approval of a nonpreferred oral antihistamine. Two of the trials must be with cetirizine and loratadine.
- ◆ Members aged 20 or younger must have unsuccessful trials of cetirizine and loratadine prior to the approval of a nonpreferred oral antihistamine.



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

Use form 470-4095, *Request for Prior Authorization: Antihistamines-Oral*, to request prior authorization. Click [here](#) to see a sample of the form.

15. Apixaban (Eliquis®)

Prior authorization is required for apixaban (Eliquis®). 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 CHADS₂ score ≥ 1 ; and
- ◆ Patient does not have a mechanical prosthetic heart valve; and
- ◆ Patient does not have active bleeding; and
- ◆ For patients requiring deep vein thrombosis (DVT) prophylaxis undergoing hip or knee replacement. Requests will be considered when the patient has contraindications to use of the preferred agents. If the patient meets criteria for coverage, requests will be approved for the following doses:
 - Hip replacement: 2.5mg twice daily for up to 35 days following hip replacement; or
 - Knee replacement: 2.5mg twice daily for up to 12 days following knee replacement.

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

Use form 470-5207, *Request for Prior Authorization: Apixaban (Eliquis®)*, to request prior authorization. Click [here](#) to see a sample of the form.



Request for Prior Authorization
APIXABAN (ELIQUIS®)

(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 apixaban (Eliquis®). Payment will be considered under the following conditions: 1) Patient does not have a mechanical prosthetic heart valve; and 2) Patient does not have active pathological bleeding; and 3) Patient has a diagnosis of non-valvular atrial fibrillation; with 4) 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 5) Presence of at least one additional risk factor for stroke, with a CHADS2 score ≥ 1; OR 6) For patients requiring deep vein thrombosis (DVT) prophylaxis undergoing hip or knee replacement.

Non-Preferred

[] Eliquis®

Strength Dosage Instructions Quantity Days Supply

Diagnosis (additional criteria below):

[] Atrial Fibrillation

Patient has a diagnosis of non-valvular atrial fibrillation: [] Yes [] No

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

**Request for Prior Authorization
APIXABAN (ELIQUIS®)**

(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	

Prophylaxis of DVT following Hip or Knee Replacement

- **Preferred Drug Trial:** Drug Name & Dose: _____ Trial start & end date: _____
Reason for Failure: _____
- Requests will be considered for the following dosing:
 - Hip replacement: 2.5mg twice daily for up to 35 days following hip replacement
 - Knee replacement: 2.5mg twice daily for up to 12 days following knee replacement

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.



16. 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.

17. 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.



18. **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.

19. **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.



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.

20. **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.

21. **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.

22. **BRAF Inhibitors**

Prior authorization is required for BRAF inhibitors. 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.



23. 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.

24. 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.

25. 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.

26. 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.



27. 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.

28. 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.

29. Dabigatran (Pradaxa®)

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

- ◆ Patient does not have a mechanical prosthetic heart valve; and
- ◆ Patient does not have active pathological bleeding; and
- ◆ Patient has a diagnosis of non-valvular atrial fibrillation and documentation of a previous trial and therapy failure with warfarin (TIA, stroke, recurrence of DVT/PE, or inability to maintain a therapeutic INR with a minimum six month trial); and



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, and Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for dabigatran (Pradaxa®). Payment will be considered under the following conditions: 1) Patient does not have a mechanical prosthetic heart valve; and 2) Patient does not have active pathological bleeding; and 3) Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, recurrence of DVT/PE or inability to maintain a therapeutic INR with a minimum 6 month trial). Non-valvular atrial fibrillation (in addition to above): 1) Presence of at least one additional risk factor for stroke, with a CHADS2 score ≥ 1; and 2) Patient does not have severe renal impairment (CrCl < 15mL/min) or is not on dialysis. Treatment and prevention of DVT or PE (in addition to above): 1) Patient does not have a CrCl < 30mL/min or is not on dialysis. 2) Patients with current DVT/PE, in addition to warfarin trial, must have documentation of 5 to 10 days of parenteral anticoagulation prior to initiation of dabigatran. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

[] Pradaxa®

Strength Dosage Instructions Quantity Days Supply

Diagnosis: _____

Does patient have mechanical prosthetic heart valve? [] Yes [] No

Does patient have active pathological bleeding? [] Yes [] No

Is patient on dialysis? [] Yes [] No

Treatment failure with warfarin:

Trial dose: _____ Trial dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies: _____

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

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Atrial Fibrillation (in addition to above)

Patient has a diagnosis of non-valvular atrial fibrillation: Yes No

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

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 (in addition to above):

Does patient have severe renal impairment (CrCl < 30mL/min)? Yes No

Documentation of parenteral anticoagulation:

Drug Name & Dose: _____ Trial start & end dates: _____

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.*



- ◆ Non-valvular atrial fibrillation (in addition to the above):
 - Presence of at least one additional risk factor for stroke, with a CHADS₂ score ≥ 1 ; and
 - Patient does not have severe renal impairment (CrCl $< 15\text{mL/min}$) or is not on dialysis.
- ◆ Treatment and prevention of DVT or PE (in addition to the above):
 - Patient does not have a CrCl $< 30\text{mL/min}$ or is not on dialysis.
 - For patients with current DVT/PE, in addition to warfarin trial, patient must have documentation of 5 to 10 days of parenteral anticoagulation before initiation of dabigatran.

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.

30. **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.



31. **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.

32. **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.

33. **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.



34. 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.

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.



35. 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.

36. 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.

37. 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.



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, Amoxicillin ER, Astagraf XL, 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, Prozac Weekly, Qudexy XR, Rayos, Requip XL, Rythmol SR, Ryzolt, Sanctura XR, Seroquel XR, Sitavig, Solodyn ER, topiramate er, tramadol sr, Trokendi XR, 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.



Request for Prior Authorization
GRANULOCYTE COLONY STIMULATING FACTOR

(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 granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s).

Preferred

Neupogen

Non-Preferred

Granix

Neumega

Leukine

Neulasta

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis (or indication for the product):

- Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
Treatment of neutropenia in patients with malignancies undergoing myeloblastic chemotherapy followed by a bone marrow transplant.
Moibilization of progenitor cells into the peripheral blood stream for leukapheresis collections to be used after myeloblastic chemotherapy.
Treatment of congenital, cyclic, or idopathic neutropenia in symptomatic patients.
On current chemotherapy drug(s) that would cause severe neutropenia (specify)
Other condition specify

Absolute Neutrophil Count (ANC):

Dates of routine CBC:

Platelet Counts:

Pertinent Lab data:

Previous therapy (include drug name, strength and exact date ranges):

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.



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.

38. 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.

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.

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39. 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.



40. Hepatitis C Antiviral Agents, Oral

Prior authorization is required for direct-acting oral antiviral agents against the hepatitis C virus. Requests for nonpreferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions:

- ◆ Patient is 18 years of age or older; and
- ◆ Patient's previous treatment history is provided (treatment naïve, previous null responder, partial responder, or relapse); and
- ◆ If patient has a history of failed treatment due to non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and
- ◆ Patient has not previously tried or failed therapy with a hepatitis C protease inhibitor; and
- ◆ Patient is not a pregnant female or a male with a pregnant female partner; and
- ◆ Women of childbearing potential and their male partners must use two forms of effective contraception (non-hormonal contraception for patients taking Incivek and Sovaldi) during treatment and for at least six months after treatment has concluded; and
- ◆ Documentation that routine monthly pregnancy tests are performed during this time; and
- ◆ Patient has abstained from the use of illicit drugs and alcohol for a minimum of three months as evidenced by a negative urine confirmation test; and
- ◆ Prescriber is an infectious disease specialist, gastroenterologist, hepatologist, or other hepatitis specialist.

Non-FDA approved or non-compensated combination therapy regimens will not be approved.

Lost or stolen medication replacement requests will not be authorized.

The 72-hour emergency supply rule does not apply to oral hepatitis C antiviral agents.



a. Victrelis

Payment will be considered when all of the following criteria are met:

- ◆ Patient has a documented diagnosis of hepatitis C genotype 1; and
- ◆ Administered in combination with peg-interferon alfa and ribavirin; and
- ◆ Patient does not have HIV co-infection; and
- ◆ Patient does not have decompensated cirrhosis.

HCV-RNA results are required at treatment week 8, 12, and 24 (including lead in period).

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 44 weeks of therapy based on response.

b. Olysio

Payment will be considered when all of the following criteria are met:

- ◆ Patient has a documented diagnosis of hepatitis C genotype 1; and
- ◆ Administered in combination with peg-interferon alfa and ribavirin; and
- ◆ Patient does not have HIV co-infection; and
- ◆ Patient does not have the NS3 Q80K polymorphism with hepatitis C genotype 1a; and
- ◆ The patient is not receiving dialysis or does not have a CrCl < 30 mL/min.

HCV-RNA results are required at treatment week four.

Additional prior authorizations will be considered with documentation of response to treatment, measured by HCV-RNA levels.

A maximum of 12 weeks of therapy will be allowed.



c. Sovaldi

Payment will be considered under the following conditions:

- ◆ The patient is not receiving dialysis or does not have a CrCl < 30 mL/min and the patient does not have decompensated cirrhosis. The patient has stage three or greater fibrosis as confirmed and documented by a liver biopsy.
- ◆ The patient has a documented diagnosis of hepatitis C (mono-infected or HCV/HIV co-infected) and used in combination with peg-interferon and ribavirin.
 - A maximum 12 weeks of therapy will be allowed for genotypes 1, 2, or 4.
 - A maximum 24 weeks of therapy will be allowed for genotype 3.
- ◆ The patient had a documented diagnosis of hepatitis C genotype 1, 2, 3, or 4 with a diagnosis of hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation) and in combination with ribavirin for up to 48 weeks or until liver transplantation, whichever comes first. Milan criteria are defined as:
 - One lesion smaller than 5 cm in diameter for subjects with a single lesion;
 - Up to 3 lesions smaller than 3 cm in diameter in subjects with multiple lesions;
 - No extrahepatic manifestations;
 - No vascular invasion.

Requests for peg-interferon alfa free regimens will be considered on a case-by-case basis for patients with hepatitis C genotype 1 or 4 where peg-interferon alfa is contraindicated. Contraindications include:

- ◆ Documented life-threatening side effects;
- ◆ Decompensated hepatic disease;
- ◆ Autoimmune hepatitis or other autoimmune disorders;
- ◆ A baseline neutrophil count below 1500/ μ L;
- ◆ A baseline platelet count below 90,000 μ L; or
- ◆ A baseline hemoglobin below 10g/dL; and
- ◆ A history of preexisting unstable cardiac disease.



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

Use form 470-5270, *Request for Prior Authorization: Hepatitis C Antiviral Agents*, to request prior authorization for Sovaldi. Click [here](#) to see a sample of the form.

41. 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.

42. 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.



Request for Prior Authorization
HEPATITIS C ANTIVIRAL AGENTS
PROTEASE 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.

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

Prior authorization is required for direct-acting oral antiviral agents against the hepatitis C virus. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions: 1) Patient is 18 years of age or older, and 2) Patient's prior treatment history is provided (treatment naïve, prior null responder, partial responder, or relapser); and 3) If patient has a history of failed treatment due to non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and 4) Patient has not previously tried or failed therapy with a hepatitis C protease inhibitor; and 5) Patient is not a pregnant female or a male with a pregnant female partner; and 6) Women of childbearing potential and their male partners must use two forms of effective contraception (non-hormonal contraception for patients taking Incivek) during treatment and for at least 6 months after treatment has concluded; and 7) Documentation that routine monthly pregnancy tests are performed during this time; and 8) Patient has abstained from the use of illicit drugs and alcohol for a minimum of three (3) months as evidenced by a negative urine confirmation test; and 9) Prescriber is an infectious disease specialist, gastroenterologist, hepatologist, or other hepatitis specialist. 10) Non-FDA approved or non-compensated combination therapy regimens will not be approved. 11) Lost or stolen medication replacement requests will not be authorized. 12) The 72-hour emergency supply rule does not apply to oral hepatitis C antiviral agents.

Preferred: [] Victrelis Non-Preferred: [] Olysio

Diagnosis:

[] Chronic Hepatitis C HCV Genotype (attach results) [] 1a [] 1b [] 2 [] 3 [] 4

[] Treatment naïve [] Relapser [] Partial Responder [] Prior null responder

[] Treatment Initiation [] Continuation of therapy, current week: _____

Prior Hepatitis Treatment: [] Yes (complete below information) [] No

Drug Name & Dose: _____ Dates/Duration of use: _____

Drug Name & Dose: _____ Dates/Duration of use: _____

Has member been previously treated with a HCV protease inhibitor? [] Yes [] No

Medical necessity for retreatment: _____

Member History:

[] Does member currently have substance use disorder (illicit drugs or alcohol)? [] Yes [] No

If no, has member been abstinent for a minimum of 3 months confirmed by urine confirmation test?

[] Yes (attach results) [] No

[] Does member have a history of non-compliance? [] Yes [] No



Request for Prior Authorization
HEPATITIS C ANTIVIRAL AGENTS
PROTEASE INHIBITORS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

If yes, document steps taken to correct or address non-compliance:

If female of childbearing years, confirmed negative serum pregnancy test: Yes No Date of test:

Will monthly pregnancy tests be performed during treatment and for 6 months after treatment is concluded:

Yes No

If male, pregnant female partner: Yes No

Specify two forms of contraception:

Does patient have HIV co-infection: Yes No

Is patient receiving dialysis: Yes No CrCl: Date Obtained:

Does patient have decompensated cirrhosis: Yes No

Prescriber information:

infectious disease specialist gastroenterologist hepatologist

other hepatitis specialist (please specify): other (please specify):

Patient receiving concurrent peg-interferon alfa and ribavirin? Yes No

Victrelis (A maximum 24, 32 or 44 weeks will be allowed based on response)

Dosing Instructions:

HCV-RNA Results at Week 8 (including lead in period):

HCV-RNA Results at Week 12 (including lead in period):

HCV-RNA Results at Week 24 (including lead in period):

Olysio (A maximum 12 weeks of therapy will be allowed based on response)

If treating genotype 1a, is the NS3 Q80K polymorphism present: Yes No

HCV-RNA Results at Week 4: Date Drawn:

Reason for use of non-preferred drug:

Attach lab results and other documentation as necessary.

Table with 2 columns: 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.



Request for Prior Authorization
HEPATITIS C ANTIVIRAL AGENTS
SOFOSBUVIR CONTAINING REGIMENS

(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 (PA) is required for direct-acting oral antiviral agents against the hepatitis C virus. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions: 1) Patient is 18 years of age or older; and 2) Patient's prior treatment history is provided (treatment naïve, prior null responder, partial responder, or relapser); and 3) If patient has a history of failed treatment due to non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and 4) Patient has not previously tried or failed therapy with a hepatitis C protease inhibitor; and 5) Patient is not a pregnant female or a male with a pregnant female partner; and 6) Women of childbearing potential and their male partners must use two forms of effective contraception (non-hormonal contraception for patients taking Sovaldi) during treatment and for at least 6 months after treatment has concluded; and 7) Documentation that routine monthly pregnancy tests are performed during this time; and 8) Patient has abstained from the use of illicit drugs and alcohol for a minimum of three (3) months as evidenced by a negative urine confirmation test; and 9) Prescriber is an infectious disease specialist, gastroenterologist, hepatologist, or other hepatitis specialist; and 10) Documentation of a viral load taken within 6 months of beginning therapy is provided. 11) Non-FDA approved or non-compensated combination therapy regimens will not be approved. 12) Lost or stolen medication replacement requests will not be authorized. 13) The 72-hour emergency supply rule does not apply to oral hepatitis C antiviral agents.

Requests for sofosbuvir containing regimens will be considered upon documentation the patient has stage 3 or greater fibrosis as confirmed by a liver biopsy.

Requests for Harvoni will only be considered for patients with a documented diagnosis of hepatitis C, genotype 1 who meet the PA criteria for a contraindication to peg-interferon alfa and all remaining criteria.

Preferred: [] Sovaldi Non-Preferred: [] Harvoni

Dosing Instructions: _____ Length of Therapy: _____

Diagnosis:

[] Chronic Hepatitis C

HCV Genotype (attach results)

[] 1 (maximum 12 weeks of Sovaldi therapy will be allowed) [] 3 (maximum 24 weeks of Sovaldi therapy will be allowed)

[] 2 (maximum 12 weeks of Sovaldi therapy will be allowed) [] 4 (maximum 12 weeks of Sovaldi therapy will be allowed)

[] Other: _____

Liver Fibrosis Stage (attach biopsy results) [] F0-F2 [] F3-F4

[] Hepatocellular carcinoma awaiting liver transplantation (maximum 48 weeks of therapy or until liver transplantation)

Anticipated date of liver transplantation: _____

[] Treatment naïve [] Relapser [] Partial Responder [] Prior null responder

**Request for Prior Authorization
HEPATITIS C ANTIVIRAL AGENTS
SOFOSBUVIR CONTAINING REGIMENS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Prior Hepatitis Treatment: Yes (complete below information) No

Drug Name & Dose: _____ Dates/Duration of use: _____

Drug Name & Dose: _____ Dates/Duration of use: _____

Has member been previously treated with a HCV protease inhibitor? Yes No

Medical necessity for retreatment: _____

Member History:

Does member currently have substance use disorder (illicit drugs or alcohol)? Yes No

If no, has member been abstinent for a minimum of 3 months confirmed by urine confirmation test?

Yes (**attach results**) No

Does member have a history of non-compliance? Yes No

If yes, document steps taken to correct or address non-compliance: _____

If female of childbearing years, confirmed negative serum pregnancy test: Yes No Date of test: _____

Will monthly pregnancy tests be performed during treatment and for 6 months after treatment is concluded:

Yes No

If male, pregnant female partner: Yes No

Specify two forms of contraception: _____

Does patient have HIV co-infection: Yes No

Is patient receiving dialysis: Yes No CrCl: _____ Date Obtained: _____

Does patient have decompensated cirrhosis: Yes No

Prescriber information:

infectious disease specialist gastroenterologist hepatologist

other hepatitis specialist (please specify): _____ other (please specify): _____

Patient receiving concurrent ribavirin: Yes No

Patient receiving concurrent peg-interferon alfa: Yes No

If no, for treatment of genotype 1 or 4, provide contraindication to use: _____

Pretreatment Viral Load: _____ **Date obtained:** _____

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.



Request for Prior Authorization
IVACAF TOR (KALYDECO)

(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 Kalydeco™ (ivacaftor). Payment will be considered for patients when the following criteria are met: 1) Patient is 6 years of age or older; and 2) Has a diagnosis of cystic fibrosis with one of the following mutations in the CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, and S549R as detected by an FDA-cleared CF mutation test; and 3) Prescriber is a CF specialist or pulmonologist; and 4) Patient does not have one of the following infections documented on the most recent sputum culture: Burkholderia cenocepacia, Burkholderia dolosa, Mycobacterium abscessus.

[] Kalydeco™

Strength Dosage Instructions Quantity Days Supply

Diagnosis (Attach copy of test results): _____

Prescriber Specialty: [] CF Specialist [] Pulmonologist [] Other (specify): _____

Most recent sputum culture negative for Burkholderia cenocepacia, Burkholderia dolosa, Mycobacterium abscessus: Date: _____ (please attach copy of results)

Attach lab results and other documentation as necessary. Minimal required results to be submitted are the results of the gene mutation test and most recent sputum culture results.

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.

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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.

43. 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.

44. 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 one of the following mutations in the CFTR gene: G551D, G1244E, G1394D, G178R, G551S, S1255P, S549N, and S549R, 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 cenocepacia*, *Burkholderia dolosa*, or *Mycobacterium abscessus*.

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

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45. 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.



46. **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.

47. **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.



48. 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.

49. 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.

50. 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
- ◆ 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.



51. 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.

52. 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 \geq 500ms.
- ◆ 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.

53. 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.

54. 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.

55. 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.

56. 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.



57. **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.

58. **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.



59. 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.

60. Omalizumab (Xolair®)

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

For moderate to severe persistent asthma:

- ◆ The patient has a diagnosis of moderate to severe persistent asthma for at least one year; and
- ◆ The patient is 12 years of age or older; and
- ◆ Pretreatment IgE level is between 30 IU/ml and 700 IU/ml; and
- ◆ The patient's weight is between 30 kg and 150 kg; and



- ◆ Has a history of a positive skin or RAST test to a perennial aeroallergen; and
- ◆ The prescriber is an allergist, immunologist, or pulmonologist; and
- ◆ The 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.
- ◆ The 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.

For chronic idiopathic urticaria, the patient:

- ◆ Has a diagnosis of moderate to severe chronic idiopathic urticaria; and
- ◆ Is 12 years of age or older; and
- ◆ Has documentation of a trial and therapy failure with at least one second-generation antihistamine, one of which must be cetirizine at a dose up to 20mg per day; and
- ◆ Had documentation of a trial and therapy failure with at least one first-generation antihistamine; and
- ◆ Has documentation of a trial and therapy failure with at least one potent H1 receptor antagonist (hydroxyzine and/or doxepin); and
- ◆ Has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second-generation antihistamine.

If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy.

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.



Request for Prior Authorization
OMALIZUMAB- (XOLAIR®)

(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 Xolair®. Payment for Xolair® will be authorized when the following criteria are met: Moderate to Severe Persistent Asthma: 1) Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and 2) Patient is 12 years of age or older; and 3) Pretreatment IgE level is between 30 IU/mL and 700 IU/mL; and 4) Patient's weight is between 30 kg and 150 kg; and 5) History of positive skin or RAST test to a perennial aeroallergen; and 6) Prescriber is an allergist, immunologist or pulmonologist; and 7) 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 (3) months of therapy. 8) Patient has 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. Chronic Idiopathic Urticaria: 1) Patient has a diagnosis of moderate to severe chronic urticaria; and 2) Patient is 12 years of age or older; and 3) Patient has documentation of a trial and therapy failure with at least one second-generation antihistamine, one of which must be cetirizine at a dose up to 20mg per day; and 4) Patient has documentation of a trial and therapy failure with at least one first-generation antihistamine; and 5) Patient has documentation of a trial and therapy failure with at least one potent H1 receptor antagonist (hydroxyzine and/or doxepin); and 6) Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first-or second- generation antihistamine. If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

Xolair [checkbox]

Strength Dosage Instructions Quantity Days Supply

Diagnosis: _____

Moderate to Severe Persistent Asthma: [checkbox] Mild [checkbox] Moderate [checkbox] Severe

Inhaled Corticosteroid trial: Drug Name: _____ Strength: _____ Instructions: _____

Trial date from: _____ Trial date to: _____

Inhaled Long-Acting Beta-Agonist trial: Drug Name: _____ Strength: _____ Instructions: _____

Trial date from: _____ Trial date to: _____

Medical or contraindication reason to override trial requirements: _____

Pretreatment IgE level: _____ Date Obtained: _____

Patient's Weight (kg): _____ Date Obtained: _____

History of positive skin or RAST test to a perennial aeroallergen: [checkbox] Yes [checkbox] No Date Performed: _____

Please state prescriber's specialty: _____

Patient has access to EpiPen: [checkbox] Yes [checkbox] No

Request for Prior Authorization
OMALIZUMAB- (XOLAIR®)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

For Renewals Only: Has patient shown adequate response to Xolair® therapy? Yes No

Please describe: _____

Chronic Idiopathic Urticaria: Mild Moderate Severe

Second-Generation Antihistamine trial: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

First-Generation Antihistamine trial: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

Potent H1 receptor antagonist trial: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

Preferred Leukotriene Receptor Antagonist in combination with a first-or second- generation antihistamine:

Leukotriene Receptor Antagonist trial: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

First-or Second-Generation Antihistamine trial: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start & end dates from: _____

For Renewals Only: Has patient shown adequate response to Xolair® therapy? Yes No

Please describe: _____

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
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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.*



61. 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.

62. 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 administration during RSV season for a maximum of five doses per patient. No allowances will be made for a sixth dose. Patients, who experience a breakthrough RSV hospitalization, should have their monthly prophylaxis discontinued, as there is an extremely low likelihood of a second RSV hospitalization in the same season. Payment for palivizumab will be considered for patients who meet one of the following criteria:

◆ Chronic Lung Disease (CLD) or prematurity:

The patient is less than 12 months of age at start of therapy and has CLD of prematurity (defined as gestational age less than 32 weeks and required greater than 21% oxygen for at least the first 28 days after birth).

Requests for patients during their second year of life (12 months to < 24 months) will be considered for patients meeting the CLD of prematurity definition above and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the six-month period before the start of the second RSV season.

◆ Premature infants (without CLD or CHD):

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

◆ Children with Neuromuscular Disorder or Anatomic Pulmonary Abnormalities:

Patient is 12 months of age or younger at the start of therapy and has either severe neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway due to an ineffective cough.

◆ Hemodynamically Significant Congenital Heart Disease (CHD):

The patient is less than 12 months of age at start of therapy and has hemodynamically significant CHD further defined by any of the following:

- Patients with acyanotic heart disease who is receiving medication to control congestive heart failure and will require cardiac surgical procedures,
- Patients with moderate to severe pulmonary hypertension, or
- Patients with cyanotic heart defects will be considered with documentation of consultation with a pediatric cardiologist that recommends patient receive palivizumab prophylaxis.



◆ Immunocompromised children:

The patient is less than 24 months of age at start of therapy and is profoundly immunocompromised during the RSV season (e.g., severe combined immunodeficiency, advanced acquired immunodeficiency syndrome, receiving chemotherapy).

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

63. Proton Pump Inhibitors

Prior authorization is not required for the **preferred** proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day.

Requests for PPIs exceeding one unit per day for a diagnosis of gastroesophageal disease 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.

Requests for twice daily dosing for a diagnosis of *Helicobacter pylori* will be considered for up to 14 days of treatment with documentation of active infection.

Payment for a non-preferred PPI will be authorized only for cases in which there is documentation of previous trial and therapy failures with three preferred products.

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



Request for Prior Authorization
PALIVIZUMAB (SYNAGIS®)

(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.

Iowa Medicaid follows the current American Academy of Pediatrics Guidelines for eligibility criteria for prophylaxis of high-risk infants and young children. Prior authorizations will be approved for administration during the RSV season for a maximum of 5 doses per patient.

Preferred

[] Synagis

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis: Gestational Age at Birth (week,day) :

Patient meets at least one of the following criterion:

Chronic Lung Disease (CLD) of Prematurity:

- [] Patient is less than 12 months of age at start of therapy and has CLD of prematurity...
[] Patient is 12 months to < 24 months meeting the CLD of prematurity definition above...
[] Chronic corticosteroid therapy Drug Name, Dose & Therapy Dates:
[] Diuretic therapy Drug Name, Dose & Therapy Dates:
[] Supplemental oxygen Therapy Dates:

Premature Infants (without CLD of Prematurity or CHD):

- [] Patient is less than 12 months of age at start of therapy with a gestational age less than 29 weeks.

Neuromuscular Disorders or Anatomic Pulmonary Abnormalities: Patient is 12 months of age or younger at the start of therapy and has either severe neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway due to an ineffective cough.

- o Describe:

Hemodynamically Significant Congenital Heart Disease (CHD): Patient is less than 12 months of age at start of therapy and has hemodynamically significant congenital heart disease further defined by any of the following:

- [] Patient with acyanotic heart disease who is receiving medication to control congestive heart failure and will require cardiac surgical procedures.
o Hemodynamically Significant CHD diagnosis:
o Current Medication(s): Drug Name, Dose & Therapy Dates:
o Cardiac Surgical Procedure: Procedure & Expected Completion Date:
[] Patient with moderate to severe pulmonary hypertension
[] Requests for patients with cyanotic heart defects will be considered with documentation of consultation with a pediatric cardiologist that recommends patient receive palivizumab prophylaxis.

Request for Prior Authorization
PALIVIZUMAB (SYNAGIS®)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Immunodeficiency: Patient is less than 24 months of age at start of therapy and is profoundly immunocompromised during the RSV season (e.g., severe combined immunodeficiency, advanced acquired immunodeficiency syndrome, receiving chemotherapy).

o Describe: _____

Please indicate if the patient has received any previous Synagis® doses this RSV season. If yes, please provide the date(s) of administration: No Yes Administration Date(s): _____

Please indicate setting in which Synagis is to be administered: _____

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
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

- List of medications with checkboxes: Epoprostenol, Letairis, Sildenafil, Tracleer, Ventavis, Adcirca, Adempas, Flolan, Opsumit, Orenitram, Revatio, Tyvaso, Veletri.

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

- Diagnosis options: 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.) Date of submission

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



64. 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.

65. 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.

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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
Caduet 2.5-20 mg (amlodipine/atorvastatin)	30	30	
Caduet 2.5-40 mg (amlodipine/atorvastatin)	30	30	
Caduet 2.5-100 mg (amlodipine/atorvastatin)	30	30	
Caduet 5-10 mg (amlodipine/atorvastatin)	30	30	
Caduet 5-20 mg (amlodipine/atorvastatin)	30	30	
Caduet 5-40 mg (amlodipine/atorvastatin)	30	30	
Caduet 5-80 mg (amlodipine/atorvastatin)	30	30	
Caduet 10-10 mg (amlodipine/atorvastatin)	30	30	
Caduet 10-20 mg (amlodipine/atorvastatin)	30	30	
Caduet 10-40 mg (amlodipine/atorvastatin)	30	30	
Caduet 10-80 mg (amlodipine/atorvastatin)	30	30	
Catapres 0.1 mg (clonidine)	120	30	
Catapres 0.2 mg (clonidine)	90	30	
Catapres 0.3 mg (clonidine)	60	30	
Cayston 75 mg (aztreonam)	84	28	Every other month dosing allowed
Celebrex 100 mg (celecoxib)	60	30	
Celebrex 200 mg (celecoxib)	30	30	
Celebrex 400 mg (celecoxib)	30	30	
Celexa 10 mg (citalopram)	45	30	
Celexa 20 mg (citalopram)	45	30	
Claritin OTC 10 mg (loratadine)	30	30	
Clindesse 2% vaginal cream (clindamycin phosphate)	40 gm	30	
Cocet (acetaminophen/codeine)	180	30	
Codeine Sulfate 15 mg	180	30	
Codeine Sulfate 30 mg	180	30	
Codeine Sulfate 60 mg	180	30	
Combunox (oxycodone/ibuprofen)	28	30	
Complera (emtricitabine/rilpivirine/ tenofovir disoproxil fumarate)	30	30	
Concerta SA 18 mg (methylphenidate ER)	60	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)	2	30	
Glucagon emergency kit	2	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
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	
Metrogel vaginal (metronidazole vaginal gel 0.75%)	70 gm	30	



Drug Product	Quantity	Days' Supply	Comments
Mevacor 10 mg (lovastatin)	30	30	
Mevacor 20 mg (lovastatin)	30	30	
Mevacor 40 mg (lovastatin)	60	30	
Miacalcin nasal 200 U/dose (calcitonin)	4 ml	30	
Mobic 7.5 mg (meloxicam)	30	30	
Mobic 15 mg (meloxicam)	30	30	
Monopril 10 mg (fosinopril)	60	30	
Monopril 20 mg (fosinopril)	60	30	
Monopril 40 mg (fosinopril)	60	30	
Mscontin 15 mg (morphine sulfate SA)	90	30	
Mscontin 30 mg (morphine sulfate SA)	90	30	
Mscontin 60 mg (morphine sulfate SA)	90	30	
Mscontin 100 mg (morphine sulfate SA)	300	30	
Namenda 2 mg/1 ml oral solution (memantine)	300 ml	30	Comes in 360 ml containers
Namenda 5 mg (memantine)	60	30	
Namenda 10 mg (memantine)	60	30	
Namenda XR 7 mg (memantine)	30	30	
Namenda XR 14 mg (memantine)	30	30	
Namenda XR 21 mg (memantine)	30	30	
Namenda XR 28 mg (memantine)	30	30	
Nasacort AQ (triamcinolone acetonide)	2 bottles (33 gm)	30	
Nasarel (flunisolide)	3 bottles (75 ml)	30	
Nasonex 50 mcg nasal spray (mometasone furoate)	2 bottles (34 gm)	30	
Nexium 20 mg (esomeprazole)	30	30	
Nexium 40 mg (esomeprazole)	60	30	
Niaspan 500 mg (niacin)	30	30	
Niaspan 750 mg (niacin)	60	30	
Niaspan 1000 mg (niacin)	60	30	
Norco 5/325 mg (hydrocodone/ acetaminophen)	360	30	
Norco 7.5/325 mg (hydrocodone/ acetaminophen)	240	30	
Norco 10/325 mg (hydrocodone/ acetaminophen)	180	30	



Drug Product	Quantity	Days' Supply	Comments
Singulair 4 mg granules (montelukast)	30	30	
Singulair 4 mg chew tablets (montelukast)	30	30	
Singulair 5 mg chew tablets (montelukast)	30	30	
Singulair 10 mg tablets (montelukast)	30	30	
Soma 350 mg (carisoprodol)	120	30	
Sonata 5 mg (zaleplon)	30	30	
Sonata 10 mg (zaleplon)	60	30	
Spiriva cap handihaler pkg size 30 (tiotropium bromide)	30	30	
Strattera 10 mg (atomoxetine)	60	30	
Strattera 18 mg (atomoxetine)	60	30	
Strattera 25 mg (atomoxetine)	60	30	
Strattera 40 mg (atomoxetine)	60	30	
Strattera 60 mg (atomoxetine)	30	30	
Strattera 80 mg (atomoxetine)	30	30	
Strattera 100 mg (atomoxetine)	30	30	
Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir/disoproxil fumarate)	30	30	
Stromectol (ivermectin)	15	30	
Sudafed 30 mg (pseudoephedrine)	72	30	Allowed for a cumulative 90 days per 12 month period
Sudafed 60 mg (pseudoephedrine)	72	30	Allowed for a cumulative 90 days per 12 month period
Sudafed 30 mg/5 ml (pseudoephedrine)	240 ml	30	Allowed for a cumulative 90 days per 12 month period
Sutent 12.5 mg (sunitinib)	30	30	
Sutent 25 mg (sunitinib)	30	30	
Sutent 37.5 mg (sunitinib)	30	30	
Sutent 50 mg (sunitinib)	30	30	
Talacen (pentazocine/acetaminophen)	180	30	
Tenex 1 mg (guanfacine)	90	30	
Tenex 2 mg (guanfacine)	90	30	
Terazol 3 (terconazole vaginal cream 0.8%)	20 gm	30	



Drug Product	Quantity	Days' Supply	Comments
Terazol 7 (terconazole vaginal cream 0.4%)	45 gm	30	
Tilade inhaler (nedocromil sodium)	3 inhalers (48.6 gm)	30	
Timoptic ophthalmic solution 0.25% (timolol)	15 ml	30	
Timoptic ophthalmic solution 0.5% (timolol)	15 ml	30	
Timoptic-XE 0.25% (timolol gel forming)	15 ml	30	
Timoptic-XE 0.5% (timolol gel forming)	15 ml	30	
Topamax 25 mg (topiramate)	60	30	
Topamax 50 mg (topiramate)	60	30	
Topamax 100 mg (topiramate)	60	30	
Toprol XL 25 mg (metoprolol ER)	45	30	
Toprol XL 50 mg (metoprolol ER)	45	30	
Toprol XL 100 mg (metoprolol ER)	45	30	
Toprol XL 200 mg (metoprolol ER)	60	30	
Toviaz 4 mg (fesoterodine)	30	30	
Toviaz 8 mg (fesoterodine)	30	30	
Transderm Scop 1.5mg (scopolamine)	8	30	
Travatan Z (travoprost)	5 ml	30	
Tricor 48 mg (fenofibrate)	30	30	
Tricor 145 mg (fenofibrate)	30	30	
Triglide 160 mg (fenofibrate)	30	30	
Twinject (epinephrine)	4 units	30	
Tylenol w/ codeine elixir (acetaminophen/codeine)	2700 ml	30	
Tylenol with codeine No. 2 (acetaminophen/codeine)	390	30	
Tylenol with codeine No. 3 (acetaminophen/codeine)	390	30	
Tylenol with codeine No. 4 (acetaminophen/codeine)	390	30	
Uloric 40 mg (febuxostat)	30	30	
Ultracet (tramadol/apap)	240	30	
Ultram 50 mg (tramadol)	240	30	
Ultram ER 100 mg (tramadol ER)	30	30	
Ultram ER 200 mg (tramadol ER)	30	30	
Ultram ER 300 mg (tramadol ER)	30	30	
Uroxatral (alfuzosin)	30	30	



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	

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

Prior authorization is required for repository corticotropin 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 corticotropin 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.

67. 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).



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

68. 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.

69. 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.

70. 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
SEROTONIN 5-HT1 RECEPTOR AGONISTS

(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 preferred 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.

Preferred (PA required after 12 doses in 30 days)

- Imitrex Injectable
Imitrex Nasal Spray
Relpax
Rizatriptan Tablets
Sumatriptan Tablets

Non- Preferred (PA required from Day 1)

- Amerge
Axert
Frova
Imitrex Tablets
Maxalt
Maxalt MLT
Naratriptan
Rizatriptan ODT
Sumatriptan NS
Sumatriptan Inj
Sumavel DosePro
Treximet*
Zolmitriptan
Zomig
Zomig ZMT

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

If Migraine, please document the current prophylactic therapy or 2 previous trials and therapy failures with two different prophylactic medications including drug names, strength, exact date ranges and failure reasons:

Medical or contraindication reason to override trial requirements:

Previous migraine therapy (include drug/dose/duration):

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.



71. 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.

72. 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.



73. 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.

74. 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.



- ◆ 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®.
- ◆ Patients with and without a history of substance abuse have been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence.
- ◆ The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring website at <https://pmp.iowa.gov/IAPMPWebCenter/> prior to requesting prior authorization.

Requests for patients with 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.

75. 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



Request for Prior Authorization
TESTOSTERONE PRODUCTS

(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 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.

- 1) Patient is male and 18 years of age or older (or 12 years of age and older for testosterone cypionate); and
2) Patient has two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (attach results); and
3) Patient has at least one of the signs and symptoms specific to androgen deficiency; and
4) Patient does not have: Breast or prostate cancer, Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL, Hematocrit > 50%, Untreated severe obstructive sleep apnea, Severe lower urinary tract symptoms, Uncontrolled or poorly controlled heart failure

If criteria for coverage are met, initial authorizations will be given for 3 months. Requests for continuation of therapy will require the following:

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

Requests for FDA approved and compendia 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 use of these agents would be medically contraindicated.

Preferred

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

Non-Preferred

- Androgel
- Aveed
- Axiron
- Depo-Testosterone
- Fortesta
- Methitest
- Striant
- Testosterone Gel
- Vogelxo

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.



76. 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.

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.

77. 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.

78. Trametinib (Mekinist™)

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

- ◆ Patient is 18 years of age or older, and
- ◆ Patient has a documented diagnosis of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutation as detected by an FDA-approved test, and
- ◆ Patient has not received prior therapy with a BRAF-inhibitor, and
- ◆ Prescriber is an oncologist.

If 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 470-5260, *Request for Prior Authorization: Trametinib (Mekinist™)*, to request prior authorization. Click [here](#) to see a sample of the form.

79. 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.

80. 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.



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 capsules	√
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.

6. Override Codes

A 72-hour emergency supply of medication may be dispensed using prior authorization type code "1" as a point of sale override. The provision for a 72-hour supply can be used in an emergency situation only one time per member, per drug.

A seven-day override of the prior authorization requirement will be allowed while the prescriber is requesting prior authorization for certain mental health drugs. The override applies to drugs that are deemed to have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class. See the Preferred Drug List at: www.iowamedicaidpdl.com

The pharmacy may use a prior authorization type code "7" as a point of sale override for applicable mental health drugs. The seven-day provision can be used only one time per member, per NDC, per 30 days.

7. Proper Reporting of NDCs

The Iowa Medicaid Program can cover only drugs from manufacturers who have signed national Medicaid drug rebate agreements with the Centers for Medicare and Medicaid Services (CMS). Drug companies sign the agreements for specific drug manufacturer codes called national drug codes (NDC).

Since rebates are determined by Iowa Medicaid's utilization data, it is imperative that pharmacies and providers bill Iowa Medicaid using the correct NDC number of the drug actually dispensed or administered.

If a provider is dispensing or administering one drug and billing for an NDC different from the drug being dispensed or administered, it is considered fraud, which can result in claims being recouped, sanctions, and termination of provider agreements. The Program Integrity Unit will be monitoring for this in their reviews.