



Iowa Department of Human Services

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Employees' Manual, Title 8
Medicaid Appendix

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PRESCRIBED DRUGS MANUAL TRANSMITTAL NO. 16-1

ISSUED BY: Division of Medical Services

SUBJECT: **PRESCRIBED DRUGS**, Chapter III, *Provider-Specific Policies*, Contents (pages 1 through 5), revised; Contents (page 6), new; pages 1, 4, 5, 15, and 17 through 149, revised; pages 150 through 164, new; and the following forms:

- 470-5018 *Request for Prior Authorization: Alpha₂ Agonists, Extended-Release*, revised
- 470-5365 *Request for Prior Authorization: Alpha₁ Proteinase Inhibitor Enzymes*, new
- 470-4093 *Request for Prior Authorization: Anti-Acne Products-Topical*, revised
- 470-5259 *Request for Prior Authorization: Anti-Diabetic Non-Insulin Agents*, revised
- 470-4410 *Request for Prior Authorization: Antiemetic-5HT₃ Receptor Antagonists/Substance P Neurokinin Products*, revised
- 470-4094 *Request for Prior Authorization: Antifungal Drugs*, revised
- 470-5336 *Request for Prior Authorization: Binge Eating Disorder Agents*, revised
- 470-4521 *Request for Prior Authorization: Biologicals for Ankylosing Spondylitis*, revised
- 470-4523 *Request for Prior Authorization: Biologicals for Inflammatory Bowel Disease*, revised
- 470-4524 *Request for Prior Authorization: Biologicals for Plaque Psoriasis*, revised
- 470-5017 *Request for Prior Authorization: Buprenorphine Transdermal System (Butrans) & Buccal Film (Belbuca)*, revised and renamed
- 470-5391 *Request for Prior Authorization: Cholic Acid (Cholbam[®])*, new
- 470-4116 *Request for Prior Authorization: CNS Stimulants and Atomoxetine*, revised
- 470-5330 *Request for Prior Authorization: Deferasirox*, revised
- 470-5345 *Request for Prior Authorization: Edoxaban (Savaysa[®])*, new

470-4550 *Request for Prior Authorization: Extended Release Formulations, revised*

470-4099 *Request for Prior Authorization: Granulocyte Colony Stimulating Factor, revised*

470-4100 *Request for Prior Authorization: Growth Hormones, revised*

470-5270 *Request for Prior Authorization: Hepatitis C Treatments, revised*

470-5346 *Request for Prior Authorization: Idiopathic Pulmonary Fibrosis, new*

470-5040 *Request for Prior Authorization: Immunomodulators-Topical, revised*

470-4111 *Request for Prior Authorization: Insulin, Pre-Filled Pens, revised*

470-4101 *Request for Prior Authorization: Isotretinoin (Oral), revised*

470-5117 *Request for Prior Authorization: Ivacaftor (Kalydeco™), revised*

470-4275 *Request for Prior Authorization: Linezolid (Zyvox®), revised*

470-5366 *Request for Prior Authorization: Lumacaftor/Ivacaftor (Orkambi™), new*

470-4705 *Request for Prior Authorization: Modified Formulations, revised*

470-4107 *Request for Prior Authorization: Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products, revised*

470-4109 *Request for Prior Authorization: Nonsteroidal Anti-Inflammatory Drugs, revised*

470-5174 *Request for Prior Authorization: Oral Constipation Agents, revised*

470-5399 *Request for Prior Authorization: PCSK9 Inhibitors, new*

470-5367 *Request for Prior Authorization: Select Oncology Agents, new*

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

470-4899 *Request for Prior Authorization: Short Acting Narcotics, revised*

470-5016 *Request for Prior Authorization: Sodium Oxybate (Xyrem®), revised*

470-5188 *Request for Prior Authorization: Testosterone Products, revised*

470-5368 *Request for Prior Authorization: Topical Antifungals for Onychomycosis, new*

470-5347 *Request for Prior Authorization: Topical Corticosteroids, new*

470-4114 *Request for Prior Authorization: Topical Retinoids for Acne, revised*

470-5398 *Request for Prior Authorization: Valsartan/Sacubitril (Entresto), new*

Summary

The Prescribed Drug manual is revised to:

- ◆ Revise 29 forms for requesting drug prior authorization.
- ◆ Add 10 forms for requesting drug prior authorization.
- ◆ Remove the following forms for requesting drug prior authorization:
 - 470-5136, *Request for Prior Authorization: BRAF Inhibitors*
 - 470-5332, *Request for Prior Authorization: Ceritinib (Zykadia™)*
 - 470-5118, *Request for Prior Authorization: Crizotinib (Xalkori)*
 - 470-5260, *Request for Prior Authorization: Trametinib (Mekinist)*
- ◆ Rename form 470-5017 from *Request for Prior Authorization: Buprenorphine (Butrans) Transdermal System* to *Request for Prior Authorization: Buprenorphine Transdermal System (Butrans) & Buccal Film (Belbuca)*.
- ◆ Update the quantity limit chart.
- ◆ Update definitions.
- ◆ Update new drug entity process.
- ◆ Add non-enrolled prescriber requirement.
- ◆ Remove after hours contact information.
- ◆ Remove three cost effectiveness edits.
- ◆ Remove one dosage form edit.
- ◆ Remove three therapeutic duplication edits.
- ◆ Update nonprescription drug billing requirement.
- ◆ Update links.

Date Effective

Upon receipt.

Material Superseded

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

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Chapter III	
Contents (pages 1-5)	September 1, 2015
1	September 1, 2015
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103-106	September 1, 2015
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470-4114	1/14
107, 108	September 1, 2015
470-5260	6/14
109-149	September 1, 2015

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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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. GENERAL PHARMACY GUIDELINES

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

www.iadur.org

www.dhs.iowa.gov/ime/about

www.iowamedicaidpdl.com

www.mslc.com/iowa

www.iowamedicaidpos.com

Drug Utilization Review (DUR) Commission
Iowa Medicaid Enterprise (IME)
Pharmaceutical and Therapeutics (P&T)
Committee and Preferred Drug List (PDL)
Pharmacy Reimbursement
Point of Sale (POS) system for pharmacy claims

1. Definitions

340B Program means the federal 340B Drug Pricing program as set forth in Section 340B of the Public Health Service (PHS) Act (1992) and managed by Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). The program allows certain designated facilities to purchase prescription medications at discounts, so these facilities can offer some medications to their patients at reduced prices.

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

340B Covered entity (CE) means facilities and programs listed in the 340B statute as eligible to purchase drugs through the 340B program and appear on the HRSA 340B database.

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

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

Compendium of drug information means one of the following:

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



Nonrecommended drug means a drug placed on a voluntary list designed to inform prescribers of cost-effective alternatives and, if used, will be more costly to the Medicaid program. The drug does not require a prior authorization unless a number is in the comments column to indicate a prior authorization is required. A nonrecommended drug is designated “NR” on the Preferred Drug List.

Pharmaceutical and Therapeutics (P&T) Committee means a committee of nine members appointed by the Governor that is charged with developing and providing ongoing review of the Preferred Drug List pursuant to Iowa Code section 249A.20A.

Preferred drug means a drug on the Preferred Drug List that provides medical equivalency to the Medicaid member in a cost-effective manner (by virtue of OBRA '90 and Supplemental Rebate) and does not require a prior authorization. A preferred drug is designated “P” on the Preferred Drug List.

Preferred Drug List (PDL) means a list comprised of drugs recommended to the Iowa Department of Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that have been identified as being therapeutically equivalent within a drug class and that provide cost benefit to the Medicaid program.

Preferred drug with conditions means a drug is a “preferred” agent but before getting the drug a patient must meet medical criteria and guidelines that coincide with current prior authorization criteria. A preferred drug with conditions is designated “P” on the Preferred Drug List and has a number in the comments column to indicate a prior authorization is required, as defined on the first page of the Preferred Drug List (PDL).

Prior authorization (PA) means obtaining approval for a drug before the drug is provided to a member, as a precondition for provider reimbursement. Prior authorization is requested at the prescriber level and is a prescriber fax-only system using the forms provided by the Iowa Medicaid Enterprise.

Professional dispensing fee means payment provided for the costs incurred by a pharmacy to dispense a drug. The fee reflects the pharmacist’s professional services and costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid member.



Prospective drug utilization review (Pro-DUR) means a process in which a request for a drug product for a particular patient is screened for potential drug therapy problems before the product is dispensed.

Recommended drug means a drug placed on a voluntary list designed to inform prescribers of cost-effective alternatives and, if used, will result in a cost savings to the Medicaid program. The drug does not require a prior authorization unless a number is in the comments column to indicate a prior authorization is required. A recommended drug is designated "R" on the Preferred Drug List.

Recommended drug list (RDL) means a voluntary list of drugs recommended to the Department of Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that informs prescribers of cost-effective alternatives that do not require a prior authorization unless otherwise indicated in the comments column. The RDL is a component of the PDL.

Retrospective drug utilization review (Retro-DUR) means the process in which patient drug utilization is periodically reviewed to identify patterns of fraud, abuse, gross overuse, or inappropriate or unnecessary care.

Usual and customary charge means the fee that the provider typically charges the general public for the product or service.

Wholesale Acquisition Cost (WAC) represents the cost reported to Medi-Span by a manufacturer (updated in a number of ways) at which wholesalers purchase drug products from that manufacturer.

2. Entities Involved in Developing Medicaid Drug Policies

a. Drug Utilization Review Commission

The Iowa Medicaid Drug Utilization Review (DUR) Commission, established pursuant to Iowa Code section 249A.24, is a quality assurance body of nine members that seeks to improve the quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid members in Iowa.

This Commission meets six times a year in a public forum. The Commission discusses potential medications or therapeutic classes where prior authorization may be beneficial, and discusses existing criteria to determine if the criteria continue to be therapeutically valid.



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

5. Nonpreferred Drugs

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

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

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

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

6. Newly Released Drugs

a. New Drug Entities

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

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



7. Nonprescription Drugs

Payment will be made for the following listed nonprescription drugs with a prescription, subject to prior authorization requirements as indicated below and specified in the preferred drug list.

Nonprescription drugs cannot be billed to IME Medicaid POS for members residing in Nursing Facilities (NF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID), and Psychiatric Medical Institutions for Children (PMIC) facilities. These are considered 'stock items' and are to be included in the facility's Medicaid cost report and reimbursed through per diem calculations.

The only exclusions to this policy are as follows:

- ◆ OTC insulin: Bill dual eligible member's Medicare Part D plan; for the Medicaid only, bill Medicaid as a POS claim.
- ◆ Pseudoephedrine: Since these agents are classified as controlled substances in Iowa, for the dual eligible and Medicaid only, bill Medicaid as a POS claim.

Payment will be made in the same manner as for prescription drugs.

Drug	√ = Prior Authorization Required
Acetaminophen tablets, 325 mg	
Acetaminophen tablets, 500 mg	
Acetaminophen elixir, 160 mg/5 ml	
Acetaminophen solution, 100 mg/ml	
Acetaminophen suppositories, 120 mg	
Artificial tears ophthalmic solution	
Artificial tears ophthalmic ointment	
Aspirin, 81 mg (chewable)	
Aspirin, 81 mg (plain, enteric-coated)	
Aspirin tablets, 325 mg	
Aspirin tablets, 650 mg	
Aspirin tablets, enteric-coated, 325 mg	
Aspirin tablets, enteric-coated, 650 mg	
Aspirin tablets, buffered, 325 mg	



Drug	√ = Prior Authorization Required
Bacitracin ointment, 500 units/gm	
Benzoyl peroxide 5% gel	
Benzoyl peroxide 5% lotion	
Benzoyl peroxide 10% gel	
Benzoyl peroxide 10% lotion	
Cetirizine 1 mg/ml liquid	
Cetirizine 5 mg tablets	
Cetirizine 10 mg tablets	
Chlorpheniramine maleate tablets, 4 mg	
Clotrimazole vaginal cream 1%	
Diphenhydramine hydrochloride capsules, 25 mg	
Diphenhydramine hydrochloride elixir, 12.5 mg/5 ml	
Diphenhydramine hydrochloride liquid, 12.5 mg/5 ml	
Diphenhydramine hydrochloride syrup, 12.5 mg/5 ml	
Epinephrine, racemic solution 2.25%	
Guaifenesin, 100 mg/5 ml with dextromethorphan liquid, 10 mg/5 ml	
Ibuprofen suspension 100 mg/5 ml	
Ibuprofen tablets, 200 mg	
Loperamide HCl liquid, 1 mg/5 ml	
Loperamide HCl tablets, 2 mg	
Loratadine tablets, 10 mg	
Loratadine syrup, 5 mg/5 ml	
Magnesium hydroxide suspension, 400 mg/5 ml	
Meclizine hydrochloride tablets, 12.5 mg	
Meclizine hydrochloride tablets, 25 mg	
Meclizine hydrochloride chewable tablets, 25 mg	
Miconazole nitrate cream, 2% topical	
Miconazole nitrate cream, 2% vaginal	
Miconazole nitrate vaginal suppositories, 100 mg	
Neomycin-bacitracin-polymyxin ointment	
Nicoderm transdermal patch, 7 mg/24 hr	√
Nicotine transdermal patch, 7 mg/24 hr	√
Nicoderm transdermal patch, 14 mg/24 hr	√
Nicotine transdermal patch, 14 mg/24 hr	√
Nicoderm transdermal patch, 21 mg/24 hr	√
Nicotine transdermal patch, 21 mg/24 hr	√
Nicorette gum, 2 mg	√
Nicotine gum, 2 mg	√
Nicorette gum, 4 mg	√
Nicotine gum, 4 mg	√



Drug	√ = Prior Authorization Required
Commit lozenge, 2 mg	√
Nicotine polacrilex lozenge, 2 mg	√
Commit lozenge, 4 mg	√
Nicotine polacrilex lozenge, 4 mg	√
Permethrin lotion, 1%	
Polyethylene glycol 3350 powder 119 grams	√ for ages 13-18
Polyethylene glycol 3350 powder 238 grams	√ for ages 13-18
Polyethylene glycol 3350 powder 510 grams	√ for ages 13-18
Pseudoephedrine syrup, 30 mg/5 ml	
Pseudoephedrine tablets, 30 mg	
Pseudoephedrine tablets, 60 mg	
Pyrethrins-piperonyl butoxide liquid, 0.33-4%	
Pyrethrins-piperonyl butoxide shampoo, 0.3-3%	
Pyrethrins-piperonyl butoxide shampoo, 0.33-4%	
Salicylic acid liquid 17%	
Sennosides-docusate sodium tablets, 8.6-50 mg	
Sennosides syrup, 8.8 mg/5 ml	
Sennosides tablets, 8.6 mg	
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:

- ◆ [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 \(Eliquis[®]\)](#)
- ◆ [Apremilast \(Otezla[®]\)](#)
- ◆ [Becaplermin \(Regranex[®]\)](#)
- ◆ [Benzodiazepines](#)
- ◆ [Binge eating disorder agents](#)
- ◆ [Biologicals for ankylosing spondylitis](#)
- ◆ [Biologicals for arthritis](#)
- ◆ [Biologicals for inflammatory bowel disease](#)
- ◆ [Biologicals for plaque psoriasis](#)
- ◆ [Buprenorphine transdermal system \(Butrans[™]\) & buccal film \(Belbuca[™]\)](#)
- ◆ [Buprenorphine/Naloxone \(Suboxone[®]\)](#)
- ◆ [Cholic acid \(Cholbam[®]\)](#)
- ◆ [Chronic pain syndrome agents](#)
- ◆ [CNS Stimulants and Atomoxetine](#)
- ◆ [Colchicine \(Colcrys[®]\)](#)
- ◆ [Concurrent IM/PO antipsychotic use](#)
- ◆ [Dabigatran \(Pradaxa[®]\)](#)
- ◆ [Dalfampridine \(Ampyra[™]\)](#)
- ◆ [Deferasirox \(Exjade[®]\)](#)
- ◆ [Dextromethorphan and Quinidine \(Nuedexta[™]\)](#)
- ◆ [Dornase alfa \(Pulmozyme[®]\)](#)
- ◆ [Edoxaban \(Savaysa[®]\)](#)
- ◆ [Eplerenone \(Inspra[®]\)](#)
- ◆ [Erythropoiesis stimulating agents](#)
- ◆ [Extended release formulations](#)
- ◆ [Febuxostat \(Uloric[®]\)](#)
- ◆ [Fentanyl, short-acting oral products](#)



- ◆ [Granulocyte colony stimulating factor agents](#)
- ◆ [Growth hormones](#)
- ◆ [Hepatitis C treatments](#)
- ◆ [Idiopathic pulmonary fibrosis](#)
- ◆ [Immunomodulators, topical](#)
- ◆ [Insulin, pre-filled pens](#)
- ◆ [Isotretinoin \(oral\)](#)
- ◆ [Ivacaftor \(Kalydeco™\)](#)
- ◆ [Janus Kinase Inhibitors](#)
- ◆ [Ketorolac tromethamine \(Toradol®\)](#)
- ◆ [Lidocaine patch \(Lidoderm®\)](#)
- ◆ [Linezolid \(Zyvox®\)](#)
- ◆ [Long acting narcotics](#)
- ◆ [Lumacaftor/Ivacaftor \(Orkambi™\)](#)
- ◆ [Methotrexate injection](#)
- ◆ [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 \(Lubiprostone and Linaclotide\)](#)
- ◆ [Oral immunotherapy](#)
- ◆ [Palivizumab \(Synagis®\)](#)
- ◆ [PCSK9 inhibitors](#)
- ◆ [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](#)
- ◆ [Select oncology agents](#)
- ◆ [Selected brand name drugs](#)
- ◆ [Serotonin 5-HT1 receptor agonists](#)



- ◆ [Short-acting narcotics](#)
- ◆ [Smoking cessation therapy \(oral\)](#)
- ◆ [Sodium oxybate \(Xyrem®\)](#)
- ◆ [Tasimelteon \(Hetlioz®\)](#)
- ◆ [Testosterone products](#)
- ◆ [Thrombopoietin receptor agonists](#)
- ◆ [Topical antifungals for onychomycosis](#)
- ◆ [Topical corticosteroids](#)
- ◆ [Topical retinoids for acne](#)
- ◆ [Valsartan/Sacubitril \(Entresto™\)](#)
- ◆ [Vitamins, minerals and multiple vitamins](#)
- ◆ [Vorapaxar \(Zontivity™\)](#)
- ◆ [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.



1. Completing a Prior Authorization Request

Each category of prior authorization uses a specific request form to reflect the criteria for approval. The following instructions refer to items common to all *Requests for Prior Authorization*.

IA MEDICAID MEMBER ID #: Copy this number directly from the member's *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven numeric digits and one alphabetical character).

PATIENT NAME: Provide the first and last name of the member. Use the *Medical Assistance Eligibility Card* for verification.

DATE OF BIRTH (DOB): Copy the member's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (i.e., 04/11/67).

PATIENT ADDRESS: Enter the member's home address.

PRESCRIBER NUMBER: Enter the national provider identifier (NPI) of the prescribing practitioner.

PRESCRIBER NAME: Enter the name of the prescribing practitioner.

PRESCRIBER PHONE NUMBER: Enter the prescriber's office phone number.

PRESCRIBER ADDRESS: Enter the prescriber's office address.

PRESCRIBER FAX NUMBER: Enter the prescribing practitioner's office FAX number.

PHARMACY NAME: Enter the name of the pharmacy where the prescription will be filled.

PHARMACY ADDRESS: Enter the street address and city of the pharmacy.

PHARMACY PHONE NUMBER: Enter the phone number of the pharmacy.

PHARMACY NPI: Enter the pharmacy national provider identifier (NPI) number.

NDC: If available, enter the National Drug Code of the product being requested.



DRUG NAME: Provide the complete drug name of the product being requested.

STRENGTH: Enter the strength of the drug being requested.

DOSAGE INSTRUCTIONS: Enter the instructions for use for the requested product.

QUANTITY: Enter the quantity on the prescription (cannot exceed a one-month supply).

DAYS SUPPLY: Enter the number of days' supply requested (cannot exceed a one-month supply).

LENGTH OF THERAPY ON PRESCRIPTION (DATE RANGE): Provide an estimate of the duration of therapy. The prior authorization period granted will be subject to adjustment by the reviewer according to established criteria and individual consideration.

DIAGNOSIS: Enter the patient's diagnosis relevant to the requested product.

PREVIOUS THERAPY: Enter drug names, strengths, dosage instructions, and exact date ranges of other medications that have previously been tried and failed by patient.

PERTINENT LAB DATA: Enter any laboratory 909 data that may affect the outcome of this request.

OTHER MEDICAL CONDITIONS TO CONSIDER: Enter any other medical conditions the patient has that may help the Prior Authorization Unit make a decision.

POSSIBLE DRUG INTERACTIONS/CONFLICTING DRUG THERAPIES: If the patient is taking any other medications that may negatively affect the requested product, list them here.

PRESCRIBER SIGNATURE: The prescriber must sign the form and the signature must match the prescriber name listed at the top of the request form.

DATE OF SUBMISSION: Enter the date the prior authorization request was submitted.



2. Submitting a Prior Authorization Request

Completed drug prior authorization requests must be submitted **via FAX** to the IME Drug Prior Authorization Unit at 800-574-2515.

Regular working hours for the provider help desk are Monday through Friday, 8:00 a.m. to 5:00 p.m.

State-recognized holidays are as follows:

- ◆ New Year's Day
- ◆ Martin Luther King Jr.'s birthday
- ◆ Memorial Day
- ◆ Independence Day
- ◆ Labor Day
- ◆ Veterans' Day
- ◆ Thanksgiving Day
- ◆ The Friday following Thanksgiving
- ◆ Christmas Day

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction for prior authorization requests (278 transaction). However, there is no standard to use in submitting additional documentation electronically.

Therefore, if you submit a prior authorization request electronically, you must submit the additional documentation on paper using the following procedure:

- ◆ Complete form 470-3970, *Prior Authorization Attachment Control*. To view a sample of this form on line, click [here](#).

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

- ◆ **Staple** the additional information to the *Prior Authorization Attachment Control*.



- ◆ **Fax** the form with attachments to the Prior Authorization Unit at 800-574-2515 **or mail** the information to:

Iowa Medicaid Enterprise
PO Box 36478
Des Moines, IA 50315

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

3. Prior Authorization Response

The pharmacist reviewer will make a decision and respond within 24 hours of the request. In evaluating requests for prior authorization, the reviewer will consider the drug from the standpoint of published criteria only.

If a prior authorization request is denied, a letter of denial will be faxed to both the prescriber and the pharmacist. A letter of denial will be mailed to the member.

Upon approval of a prior authorization request, a letter of approval will be faxed to the prescriber and the pharmacy indicating the prior authorization number and dates of authorization.

NOTE: When approval of a request is granted, this does not indicate validity of the prescription, nor does it indicate that the member continues to be eligible for Medicaid. If you are not billing on the point-of-sale system, it is your responsibility to establish that the member continues to be eligible for Medicaid, either by:

- ◆ Calling the eligibility verification system (ELVS) at (515) 323-9639 (local calls) or 800-338-7752; or
- ◆ Checking the IME web portal;
<http://www.edissweb.com>



Request for Prior Authorization
ALPHA2 AGONISTS, EXTENDED-RELEASE

(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 extended-release alpha2 agonists. Payment will be considered for patients when the following is met: 1) The patient has a diagnosis of ADHD and is between 6 and 17 years of age. 2) 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 3) Previous trial and therapy failure at a therapeutic dose with one preferred amphetamine and one preferred non-amphetamine stimulant; and 4) Previous trial and therapy failure at a therapeutic dose with atomoxetine (Strattera®). The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

Non-Preferred

[] Guanfacine ER

[] Intuniv

[] Kapvay

[] Clonidine ER

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

Trial of preferred immediate release product of same chemical entity: Drug Name & Dose:

Trial Dates: Failure Reason:

Trial of preferred amphetamine stimulant: Drug Name & Dose:

Trial Dates: Failure Reason:

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

Trial dates: Failure Reason:

Trial of atomoxetine (Strattera®): Dose: Trial Dates:

Failure Reason:

Medical or contraindication reason to override trial requirements:

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
ALPHA1-PROTEINASE INHIBITOR ENZYMES

(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 Alpha1-Proteinase Inhibitor enzymes. Payment for a non-preferred Alpha1-Proteinase Inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

- 1. Patient has a diagnosis of congenital alpha1-antitrypsin (AAT) deficiency; with a pretreatment serum concentration of AAT less than 11µM/L or 80mg/dl if measured by radial immunodiffusion, or 50mg/dl if measured by nephelometry; and
2. Patient has a high-risk AAT deficiency phenotype (PiZZ, PiZ (null), or PI (null)(null) or other phenotypes associated with serum AAT concentrations of less than 11µM/L, such as PiSZ or PiMZ); and
3. Patient has documented progressive panacinar emphysema with a documented rate of decline in forced expiratory volume in 1 second (FEV1); and
4. Patient is 18 years of age or older; and
5. Patient is currently a non-smoker; and
6. Patient is currently on optimal supportive therapy for obstructive lung disease (inhaled bronchodilators, inhaled steroids); and
7. Medication will be administered in the member's home by home health or in a long-term care facility.

If the criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met:

- 1. Evidence of clinical efficacy, as documented by:
a. An elevation of AAT levels (above protective threshold i.e., > 11µM/L); and
b. A reduction in rate of deterioration of lung function as measured by a decrease in the FEV1 rate of decline; and
2. Patient continues to be a non-smoker; and
3. Patient continues supportive therapy for obstructive lung disease.

Preferred: [] Prolastin C Non-Preferred: [] Aralast NP [] Glassia [] Zemaira

Strength _____ Dosage instructions _____ Quantity _____ Days supply _____

Diagnosis: _____

Provide member's AAT deficiency phenotype (attach results): _____

Pretreatment serum concentration of AAT (attach results): _____

Does member have progressive panacinar emphysema with documented rate of decline in FEV1?

[] Yes (attach documentation of FEV1 decline) [] No

Is the member currently a smoker? [] Yes [] No

**Request for Prior Authorization
ALPHA₁-PROTEINASE INHIBITOR ENZYMES**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Member is currently on supportive therapy for obstructive lung disease (inhaled bronchodilators, inhaled steroids):

Yes (provide information below) No

Medication	Strength	Dosage Instructions	Start Date

Please indicate setting in which medication is to be administered:

Home by home health Long-term care facility Other: _____

Renewal Requests:

List and attach updated AAT levels: Level: _____ Date: _____

Does member have of a reduction in rate of deterioration of lung function as measured by FEV₁:

Yes (attach documentation) No

Does the member continue to be a non-smoker? Yes No

Is the member continuing supportive therapy for obstructive lung disease?

Yes (provide information below) No

Medication	Strength	Dosage Instructions	Start Date

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

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

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



4. **Alpha₂ Agonists, Extended-Release**

Prior authorization is required for extended-release alpha₂ agonists. Payment will be considered when the following is met:

- ◆ The patient has a diagnosis of ADHD and is between 6 and 17 years of age; and
- ◆ 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 one preferred amphetamine and one preferred non-amphetamine stimulant; and
- ◆ Previous trial and therapy failure at a therapeutic dose with atomoxetine (Strattera[®]).

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

Use form 470-5018, *Request for Prior Authorization: Alpha₂ Agonists, Extended-Release*, to request prior authorization. Click [here](#) to see a sample of the form.

5. **Alpha₁ Proteinase Inhibitor Enzymes**

Prior authorization is required for alpha₁-proteinase inhibitor enzymes.

Payment for a nonpreferred alpha₁-proteinase inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

Payment will be considered for patients when the following is met:

- ◆ Patient has a diagnosis of congenital alpha₁-antitrypsin (AAT) deficiency; with a pretreatment serum concentration of AAT less than 11µM/L, or
 - 80mg/dl if measured by radial immunodiffusion, or
 - 50mg/dl if measured by nephelometry; and
- ◆ Patient has a high-risk AAT deficiency phenotype (PiZZ, PiZ (null), or PI (null)(null) or other phenotypes associated with serum AAT concentrations of less than 11µM/L, such as PiSZ or PiMZ); and



- ◆ Patient has documented progressive panacinar emphysema with a documented rate of decline in forced expiratory volume in 1 second (FEV1); and
- ◆ Patient is 18 years of age or older; and
- ◆ Patient is currently a non-smoker; and
- ◆ Patient is currently on optimal supportive therapy for obstructive lung disease (inhaled bronchodilators, inhaled steroids); and
- ◆ Medication will be administered in the member's home by home health or in a long-term care facility.

If the criteria for coverage are met, initial requests will be given for six months. Additional authorizations will be considered at six month intervals when the following criteria are met:

- ◆ Evidence of clinical efficacy, as documented by:
 - An elevation of AAT levels (above protective threshold i.e., > 11 μ M/L); and
 - A reduction in rate of deterioration of lung function as measured by a decrease in the FEV1 rate of decline; and
- ◆ Patient continues to be a non-smoker; and
- ◆ Patient continues supportive therapy for obstructive lung disease.

Use form 470-5365, *Request for Prior Authorization: Alpha₁-Proteinase Inhibitor Enzymes*, to request prior authorization. Click [here](#) to see a sample of the form.

6. Amylino Mimetic (Symlin[®])

Prior authorization is required for amylyno mimetics (Symlin[®]). Payment will be considered under the following conditions:

- ◆ Diagnosis of Type 1 or Type 2 diabetes mellitus,
- ◆ Concurrent use of insulin therapy,
- ◆ Documentation of blood glucose monitoring three or more times daily,
- ◆ Inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin-dosing regiments.



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 improvement in HbgA1C since the beginning of the initial prior authorization period.

Use form 470-4406, *Request for Prior Authorization: Amylino Mimetic (Symlin[®])*, to request prior authorization. Click [here](#) to see a sample of the form.

7. Angiotensin Receptor Blocker (ARB)

Payment for ARB and ARB combinations will be considered only for cases in which there is a contraindication or therapy failure with at least one ACE-I or ACE-I combination.

A completed prior authorization form will need to be submitted if:

- ◆ A trial with an ACE-I or ACE-I combination of at least 30 days in length is not found in the point-of-sale system, or
- ◆ Evidence is provided that use of an ACE-I or ACE-I combination would be medically contraindicated.

Prior authorization is required for all nonpreferred ARBs and ARB combinations beginning the first day of therapy.

Payment for nonpreferred ARB or ARB combinations will be considered following documentation of recent trials and therapy failures with a preferred ACE-I or ACE-I combination **and** a preferred ARB or ARB combination.

Use form 470-4593, *Request for Prior Authorization: Angiotensin Receptor Blocker Before ACE Inhibitor*, to request prior authorization. Click [here](#) to see a sample of the form.



8. Anti-Acne Products

Prior authorization is required for **all** prescription topical acne products.

Payment for the treatment of **mild** to **moderate** acne vulgaris will be considered under the following conditions:

- ◆ The patient has had previous trial and therapy failure with a preferred over-the-counter benzoyl peroxide product (covered without prior authorization).
- ◆ Requests for nonpreferred topical acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical agents of a different chemical entity.
- ◆ Requests for nonpreferred combination products will be considered only after documented separate trials and therapy failures with the individual ingredients.
- ◆ The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Form 470-4093, *Request for Prior Authorization: Anti-Acne Products - Topical*, is submitted to request prior authorization. Click [here](#) to see a sample of the form.

If the patient presents with a preponderance of **comedonal** acne, topical retinoid products may be used as first-line agents with prior authorization. See [Topical Retinoids](#) for conditions specific to retinoid products.

9. Anti-Diabetic, Non-Insulin Agents

Prior authorization is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions:

- ◆ A diagnosis of Type 2 Diabetes Mellitus, and
- ◆ Patient is 18 years of age or older, and
- ◆ The patient has not achieved HgbA1C goals after a minimum three month trial with Metformin at maximally tolerated dose, unless evidence is provided that use of the agent would be medically contraindicated.



Request for Prior Authorization
ANTI-ACNE PRODUCTS-TOPICAL

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

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

Preferred

- Azelex
BenzaClin Pump
Benzoyl Peroxide 7% Cleanser
Clindamycin
Erythromycin
Erythromycin/BPO
MetroGel 1%
MetroLotion
Metronidazole 0.75% Cream

Non-Preferred

- Aczone
Akne-Mycin
BenzaClin
Benzamycin
Benzamycin Pak
Cleocin T
Clindamycin/BPO
Duac
Finacea
Klaron
MetroCream
Metronidazole Gel & Lotion
Noritate
Onexton
Rosanil Cleanser
Sodium Sulfa/Sulf
Soolantra

Other (specify) _____

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

Diagnosis:

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

Trial date from: _____ Trial date to: _____

Medical or contraindication reason to override trial requirements: _____

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

Pertinent Lab data: _____

Other relevant information: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

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

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



Request for Prior Authorization
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

Non- Preferred DPP-4 Inhibitors and Combinations

- Janumet, Jentadueto, Janumet XR, Tradjenta, Januvia

- Glyxambi, Nesina, Kazano, Onglyza, Kombiglyze XR, Oseni

Preferred Incretin Mimetics

Non-Preferred Incretin Mimetics

- Byetta, Tanzeum

- Bydureon, Victoza, Trulicity

Non-Preferred SGLT2 Inhibitors and Combinations

- Farxiga, Invokana, Synjardy, Invokamet, Jardiance, Xigduo XR

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:

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

Most recent HgbA1C Level: _____ Date this level was obtained: _____

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
--	--------------------

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 nonpreferred 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.

10. Antidepressants

Prior authorization is required for nonpreferred antidepressants subject to clinical criteria. Requests for doses above the manufacturer recommended dose will be 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
 - One preferred generic SNRI; and
 - 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.



11. 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
 - Eight vials (1 mg/ml)
 - Two vials (4 mg/ml)
- ◆ Ondansetron ODT/Zofran ODT[®]:
 - Sixty 4 mg tablets
 - Sixty 8 mg tablets
- ◆ Ondansetron/Zofran[®]:
 - Sixty 4 mg tablets
 - Sixty 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.



Request for Prior Authorization
ANTIEMETIC-5HT3 RECEPTOR ANTAGONISTS/
SUBSTANCE P NEUROKININ 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.

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

Prior authorization is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the dosage limits provided in parentheses. Payment for Antiemetic-5HT3 Receptor Agonists/Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation.

Prior authorization will be required for all non-preferred Antiemetic-5HT3 ReceptorAntagonists/ Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent in this class. Note: Aprepitant (Emend®) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.

Preferred

- Ondansetron 4mg tablets (60)
Ondansetron 8mg tablets (60)
Ondansetron 2mg/mL (4 - 20mL vials)
Ondansetron 2mg/mL (8 - 2mL vials)
Ondansetron ODT 4mg tablets (60)
Ondansetron ODT 8mg tablets (60)

Non Preferred

- Akynzeo (2)
Aloxi 0.25mg/5mL (4 vials)
Anzemet 50mg & 100mg tablets (5)
Anzemet 100mg/5mL (4 vials)
Anzemet 12.5mg/0.625mL (8 ampules)
Emend 125mg capsules (4)
Emend 80mg capsules (8)
Granisetron 1mg tablets (8)
Granisetron 1mg/mL (8 vials)
Granisetron 4mg/4mL (2 vials)
Ondansetron 4mg/5mL oral solution (50mL/month)
Sancuso Patch
Zuplenz

Strength Dosage Instructions Quantity Days Supply

Diagnosis: _____

Medical reasoning for therapy exceeding dosage limits: _____

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

Attach lab results and other documentation as necessary.

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

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



Request for Prior Authorization
ANTIFUNGAL DRUGS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

Prior authorization is not required for preferred oral antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. Prior authorization is required for all non-preferred oral antifungal therapy as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy.

Preferred (PA required after 90 days)

- Clotrimazole Troche
Fluconazole
Gris-Peg
Griseofulvin Suspension
Terbinafine
Voriconazole

Non-Preferred (PA required from Day 1)

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

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

Diagnosis:

Does the patient have an immunocompromised condition? Yes No

If yes, diagnosis:

Does the patient have a systemic fungal infection? Yes No

If yes, date of diagnosis: Type of infection:

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

Trial Date from Trial Date to:

Medical or contraindication reason to override trial requirements:

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

Attach lab results and other documentation as necessary.

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

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



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.

12. 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.

13. 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.



14. Apixaban (Eliquis[®])

Prior authorization is required for apixaban (Eliquis[®]). 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.

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.

a. Atrial Fibrillation

In addition to the above criteria being met:

- ◆ Patient has a diagnosis of non-valvular atrial fibrillation; with
- ◆ 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
- ◆ Requests will be considered for the following dosing:
 - 5 mg twice daily; or
 - 2.5 mg twice daily in patients with any two of the following:
 - Age ≥ 80 years
 - Body weight ≤ 60 kg
 - Serum creatinine ≥ 1.5 mg/dL

b. Treatment and Prevention of DVT or PE

In addition to the above criteria being met:

- ◆ 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).
- ◆ Requests will be considered for the following dosing:
 - Initial treatment of DVT or PE: 10 mg twice daily for 7 days, followed by 5 mg twice daily up to 12 months of treatment.



- Prevention of DVT or PE following initial therapy with standard anticoagulation therapy for 6 to 12 months of treatment for DVT or PE: 2.5 mg twice daily.

c. Prophylaxis of DVT Following Hip or Knee Replacement Surgery

In addition to the above criteria being met:

- ◆ Requests will be considered when the patient has contraindications to use of the preferred agents.
- ◆ Requests will be considered for the following dosing:
 - *Hip replacement:* 2.5 mg twice daily for up to 35 days following hip replacement; or
 - *Knee replacement:* 2.5 mg twice daily for up to 12 days following knee replacement.

15. Apremilast (Otezla®)

Prior authorization is required for apremilast (Otezla®). Payment will be considered under the following conditions:

- ◆ Patient is 18 years of age or older; and
- ◆ Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints); and
- ◆ Patient has a diagnosis of moderate to severe plaque psoriasis; and
- ◆ Prescribed by a rheumatologist or a dermatologist; and
- ◆ Patient does not have severe renal impairment ($\text{CrCl} < 30 \text{ mL/min}$).

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

Use form 470-5293, *Request for Prior Authorization: Apremilast (Otezla®)*, to request prior authorization. Click [here](#) to see a sample of the form.



a. Psoriatic Arthritis

In addition to the above criteria being met:

- ◆ Patient has documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
- ◆ Patient has documentation of trials and therapy failures with two preferred biological agents used for psoriatic arthritis.

b. Plaque Psoriasis

In addition to the above criteria being met:

- ◆ Patient has documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; and
- ◆ Patient has documentation of trials and therapy failures with two preferred biological agents.

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.



Request for Prior Authorization
BIOLOGICALS FOR ANKYLOSING SPONDYLITIS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

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

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

Preferred

Non-Preferred

- Enbrel
Humira

- Cimzia
Remicade
Simponi

Strength Dosage Instructions Quantity Days Supply

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

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

Screening for Latent TB infection: Date: Results:

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

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

**Request for Prior Authorization
BIOLOGICALS FOR ANKYLOSING SPONDYLITIS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

Reason for Failure: _____

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

Reason for Failure: _____

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

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

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

Other medical conditions to consider: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

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



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. 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 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.

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

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 diagnosed conditions:

- ◆ Rheumatoid arthritis
- ◆ Moderate to severe psoriatic arthritis
- ◆ Moderate to severe juvenile idiopathic arthritis

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.

a. 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.

b. 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).

c. 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).



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.



Request for Prior Authorization
BIOLOGICALS FOR INFLAMMATORY BOWEL DISEASE

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

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

Preferred

Humira []
Humira Starter Kit []

Non-Preferred

Cimzia (prefilled syringe) [] Simponi []
Remicade []

Strength Dosage Instructions Quantity Days Supply

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

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

Screening for Latent TB infection: Date: Results:

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

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

**Request for Prior Authorization
BIOLOGICALS FOR INFLAMMATORY BOWEL
DISEASE**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

Trial Drug Name/Dose: _____ Trial dates: _____

Reason for failure: _____

Trial Drug Name/Dose: _____ Trial dates: _____

Reason for failure: _____

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

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

Trial Drug Name/Dose: _____ Trial dates: _____

Reason for failure: _____

Trial Drug Name/Dose: _____ Trial dates: _____

Reason for failure: _____

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

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

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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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
BIOLOGICALS FOR PLAQUE PSORIASIS

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

Preferred

- Enbrel, Cosentyx (after Humira trial)

Non-Preferred

- Amevive, Stelara, Remicade, Humira

Strength, Dosage Instructions, Quantity, Days Supply

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

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

Screening for Latent TB infection: Date: Results:

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

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

**Request for Prior Authorization
BIOLOGICALS FOR PLAQUE PSORIASIS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Treatment failure with a preferred oral therapy: Trial Drug Name: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Non-Pharmacological Treatments Tried: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

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

Other medical conditions to consider: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

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

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. 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
BUPRENORPHINE TRANSDERMAL SYSTEM (BUTRANS)
& BUCCAL FILM (BELBUCA)

(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 Butrans™ and Belbuca™. Payment will be considered when the following criteria are met: 1) 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. 2) A trial and therapy failure with fentanyl patch at maximum tolerated dose. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

[] Belbuca [] Butrans

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis: _____

Trials of two preferred long acting opioids:

Trial 1: Drug Name & Dose: _____

Trial Dates: _____ Failure Reason: _____

Trial 2: Drug Name & Dose: _____

Trial Dates: _____ Failure Reason: _____

Trial of short acting narcotic for breakthrough pain: Drug Name & Dose: _____

Trial dates: _____ Failure Reason: _____

Trial of fentanyl patch: 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.



22. Buprenorphine Transdermal System (Butrans™) & Buccal Film (Belbuca™)

Prior authorization is required for Butrans™ and Belbuca™. 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 Transdermal System (Butrans™) & Buccal Film (Belbuca™)*, to request prior authorization. Click [here](#) to see a sample of the form.

23. 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.

24. Cholic Acid (Cholbam®)

Prior authorization is required for cholic acid (Cholbam®). Payment will be considered under the following conditions:

- ◆ Is prescribed by a hepatologist or pediatric gastroenterologist; and
- ◆ Is prescribed for a diagnosis of bile acid synthesis disorder due to a single enzyme defect (SED) including:
 - 3-beta-hydroxy-delta-5C27-steroid oxidoreductase deficiency (3 β -HSD),
 - Aldo-keto reductase 1D1 (AKR1D1),
 - Alpha-methylacyl-CoA racemase deficiency (AMACR deficiency),
 - Sterol 27-hydroxylase deficiency (cerebrotendinous xanthomatosis [CTX]),
 - Cytochrome P450 7A1 (CYP7A1),
 - 25-hydroxylation pathway (Smith-Lemli-Opitz), or



Request for Prior Authorization
CHOLIC ACID (CHOLBAM®)

(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 cholic acid (Cholbam®). Payment will be considered under the following conditions:

- 1) Is prescribed by a hepatologist or pediatric gastroenterologist; and
2) Is prescribed for a diagnosis of bile acid synthesis disorder due to a single enzyme defect (SED) including:
3) Is prescribed as an adjunctive treatment of peroxisomal disorder (PD) in patients who exhibit manifestations of liver disease, steatorrhea, or complications from fat soluble vitamin absorption.
4) Diagnosis is confirmed by mass spectrometry or other biochemical testing or genetic testing (attach results); and
5) Baseline liver function tests are taken prior to initiation of therapy (AST, ALT, GGT, ALP, total bilirubin, INR) and provided with request; and
6) Patient must have elevated serum aminotransferases (AST and ALT) with normal serum gamma glutamyltransferase (GTT); and
7) Patient is at least 3 weeks old.

When criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 12 months at a time requiring documentation of response to therapy by meeting two of the following criteria:

- Body weight has increased by 10% or is stable at ≥50th percentile,
• Alanine aminotransferase (ALT) or aspartate aminotransferase (AST) < 50 U/L or baseline levels reduced by 80%,
• Total bilirubin level reduced to ≤1mg/dL.

**Request for Prior Authorization
CHOLIC ACID (CHOLBAM®)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Non-Preferred

Cholbam

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

Bile Acid Synthesis Disorder due to SED

3 β -HSD AKR1D1 AMACR deficiency CTX CYP7A1 Smith-Lemli-Opitz

Peroxisomal Disorder (PD)

ZWS NALD IRD

Other: _____

Attach results of diagnosis confirmation by mass spectrometry, biochemical testing, or genetic testing

Provider specialty: _____

Attach baseline liver function tests prior to initiation of therapy (AST, ALT, GGT, ALP, total bilirubin, INR)

Renewal requests: Provide documentation of adequate response to treatment by meeting two of the following criteria (attach lab results and/or chart notes):

- Body weight has increased by 10% or is stable at $\geq 50^{\text{th}}$ percentile
- ALT or AST < 50 U/L or baseline levels reduced by 80%
- Total bilirubin level reduced to ≤ 1 mg/dL

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.



- ◆ Is prescribed as an adjunctive treatment of a peroxisomal disorder (PD) in patients who exhibit manifestations of liver disease, steatorrhea, or complications from fat soluble vitamin absorption. Peroxisomal disorders include Zellweger syndrome (ZWS), neonatal adrenoleukodystrophy (NALD), or infantile refsum disease (IRD); and
- ◆ Diagnosis is confirmed by mass spectrometry or other biochemical testing or genetic testing (attach results); and
- ◆ Baseline liver function tests are taken prior to initiation of therapy (AST, ALT, GGT, ALP, total bilirubin, INR) and provided with request; and
- ◆ Patient must have elevated serum aminotransferases (AST and ALT) with normal serum gamma glutamyltransferase (GTT); and
- ◆ Patient is at least three weeks old.

When criteria for coverage are met, an initial authorization will be given for three months. Additional approvals will be granted for 12 months at a time requiring documentation of response to therapy by meeting two of the following criteria:

- ◆ Body weight has increased by 10 percent or is stable at $\geq 50^{\text{th}}$ percentile.
- ◆ Alanine aminotransferase (ALT) or aspartate aminotransferase (AST) < 50 U/L or baseline levels reduced by 80 percent.
- ◆ Total bilirubin level reduced to $\leq 1\text{mg/dL}$.

Use form 470-5391, *Request for Prior Authorization: Cholic Acid (Cholbam[®])*, to request prior authorization. Click [here](#) to see a sample of the form.

25. Chronic Pain Syndrome Agents

Prior authorization is required for pregabalin (Lyrica[®]) and milnacipran (Savella[™]). These drugs will be considered for their FDA indications and other conditions as listed in the compendia. Requests for doses above the manufacturer recommended dose will not be considered. For patients with a chronic pain diagnosis who are currently taking opioids, as seen in pharmacy claims, a plan to decrease and/or discontinue the opioids must be provided with the initial request.



Initial authorization will be given for three months. There must be a significant decrease in opioid use or discontinuation of opioids after the initial three month authorization for further approval consideration. Additional prior authorizations will be considered with documentation of a continued decrease in opioid utilization. Payment will be considered under the following conditions:

- ◆ A diagnosis of **fibromyalgia** (Lyrica[®] and Savella[™]) with:
 - A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following preferred generic agents: tricyclic antidepressant or SNRI, **with**
 - Documented non-pharmacologic therapies (cognitive behavior therapies, exercise, etc.), **and**
- ◆ 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** (Lyrica[®]) with a trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant, duloxetine, or topical lidocaine.
- ◆ A diagnosis of **partial onset seizures**, as adjunct therapy (Lyrica[®])

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. CNS Stimulants and Atomoxetine

Prior authorization is required for CNS stimulants and Atomoxetine for patients 21 years of age or older. Before requesting prior authorization for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at <https://pmp.iowa.gov/IAPMPWebCenter/>. Payment for CNS stimulants and Atomoxetine will be considered under the following conditions:

- ◆ **Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)** meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, Snap-IV). Symptoms must have been present before 12 years of age and there must be clear evidence of clinically significant impairment in two or more environments (social, academic, or occupational).



Request for Prior Authorization
CNS STIMULANTS AND ATOMOXETINE

(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 (PA) is required for CNS stimulants and atomoxetine for patients 21 years of age or older. Prior to requesting PA for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website at https://pmp.iowa.gov/IAPMPWebCenter/. Payment for CNS stimulants and atomoxetine will be considered under the following conditions: 1) Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, Snap-IV). Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms the patient continues to require medication to treat the symptoms of ADD/ADHD will be required for renewals or patients newly eligible that are established on medication to treat ADD/ADHD. 2) Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG). 3) Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist.

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 with the preferred immediate release and extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Requests for Vyvanse for Binge Eating Disorder must be submitted on the Binge Eating Disorder Agents PA form.

Preferred

- Amphetamine Salt Combo
Daytrana
Dexmethylphenidate Tabs
Focalin XR
Metadate CD
Methylin Solution
Methylphenidate IR Tabs
Methylphenidate ER Tabs (18, 27, 36, 54mg)

- Modafinil
Quillivant XR
Ritalin LA
Strattera
Vyvanse

Non-Preferred

- Adderall
Adderall XR*
Amphetamine ER*
Aptensio XR*
Concerta
Desoxyn
Dexedrine*
Dextroamphetamine ER Cap*
Dexmethylphenidate
Dexmethylphenidate ER*
Evekeo

- Focalin
Methylin Chew
Methylphenidate ER Tabs (10mg & 20mg)*
Methylphenidate ER Capsules*
Nuvigil
Procentra
Provigil
Ritalin
Ritalin SR*

Strength Dosage Instructions Quantity Days Supply

**Request for Prior Authorization
CNS STIMULANTS AND ATOMOXETINE**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Diagnosis:

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

Age of patient at onset of symptoms: _____

Date of most recent clinical visit confirming initial or continued diagnosis: _____

Rating scale used to determine diagnosis: _____

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

Current Environment 1 & description: _____

Current Environment 2 & description: _____

- 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)** _____

Prescriber review of patient's controlled substances use on the Iowa PMP website:

No Yes Date Reviewed: _____

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
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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.*



Documentation of a recent clinical visit that confirms the patient continues to require medication to treat the symptoms of ADD/ADHD will be required for renewals or patients newly eligible that are established on medication to treat ADD/ADHD.

◆ **Binge Eating Disorder (Vyvanse)**

- Patient is 18 to 55 years of age; and
- Patient meets the DSM-5 criteria for Binge Eating Disorder (BED); and
- Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number of episodes must be reported); and
- Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent three month period, that did not significantly reduce the number of binge eating episodes; and
- Prescription is written by a psychiatrist or psychiatric nurse practitioner; and
- Patient has a BMI of 25 to 45; and
- Patient does not have personal or family history of cardiovascular disease; and
- Patient has no history of substance abuse; and
- Is not being prescribed for the treatment of obesity or weight loss.

Doses above 70 mg per day will not be considered. Initial requests will be approved for 12 weeks. Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week.

DSM-5 Criteria

- Recurrent episodes of binge eating, including eating an abnormally large amount of food in a discrete period of time and has a feeling of lack of control over eating; and
- The binge eating episodes are marked by at least three of the following:
 - Eating more rapidly than normal;
 - Eating until feeling uncomfortably full;



- Eating large amounts of food when not feeling physically hungry;
- Eating alone because of embarrassment by the amount of food consumed;
- Feeling disgusted with oneself, depressed, or guilty after overeating; and
- Episodes occur at least one day a week for at least three months; and
- No regular use of inappropriate compensatory behaviors (e.g., purging, fasting, or excessive exercise) as are seen in bulimia nervosa; and
- Does not occur solely during the course of bulimia nervosa or anorexia nervosa.

Moderate to Severe BED

Based on the number of binge eating episodes per week:

Moderate - 4 to 7

Severe – 8 to 13

Extreme – 14 or more

- ◆ **Narcolepsy** with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG).
- ◆ **Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS)** with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration, or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist.

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

If a nonpreferred **long-acting** medication is requested, a trial with the preferred immediate-release and extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required.

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



Request for Prior Authorization
BINGE EATING DISORDER 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, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization (PA) is required for Vyvanse for the treatment of Binge Eating Disorder (BED). Prior to requesting PA, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website at https://pmp.iowa.gov/IAPMPWebCenter/. Payment will be considered under the following conditions: 1) Patient is 18 to 55 years of age; 2) Patient meets the DSM-5 criteria for BED; 3) Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number must be reported); 4) Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent 3 month period, that did not significantly reduce the number of binge eating episodes; 5) Prescription is written by a psychiatrist or psychiatric nurse practitioner; 6) Patient has a BMI of 25 to 45; 7) Patient does not have a personal history of cardiovascular disease; 8) Patient has no history of substance abuse; 9) Is not being prescribed for the treatment of obesity or weight loss; and 10) Doses above 70mg per day will not be considered; 11) Initial requests will be approved for 12 weeks when criteria for coverage are met; 12) Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week.

- Boxed options for Vyvanse and Other (specify) with a blank line for text.

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

Diagnosis: _____

Does member meet DSM-5 criteria for BED: [] No [] Yes (check all that apply below)

- Checkboxes for recurrent episodes of binge eating, binge eating episodes marked by at least three of the following (eating more rapidly, eating until full, eating large amounts, eating alone, feeling disgusted), episodes occur at least 1 day a week for at least 3 months, no regular use of inappropriate compensatory behaviors, and does not occur solely during the course of bulimia nervosa or anorexia nervosa.

Patient BMI: _____ Date obtained: _____

Provide number of binge eating episodes per week prior to treatment: _____

**Request for Prior Authorization
BINGE EATING DISORDER AGENTS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Does member have a history of substance abuse: Yes No

Does member have a personal history of cardiovascular disease: Yes No

Is requested medication being prescribed solely for the treatment of obesity or weight loss: Yes No

Document non-pharmacologic therapies tried including trial dates and failure reason: _____

Prescriber specialty: Psychiatrist Psychiatric Nurse Practitioner Other _____

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

Date reviewed: _____

Renewal requests:

Provide number of binge eating episodes per week while on treatment: _____

Pertinent lab data: _____

Other relevant information: _____

Attach lab results and other documentation as necessary.

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

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. 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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		Date June 1, 2016

Use form 470-4116, *Request for Prior Authorization: CNS Stimulants and Atomoxetine*, to request prior authorization. Click [here](#) to see a sample of the form.

Use form 470-5336, *Request for Prior Authorization: Binge Eating Disorder Agents*, to request prior authorization. Click [here](#) to see a sample of the form.

27. 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.

28. 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.

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
- ◆ 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 < 15mL/min) or is not on dialysis.
- ◆ Treatment and prevention of DVT or PE (in addition to the above):
 - Patient does not have a CrCl < 30mL/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.



Request for Prior Authorization
Deferasirox

(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 deferasirox. Payment will be considered under the following conditions: 1) Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance < 40mL/min; and 2) Patient does not have a poor performance status; and 3) Patient does not have a high-risk myelodysplastic syndrome; and 4) Patient does not have advanced malignancies; and 5) Patient does not have a platelet count < 50 x 10^9/L.

Preferred

Non-Preferred

Exjade

Jadenu

Strength

Dosage Instructions

Quantity

Days Supply

Patient has a diagnosis of iron overload related to anemia:

Yes (attach documentation) No (provide diagnosis):

Indicate member's current deferasirox treatment status: Initial Continuation

Patient's current weight in kg: Date obtained:

Serum Creatinine greater than 2 times the age-appropriate upper limit of normal?

Yes No Date obtained:

Creatinine Clearance: Date obtained:

Platelet Count: Date obtained:

Serum Ferritin: Date obtained: (attach labs dated within 30 days of request)

Does patient have poor performance status? Yes No

Does patient have high-risk myelodysplastic syndrome? Yes No

Does patient have advanced malignancies? Yes No

**Request for Prior Authorization
DEFERASIROX**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Transfusional Iron Overload (in addition to above):

Initiation of Therapy: 1) Patient is 2 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overload; and 4) Serum ferritin is consistently > 1000 mcg/L (attach lab results dated within past month); and 5) Starting dose does not exceed 20mg/kg/day. Calculate dose to the nearest whole tablet. 6) Initial authorizations will be considered for up to 3 months. **Continuation of therapy:** 1) Serum ferritin has been measured within 30 days of continuation therapy request (attach lab results); and 2) Ferritin levels are > 500mcg/L and 3) Dose does not exceed 40mg/kg/day.

Initial Requests:

Patient has a recent history of frequent blood transfusions resulting in chronic iron overload?

Yes (provide recent transfusion dates) _____ No

Serum ferritin consistently > 1000 mcg/L: Yes No

Non-Transfusional Iron Overload (in addition to above)

Initiation of therapy: 1) Patient is 10 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and 4) Serum ferritin levels are > 300mcg/L. 5) LIC are > 3mg Fe/g dw; and 6) dose does not exceed 10mg/kg/day (if LIC is < 15mg Fe/g dw) or 20mg/kg/day (if LIC is > 15mg Fe/g dw). 7) Initial authorizations will be considered for up to 6 months. **Continuation of Therapy:** 1) Serum ferritin and LIC have been measured within 30 days of continuation therapy request; and 2) Serum ferritin levels are > 300mcg/L; and 3) LIC is > 3mg Fe/g dw; and 4) Dose does not exceed 10mg/kg/day (if LIC is 3 to 7mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw).

Initial & Renewal Requests:

LIC: _____ **Date obtained:** _____ (attach labs dated within 30 days of request)

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.



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. Deferasirox (Exjade®)

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

- ◆ Patient does not have a serum creatinine greater than 2 times the age appropriate upper limit of normal or creatinine clearance <40mL/min; and
- ◆ Patient does not have a poor performance status; and
- ◆ Patient does not have a high-risk myelodysplastic syndrome; and
- ◆ Patient does not have advanced malignancies; and
- ◆ Patient does not have a platelet count <50 x 10⁹/L.

Use form 470-5330, *Request for Prior Authorization: Deferasirox (Exjade®)*, to request prior authorization. Click [here](#) to see a sample of the form.



a. Transfusional Iron Overload

Initiation of Therapy

- ◆ Patient is two years of age or older; and
- ◆ Patient has documentation of iron overload related to anemia (attach documentation); and
- ◆ Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overload; and
- ◆ Serum ferritin is consistently >1000 mcg/L (attach lab results dated within the past month).

Starting dose does not exceed 20 mg/kg/day. Calculate dose to the nearest whole tablet. Initial requests will be considered for up to three months.

Continuation of Therapy

- ◆ Serum ferritin has been measured within 30 days of continuation of therapy request (attach lab results); and
- ◆ Ferritin levels are >500mcg/L; and
- ◆ Dose does not exceed 40mg/kg/day.

b. Non-Transfusional Iron Overload

Initiation of Therapy

- ◆ Patient is 10 years of age or older; and
- ◆ Patient has documentation of iron overload related to anemia (attach documentation); and
- ◆ Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and
- ◆ Serum ferritin levels are >300 mcg/L; and
- ◆ Liver iron concentration (LIC) are >3 mg Fe/g dw; and
- ◆ Dose does not exceed 10 mg/kg/day (if LIC is <15 mg Fe/g dw), or 20 mg/kg/day (if LIC is >15 mg Fe/g dw).

Initial authorization will be considered for up to six months.



Continuation of Therapy

- ◆ Serum ferritin and LIC have been measured within 30 days of continuation of therapy request; and
- ◆ Serum ferritin levels are >300 mcg/L; and
- ◆ Liver iron concentration (LIC) is >3 mg Fe/g dw; and
- ◆ Dose does not exceed 10 mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20 mg/kg/day (if LIC is >7 mg Fe/g dw).

32. 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 a neurological condition.
- ◆ A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI.
- ◆ Patient has documentation of a current EKG (within past three months) without QT prolongation.
- ◆ Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Liability 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.
- ◆ The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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.

33. 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.



34. **Edoxaban (Savaysa®)**

Prior authorization is required for adoxaban (Savaysa®). Payment will be considered for patients when the following criteria are met:

- ◆ Patient does not have a mechanical heart valve; and
- ◆ Patient does not have moderate to severe mitral stenosis; and
- ◆ Patient does not have active pathological bleeding; and
- ◆ A recent creatinine clearance (CrCl) is provided and is within specified range listed below; and
- ◆ Patient does not have moderate or severe hepatic impairment (Child-Pugh B or C); and
- ◆ Patient has documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum six month trial); and
- ◆ Patient has documentation of a previous trial and therapy failure with apixaban or rivaroxaban, where applicable.

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

Use form 470-5345, *Request for Prior Authorization: Edoxaban (Savaysa®)*, to request prior authorization. Click [here](#) to see a sample of the form.

a. Atrial Fibrillation

In addition to the above criteria being met:

- ◆ Patient has documentation of a diagnosis of non-valvular atrial fibrillation; with
- ◆ Presence of at least one additional risk factor for stroke, with a CHADS2 score ≥ 1 ; and
- ◆ Patient does not have creatinine clearance (CrCl) > 95 mL/min.
- ◆ Requests will be considered for the following dosing:
 - 60mg once daily in patients with a CrCl of > 50 mL/min to ≤ 95 mL/min; or
 - 30mg once daily in patients with a CrCl of 15 to 50 mL/min



Request for Prior Authorization
EDOXABAN (SAVAYSA®)

(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 edoxaban (Savaysa®). Payment will be considered for patients when the following criteria are met: 1) Patient does not have a mechanical heart valve; and 2) Patient does not have moderate to severe mitral stenosis; and 3) Patient does not have active pathological bleeding; and 4) A recent creatinine clearance (CrCl) is provided and is within specified range listed below; and 5) Patient does not have moderate or severe hepatic impairment (Child-Pugh B or C); and 6) Patient has 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 7) Patient has documentation of a previous trial and therapy failure with apixaban or rivaroxaban, where applicable.

Non-Preferred

[] Savaysa

Strength Dosage Instructions Quantity Days Supply

Diagnosis (additional criteria below):

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

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

Does patient have moderate to severe mitral stenosis? [] Yes [] No

Does patient have moderate to severe hepatic impairment (Child-Pugh B or C)? [] Yes [] No

Provide recent creatinine clearance (CrCl): Date obtained:

Provide documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial):

Trial dose: Trial dates:

Reason for failure:

Provide documentation of a previous trial and therapy failure with apixaban or rivaroxaban (where applicable):

Drug name & dose: Trial dates:

Reason for failure:

**Request for Prior Authorization
EDOXABAN (SAVAYSA)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Atrial Fibrillation

Patient has a diagnosis of non-valvular atrial fibrillation: 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	

Does patient have CrCl > 95mL/min)? Yes No

- Requests will be considered for the following dosing:
 - 60mg once daily in patients with a CrCl of 50 mL/min to ≤ 95 mL/min; or
 - 30mg once daily in patients with a CrCl of 15 to 50 mL/min

Treatment of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)

Does patient have a current DVT or PE? Yes No

Provide documentation of 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin):

Drug name & dose: _____ Trial dates: _____

- Requests will be considered for the following dosing:
 - 60mg once daily; or
 - 30mg once daily in patients with any of the following:
 - CrCl 15 mL/min to 50 mL/min
 - Body weight ≤ 60 kg Weight (kg): _____ Date obtained: _____

Possible drug interactions/conflicting drug therapies: _____

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.



b. Treatment of Deep Vein Thrombosis or Pulmonary Embolism

In addition to the above criteria being met:

- ◆ Patient has documentation of a current deep vein thrombosis or pulmonary embolism; with
- ◆ Documentation patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin).
- ◆ Requests will be considered for the following dosing:
 - 60mg once daily; or
 - 30mg once daily in patients with any of the following:
 - CrCl 15 mL/min to 50 mL/min
 - Body weight ≤ 60 kg

35. 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.

36. 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.

37. 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.

38. 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.



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, Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned. 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. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Prior Authorization is required for the following extended release formulations: Adoxa, Amoxicillin ER, Amrix, 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, Oleptro, Oxtellar XR, pramipexole ER, Prozac Weekly, Qudexy XR, Rayos, Requip XL, Rythmol SR, Ryzolt, 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. 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
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

Zarxio

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.

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.



39. Fentanyl, Short-Acting Oral Products

Prior authorization is required for short-acting oral fentanyl products. Payment will be authorized only if the diagnosis is for breakthrough cancer pain in opioid-tolerant patients. This product carries a Black Box Warning.

Actiq[®], Fentora[®], and Onsolis[™] are indicated only for the management of breakthrough cancer pain in patients with malignancies who are already receiving and tolerant to opioid therapy for their underlying persistent cancer pain.

Actiq[®], Fentora[®], and Onsolis[™] are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use these products for patients who are not opioid-tolerant.

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

40. 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.

41. 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. Stimuli testing will not be required for the following diagnoses: Turners Syndrome, chronic renal failure, and HIV/AIDS.

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

The following FDA-approved indications for Growth Hormone therapy are considered not medically necessary and requests will be denied: Idiopathic Short Stature (ISS) and Small for Gestational Age (SGA).

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.



Request for Prior Authorization
GROWTH HORMONES

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

Prior authorization is required for therapy with growth hormones. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s).

Preferred

- Checkboxes for Norditropin, Nutropin AQ Pen, Nutropin AQ NuSpin

Non- Preferred

- Checkboxes for Genotropin, Humatrope, Omnitrope, Saizen, Tev-Tropin, Zorbtive

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

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

Number of vials per month: Estimate length of therapy: Bone Age: Date of Bone Age Test: Epiphyses open? Height: Weight: Height percentile at time of diagnosis: Weight percentile: Is standard deviation 2.0 or more below mean height for chronological age or less than fifth percentile? MRI diagnosis: Date: Growth rate per year Pertinent Medical History including growth pattern, diagnostic test, treatment plan, and response so far: Please provide 2 stimuli tests and results:

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

Attach lab results and other documentation as necessary.

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

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



Request for Prior Authorization
HEPATITIS C TREATMENTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

Prior authorization (PA) is required for hepatitis C treatments. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions: 1) Patient is 18 years of age or older and has a diagnosis of chronic hepatitis C; and 2) Patient has had testing for hepatitis C virus (HCV) genotype; and 3) Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and 4) Viral load will be submitted by the prescriber 12 weeks after the completion of therapy; and 5) Patient has advanced liver disease corresponding to a Metavir score of 3 or greater fibrosis as confirmed by one of the following: a) liver biopsy confirming a Metavir score >=3; or b) transient elastography (FibroScan) score >= 9.5kPa; or c) FibroSURE (FibroTest) score >=0.58; or d) APRI score >1.5; or e) radiological imaging consistent with cirrhosis (i.e., evidence of portal hypertension); or f) physical findings or clinical evidence consistent with cirrhosis; or g) patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), proteinuria, nephrotic syndrome, or membranoproliferative glomerulonephritis; and 6) Patient's prior treatment history is provided (treatment naive or treatment experienced); and 7) If patient has a history of non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; 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) For regimens containing sofosbuvir (Sovaldi/Harvoni), patient does not have severe renal impairment (creatinine clearance <30ml/min) or end stage renal disease requiring hemodialysis; and 10) HCV treatment is prescribed by a digestive disease, liver disease, or infectious disease provider practice; and 11) For patients on a regimen containing ribavirin, documentation of the following on the PA form: a) Patient is not a pregnant female or a male with a pregnant female partner; and b) Women of childbearing potential and their male partners must use two forms of effective contraception during treatment and for at least 6 months after treatment has concluded; and c) Monthly pregnancy tests will be performed during treatment; and 12) Prescriber has reviewed the patient's current medication list and acknowledged that there are no significant drug interactions with the HCV medication; and 13) Documentation is provided for patients who are ineligible to receive interferon or ribavirin. 14) Non-FDA approved or non-compensated combination therapy regimens will not be approved. 15) If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on established length of therapy for the particular treatment (defined below). 16) Lost or stolen medication replacement requests will not be authorized. 17) The 72-hour emergency supply rule does not apply to hepatitis C treatments.

- Preferred: [] Harvoni, [] Sovaldi, [] Viekira Pak, [] Technivie
Non-Preferred: [] Olysio, [] Daklinza

Instructions for completing the Hepatitis C Treatments PA form:

Section 1 of the PA form lists the various regimens and clinical situations for which hepatitis C treatments will be considered medically necessary according to Iowa Medicaid PA criteria. Section 2 includes additional supporting documentation that is required on the PA form.

- Check ONE box in Section 1 - Treatment Regimen.
Review and complete each numbered item in Section 2 - Supporting Documentation.
Attach lab results, chart notes, and other documentation, sign, and fax the completed form to (800) 574-2515.

Iowa Department of Human Services
Request for Prior Authorization
HEPATITIS C TREATMENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

SECTION 1 – TREATMENT REGIMEN

Check ONE box below to indicate the requested treatment regimen based on the patient’s genotype, treatment history, and extent of liver disease.

Genotype 1 (Note: the subtype is listed if there are differences in the recommended treatments)
Treatment naïve, no cirrhosis, HCV viral load < 6 million copies/ml <ul style="list-style-type: none"> <input type="checkbox"/> Harvoni 90/400 mg daily for 8 weeks (HIV negative only) <input type="checkbox"/> Harvoni 90/400 mg daily for 12 weeks <input type="checkbox"/> 1a: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) plus weight-based ribavirin for 12 weeks <input type="checkbox"/> 1b: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) for 12 weeks
Treatment naïve, no cirrhosis, HCV viral load ≥ 6 million <ul style="list-style-type: none"> <input type="checkbox"/> Harvoni 90/400 mg daily for 12 weeks <input type="checkbox"/> 1a: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) plus weight-based ribavirin for 12 weeks <input type="checkbox"/> 1b: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) for 12 weeks
Treatment naïve, compensated cirrhosis <ul style="list-style-type: none"> <input type="checkbox"/> Harvoni 90/400 mg daily for 12 weeks <input type="checkbox"/> 1a or 1b: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) plus weight-based ribavirin for 12 weeks (Child-Pugh (CP) A ONLY, contraindicated for CP B or C) <input type="checkbox"/> 1a: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) plus weight-based ribavirin for 24 weeks (Child-Pugh (CP) A ONLY, contraindicated for CP B or C)
Treatment experienced (PEG-IFN/RBV ONLY), no cirrhosis <ul style="list-style-type: none"> <input type="checkbox"/> Harvoni 90/400 mg daily for 12 weeks <input type="checkbox"/> 1a: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) plus weight-based ribavirin for 12 weeks <input type="checkbox"/> 1b: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) for 12 weeks
Treatment experienced (PEG-IFN/RBV ONLY), cirrhosis <ul style="list-style-type: none"> <input type="checkbox"/> Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶) <input type="checkbox"/> Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks <input type="checkbox"/> 1a: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) plus weight-based ribavirin for 24 weeks (Child-Pugh (CP) A ONLY, contraindicated for CP B or C) <input type="checkbox"/> 1b: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) for 12 weeks (Child-Pugh (CP) A ONLY, contraindicated for CP B or C)
Treatment experienced (PEG-IFN/RBV±PI), no cirrhosis <ul style="list-style-type: none"> <input type="checkbox"/> Harvoni 90/400 mg daily for 12 weeks
Treatment experienced (PEG-IFN/RBV±PI), compensated cirrhosis <ul style="list-style-type: none"> <input type="checkbox"/> Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶) <input type="checkbox"/> Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks
Treatment experienced (sofosbuvir + ribavirin +/- PEG-IFN or simeprevir + sofosbuvir), no cirrhosis <ul style="list-style-type: none"> <input type="checkbox"/> Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks
Treatment experienced (sofosbuvir + ribavirin +/- PEG-IFN or simeprevir + sofosbuvir), compensated cirrhosis <ul style="list-style-type: none"> <input type="checkbox"/> Harvoni 90/400 mg daily plus weight-based ribavirin for 24 weeks
Treatment experienced (prior treatment with any NS5A inhibitor (daclatasvir + sofosbuvir, ledipasvir + sofosbuvir or paritaprevir/ritonavir/ombitasvir + dasabuvir), no cirrhosis <ul style="list-style-type: none"> <input type="checkbox"/> Guidelines recommend awaiting new data to guide treatment
Treatment experienced (prior treatment with any NS5A inhibitor (daclatasvir + sofosbuvir, ledipasvir + sofosbuvir or paritaprevir/ritonavir/ombitasvir + dasabuvir), cirrhosis or urgent need for treatment <ul style="list-style-type: none"> <input type="checkbox"/> Testing for resistance-associated variants that confer decreased susceptibility to NS3 protease inhibitors and to NS5A inhibitors is recommended. Choice of agents should be based on this testing with a planned duration of 24 weeks with RBV unless contraindicated

Iowa Department of Human Services
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HEPATITIS C TREATMENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Re-infection of allograft liver after transplant <input type="checkbox"/> Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks <input type="checkbox"/> Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)
Decompensated cirrhosis, no prior sofosbuvir, including those with hepatocellular carcinoma who may or may not be candidates for liver transplantation <input type="checkbox"/> Harvoni 90/400 mg daily plus low dose ribavirin# for 12 weeks <input type="checkbox"/> Daklinza 60 mg^ daily plus Sovaldi 400mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)
Decompensated cirrhosis, prior treatment with sofosbuvir <input type="checkbox"/> Harvoni 90/400 mg daily + low dose ribavirin# for 24 weeks
Recurrent HCV infection post–liver transplantation <input type="checkbox"/> Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks <input type="checkbox"/> Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)
Recurrent HCV infection post–liver transplantation, decompensated cirrhosis <input type="checkbox"/> Harvoni 90/400 mg daily plus low dose ribavirin# for 12 weeks
Genotype 2
Treatment naïve, no cirrhosis <input type="checkbox"/> Sovaldi 400 mg daily plus weight-based ribavirin for 12 weeks <input type="checkbox"/> Daklinza 60 mg^ daily plus Sovaldi 400 mg daily for 12 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)
Treatment naïve, compensated cirrhosis <input type="checkbox"/> Sovaldi 400mg daily plus weight-based ribavirin for 16 weeks <input type="checkbox"/> Daklinza 60 mg^ daily plus Sovaldi 400 mg daily for 12 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)
Treatment experienced (PEG-IFN + ribavirin) <input type="checkbox"/> Sovaldi 400 mg daily plus weight-based ribavirin for 16 weeks (will be approved only for patients with documented ineligibility for interferon‡) <input type="checkbox"/> Sovaldi 400mg daily plus weight-based ribavirin for 24 weeks (will be approved only for patients with documented ineligibility for interferon‡) <input type="checkbox"/> Sovaldi 400mg daily plus weight-based ribavirin plus PEG-IFN for 12 weeks
Treatment experienced (sofosbuvir + ribavirin) <input type="checkbox"/> Sovaldi 400mg daily plus weight-based ribavirin plus PEG-IFN for 12 weeks <input type="checkbox"/> Daklinza 60 mg^ daily plus Sovaldi 400 mg daily for 24 weeks with or without weight-based ribavirin (will be approved only for patients with documented ineligibility for interferon‡)
Decompensated cirrhosis, including those with hepatocellular carcinoma who may or may not be candidates for liver transplantation <input type="checkbox"/> Daklinza 60 mg^ daily plus Sovaldi 400mg daily plus low dose ribavirin# for 12 weeks
Recurrent HCV infection post–liver transplantation, with or without compensated cirrhosis <input type="checkbox"/> Daklinza 60 mg^ daily plus Sovaldi 400mg daily plus low dose ribavirin# for 12 weeks <input type="checkbox"/> Daklinza 60 mg^ daily plus Sovaldi 400mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)
Recurrent HCV infection post–liver transplantation, decompensated cirrhosis <input type="checkbox"/> Sovaldi 400 mg daily plus low dose ribavirin# for 24 weeks
Hepatocellular carcinoma and awaiting liver transplant <input type="checkbox"/> Sovaldi 400 mg daily + weight-based ribavirin for up to 48 weeks or until liver transplant (requires documentation of diagnosis and reauthorization every 28 days)
Genotype 3
Regardless of prior treatment, with or without cirrhosis <input type="checkbox"/> Sovaldi 400mg daily plus weight-based ribavirin plus PEG-IFN for 12 weeks
Treatment naïve, not cirrhotic <input type="checkbox"/> Daklinza 60 mg^ daily plus Sovaldi 400mg daily for 12 weeks (will be approved only for patients with documented interferon‡ or ribavirin¶ intolerance) <input type="checkbox"/> Sovaldi 400 mg daily plus weight-based ribavirin for 24 weeks (will be approved only for patients with documented ineligibility for interferon‡)

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HEPATITIS C TREATMENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Treatment naïve, cirrhosis <input type="checkbox"/> Daklinza 60 mg [^] daily plus Sovaldi 400mg daily for 24 weeks with or without weight based ribavirin (will be approved only for patients with documented IFN ‡ or ribavirin ¶ intolerance)
Treatment experienced (PEG-IFN + ribavirin), no cirrhosis <input type="checkbox"/> Daklinza 60 mg [^] daily plus Sovaldi 400mg daily for 12 weeks (will be approved only for patients with documented ineligibility for interferon ‡ or ribavirin ¶)
Treatment experienced (PEG-IFN + ribavirin), compensated cirrhosis <input type="checkbox"/> Daklinza 60 mg [^] daily plus Sovaldi 400 mg daily for 24 weeks with weight-based ribavirin (will be approved only for patients with documented ineligibility for interferon ‡)
Treatment experienced (sofosbuvir + ribavirin) <input type="checkbox"/> Daklinza 60 mg [^] daily plus Sovaldi 400 mg daily for 24 weeks with weight-based ribavirin (will be approved only for patients with documented ineligibility for interferon ‡)
Decompensated cirrhosis, including those with hepatocellular carcinoma who may or may not be candidates for liver transplantation <input type="checkbox"/> Daklinza 60 mg [^] daily plus Sovaldi 400mg daily plus low dose ribavirin [#] for 12 weeks
Recurrent HCV infection post–liver transplantation, with or without compensated cirrhosis <input type="checkbox"/> Daklinza 60 mg [^] daily plus Sovaldi 400mg daily plus low dose ribavirin [#] for 12 weeks <input type="checkbox"/> Sovaldi 400 mg daily plus weight-based ribavirin for 24 weeks <input type="checkbox"/> Daklinza 60 mg [^] daily plus Sovaldi 400mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin ¶)
Recurrent HCV infection post–liver transplantation, decompensated cirrhosis <input type="checkbox"/> Sovaldi 400 mg daily plus low dose ribavirin [#] for 24 weeks
Hepatocellular carcinoma and awaiting liver transplant <input type="checkbox"/> Sovaldi 400 mg daily + weight-based ribavirin for up to 48 weeks or until liver transplant (requires documentation of diagnosis and reauthorization every 28 days)
Genotype 4
Regardless of prior treatment no cirrhosis <input type="checkbox"/> Harvoni 90/400 mg daily for 12 weeks <input type="checkbox"/> Sovaldi 400mg daily plus weight-based ribavirin plus PEG-IFN for 12 weeks <input type="checkbox"/> Technivie (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets daily plus weight-based ribavirin for 12 weeks)
Regardless of prior treatment, compensated cirrhosis <input type="checkbox"/> Harvoni 90/400 mg daily for 12 weeks <input type="checkbox"/> Sovaldi 400mg daily plus weight-based ribavirin plus PEG-IFN for 12 weeks
Decompensated cirrhosis, no prior sofosbuvir, including those with hepatocellular carcinoma who may or may not be candidates for liver transplantation <input type="checkbox"/> Harvoni 90/400 mg daily plus low dose ribavirin [#] for 12 weeks <input type="checkbox"/> Daklinza 60 mg [^] daily plus Sovaldi 400mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin ¶)
Decompensated cirrhosis, prior treatment with sofosbuvir <input type="checkbox"/> Harvoni 90/400 mg daily plus low dose ribavirin [#] for 24 weeks
Recurrent HCV infection post–liver transplantation, with or without compensated cirrhosis <input type="checkbox"/> Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks <input type="checkbox"/> Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin ¶)
Recurrent HCV infection post–liver transplantation, decompensated cirrhosis <input type="checkbox"/> Harvoni 90/400 mg daily plus low dose ribavirin [#] for 12 weeks
Genotype 5
Regardless of prior treatment <input type="checkbox"/> Harvoni 90/400 mg daily for 12 weeks <input type="checkbox"/> Sovaldi 400mg daily plus weight-based ribavirin plus PEG-IFN for 12 weeks
Hepatocellular carcinoma and awaiting liver transplant <input type="checkbox"/> Sovaldi 400 mg daily + weight-based ribavirin for up to 48 weeks or until liver transplant (requires documentation of diagnosis and reauthorization every 28 days)
Genotype 6
Regardless of prior treatment <input type="checkbox"/> Harvoni 90/400 mg daily for 84 days (12 weeks) <input type="checkbox"/> Sovaldi 400mg daily plus weight-based ribavirin plus PEG-IFN for 12 weeks

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HEPATITIS C TREATMENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Hepatocellular carcinoma and awaiting liver transplant

- Sovaldi 400 mg daily + weight-based ribavirin for up to 48 weeks or until liver transplant (requires documentation of diagnosis and reauthorization every 28 days)

Other Treatment Regimen

Genotype, treatment history, and extent of liver disease: _____

Drug name/regimen, dose and duration: _____

Clinical rationale for selecting regimens other than those outlined above: _____

Abbreviations: PEG-IFN=peg-interferon; RBV=ribavirin; PI=protease inhibitor

low dose ribavirin = 600 mg/day and increase as tolerated

^Dose of Daklinza (daclatasvir) MUST BE ADJUSTED with certain co-administered drugs (reduced to 30 mg daily with concurrent CYP3A4 inhibitors and increased to 90 mg daily with concurrent moderate CYP3A4 inducers)

SECTION 2 – SUPPORTING DOCUMENTATION

Review and complete each numbered item below to provide the supporting documentation for the PA request.

Diagnosis:

1. Pretreatment viral load (**attach results**): _____ Date Obtained: _____
2. Documentation of advanced liver disease (**attach results**): _____ Date Obtained: _____
- Liver biopsy confirming a Metavir score \geq F3
 - Transient elastography (FibroScan) score \geq 9.5kPa
 - FibroSURE (FibroTest) score \geq 0.58
 - APRI score $>$ 1.5
 - Radiological imaging consistent with cirrhosis (i.e. evidence of portal hypertension)
 - Physical findings or clinical evidence consistent with cirrhosis
 - Patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), proteinuria, nephrotic syndrome, or membranoproliferative glomerulonephritis.

Patient History:

3. Does the patient have a history of non-compliance? Yes No
If yes, submit chart notes documenting the steps taken to correct or address the non-compliance (**attach chart notes**)
4. Documentation in provider notes (**must be submitted**) showing that member has had no abuse of alcohol and drugs for the previous 3 months.
 MUST submit urine drug screen for members with history of abuse of drugs other than alcohol.
 Counseling **MUST** be provided and documented regarding non-abuse of alcohol and drugs as well as education on how to prevent HCV transmission
5. Is the patient receiving dialysis? Yes No
6. Is the patient's creatinine clearance \geq 30 ml/min? Yes No Child-Pugh: A B C

Prescriber Information:

7. Provider Practice: Digestive Disease Liver Disease Infectious Disease

Regimens Containing Ribavirin:

8. If the patient is female and of childbearing potential, or the patient is male with a female partner of childbearing potential, the prescriber must acknowledge the following:
- The patient is not pregnant (or a male patient with a pregnant female partner) and is not planning to become pregnant during treatment or within 6 months of stopping treatment.
 - Both partners will use two forms of effective contraception during treatment and for at least 6 months after stopping treatment.
 - Monthly pregnancy tests will be performed throughout treatment.

Iowa Department of Human Services
Request for Prior Authorization
HEPATITIS C TREATMENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

9. Complete blood count with differential (**attach results**)

10. If the patient is ineligible for ribavirin¶, select the appropriate reason from the list below:

- History of severe or unstable cardiac disease
- Pregnant women and men with pregnant partners
- Diagnosis of hemoglobinopathy (e.g., thalassemia major, sickle cell anemia)
- Hypersensitivity to ribavirin
- Baseline platelets <70,000 cells/µL
- Baseline absolute neutrophil count <1,500 cells/µL
- Baseline hemoglobin <12 g/dL in women or <13 g/dL in men
- Other: _____

Note: Laboratory values will be reviewed and requests will not be considered if labs are outside of a specific range. Patients with CrCl <50 ml/min (moderate or severe renal dysfunction, ESRD, HD) should have dosage reduced.

Regimens Containing Interferon:

11. Complete blood count with differential (**attach results**)

12. If the patient is ineligible for interferon-based therapy‡, select the appropriate reason from the list below:

- Documented life-threatening side effects or potential side effects (i.e., history of suicidality)
- Decompensated hepatic disease (Child-Pugh >6), or Child-Pugh ≥ 6 if co-infected with HIV
- Autoimmune hepatitis and other autoimmune disorders
- Baseline neutrophil count <1,500 cells/µL
- Baseline platelets <90,000 cells/µL
- Baseline hemoglobin <10 g/dL
- Pre-existing unstable or significant cardiac disease (e.g., history of MI or acute coronary syndrome)
- Other: _____

Potentially Significant Drug Interactions:

13. Coadministration of Hepatitis C treatments with the following medications is not recommended. By checking one of the following boxes, the prescriber attests that they have reviewed the patient’s medications for potentially significant drug interactions with the Hepatitis C treatment. If the medication list contains one or more of the following medications, the medication(s) will be changed to another agent.

- Harvoni:** The patient’s current medication list does NOT include: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St. John’s Wort, ritonavir, tipranavir, Stribild, rosuvastatin, H₂-receptor antagonists above the following daily doses: famotidine 80 mg, ranitidine/nizatidine 600 mg or cimetidine 1600 mg; or proton-pump inhibitors above the following daily doses: esomeprazole 20 mg, lansoprazole or 30 mg, dexlansoprazole 60mg, omeprazole 20 mg, pantoprazole 40 mg, rabeprazole 20 mg
- Sovaldi:** The patient’s current medication list does NOT include: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St. John’s Wort, or tipranavir/ritonavir
- Viekira Pak/Technivie:** The patient’s current medication list does NOT include: strong inducers of CYP3A/2C8, alfuzosin, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergotamine, dihydroergotamine, ergonovine, methylethergonovine, ethinyl estradiol-containing medications, St. John’s Wort, lovastatin, simvastatin, pimozone, efavirenz, sildenafil, trazolam, or midazolam
- Olysio:** The patient’s current medication list does NOT include significant drug interactions. Consult the full prescribing information for potential drug interactions.
- Daklinza:** The patient’s current medication list does NOT include significant drug interactions or dose is adjusted appropriately. Consult the full prescribing information for potential drug interactions including MANY that require dosage adjustment.

Attach lab results and other documentation

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



42. Hepatitis C Treatments

Prior authorization is required for hepatitis C treatments. 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 has a diagnosis of chronic hepatitis C; and
- ◆ Patient has had testing for hepatitis C virus (HCV) genotype; and
- ◆ Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and
- ◆ Viral load will be submitted by prescriber 12 weeks after completion of therapy; and
- ◆ Patient has advanced liver disease corresponding to a Metavir score of 3 or greater fibrosis as confirmed by one of the following:
 - Liver biopsy confirming a Metavir score \geq F3; or
 - Transient elastography (FibroScan) score \geq 9.5kPa; or
 - FibroSURE (FibroTest) score \geq 0.58; or
 - APRI score $>$ 1.5; or
 - Radiological imaging consistent with cirrhosis (i.e., evidence of portal hypertension); or
 - Physical findings or clinical evidence consistent with cirrhosis; or
 - Patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g., vasculitis), proteinuria, nephrotic syndrome, or membranoproliferative glomerulonephritis.
- ◆ Patient's prior treatment history is provided (treatment naïve or treatment experienced); and
- ◆ If patient has a history of non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; 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



- ◆ Patient does not have severe renal impairment (creatinine clearance <30ml/min) or end stage renal disease requiring hemodialysis; and
- ◆ HCV treatment is prescribed by a digestive disease, liver disease, or infectious disease provider practice; and
- ◆ For patients on a regimen containing ribavirin, the following must be documented on the PA form:
 - 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 during treatment and for at least six months after treatment has concluded; and
 - Monthly pregnancy tests *will be* performed during treatment; and
- ◆ Prescriber has reviewed the patient's current medication list and acknowledged that there are no significant drug interactions with the HCV medication.
- ◆ Documentation is provided for patient's who are ineligible to receive interferon or ribavirin.

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

If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on established length of therapy for the particular treatment (defined below).

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.

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



Request for Prior Authorization
IDIOPATHIC PULMONARY FIBROSIS

(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 pirfenidone (Esbriet®) and nintedanib (Ofev®). Dosing outside of the FDA approved dosing will not be considered. Concomitant use of pirfenidone and nintedanib will not be considered. Payment will be considered for patients when the following criteria are met:

- 1) Patient is 40 years of age or older; and
2) Is prescribed by a pulmonologist; and
3) Patient has a diagnosis of idiopathic pulmonary fibrosis as confirmed by one of the following (attach documentation):
- Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or
- A surgical lung biopsy demonstrating usual interstitial pneumonia (UIP); and
4) Prescriber has excluded other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity; and
5) Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC) ≥ 50% predicted; and
6) Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30% predicted; and
7) Patient does not have hepatic impairment as defined below:
- Nintedanib – Patient does not have moderate or severe hepatic impairment (Child-Pugh B or C) or
- Pifenidone – Patient does not have severe hepatic impairment (Child-Pugh C); and
8) Patient does not have renal impairment as defined below:
- Nintedanib – Patient does not have severe renal impairment (CrCl < 30 mL/min) or end-stage renal disease or
- Pifenidone – Patient does not have end-stage renal disease requiring dialysis; and
9) Patient is a nonsmoker or has been abstinent from smoking for at least six weeks.

If criteria for coverage are met, initial authorizations will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met:

- Adherence to pirfenidone (Esbriet®) and nintedanib (Ofev®) is confirmed; and
- Patient is tolerating treatment defined as improvement or maintenance of disease (<10% decline in percent predicted FVC or < 200 mL decrease in FVC); and
- Documentation is provided that the patient has remained tobacco-free; and
- ALT, AST, and bilirubin are assessed periodically during therapy.

**Request for Prior Authorization
IDIOPATHIC PULMONARY FIBROSIS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Non-Preferred

Esbriet Ofev

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

Is Prescriber a Pulmonologist? Yes No

Attach results of high-resolution computed tomography (HRCT) or surgical lung biopsy indicating usual interstitial pneumonia (UIP).

Has prescriber excluded other known causes of interstitial lung disease (ILD)? Yes No

Patient has pulmonary function test within the prior 60 days documenting a forced vital capacity (FVC) ≥ 50% predicted: Yes (attach results) No

Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30% predicted? Yes (attach results) No

Does patient have moderate to severe hepatic impairment? Yes, Child Pugh B Yes, Child Pugh C No

Does patient have moderate to severe renal impairment or end-stage renal disease? Yes No

CrCl: _____ **Date obtained:** _____ **Is patient on dialysis?** Yes No

Patient is a nonsmoker or has been abstinent from smoking for at least 6 weeks? Yes No

Renewal Requests:

Patient is adherent to therapy: Yes No

Patient has remained tobacco-free: Yes No

Patient is tolerating treatment defined as improvement or maintenance of disease (attach results):

< 10% decline in percent predicted FVC or

< 200 mL decrease in FVC

ALT, AST, and bilirubin are being assessed periodically: Yes No **Most recent date obtained:** _____

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.*



43. Idiopathic Pulmonary Fibrosis

Prior authorization is required for pirfenidone (Esbriet[®]) and nintedanib (Ofev[®]). Dosing outside of the FDA-approved dosing will not be considered. Payment will be considered for patients when the following criteria are met:

- ◆ Patient is 40 years of age or older; and
- ◆ Is prescribed by pulmonologist; and
- ◆ Patient has a diagnosis of idiopathic pulmonary fibrosis as confirmed by one of the following (attach documentation):
 - Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or
 - A surgical lung biopsy demonstrating usual interstitial pneumonia (UIP); and
- ◆ Prescriber has excluded other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity; and
- ◆ Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC) \geq 50% predicted; and
- ◆ Patient has carbon monoxide diffusion capacity (%DLco) of \geq 30% predicted, and
- ◆ Patient does not have hepatic impairment as defined below:
 - Nintedanib. Patient does not have moderate or severe hepatic impairment (Child Pugh B or C); or
 - Pirfenidone. Patient does not have severe hepatic impairment (Child Pugh C); and
- ◆ Patient does not have renal impairment as defined below:
 - Nintedanib. Patient does not have severe renal impairment (CrCl < 30 mL/min) or end-stage renal disease; or
 - Pirfenidone. Patient does not have end-stage renal disease requiring dialysis; and
- ◆ Patient is a nonsmoker or has been abstinent from smoking for at least six weeks.



If the criteria for coverage are met, initial requests will be given for six months. Additional authorizations will be considered at six month intervals when the following criteria are met:

- ◆ Adherence to pirfenidone and nintedanib is confirmed; and
- ◆ Patient is tolerating treatment defined as improvement or maintenance of disease (<10% decline in percent predicted FVC or < 200 mL decrease in FVC); and
- ◆ Documentation is provided that the patient has remained tobacco-free; and
- ◆ ALT, AST, and bilirubin are assessed periodically during therapy.

Use form 470-5346, *Request for Prior Authorization: Idiopathic Pulmonary Fibrosis*, to request prior authorization. Click [here](#) to see a sample of the form.

44. 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.



Request for Prior Authorization
IMMUNOMODULATORS-TOPICAL

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

Prior authorization is required for topical immunomodulators. Payment for pimecrolimus (Elidel®) or tacrolimus (Protopic®) 0.03% will be considered for non-immunocompromised patients two years of age and older and tacrolimus (Protopic®) 0.1% for patients 16 years of age and older when there is an adequate trial and therapy failure with two preferred topical corticosteroids.

Non-Preferred

- Elidel, Protopic, Tacrolimus Ointment

Strength Usage Instructions Quantity Days Supply

Diagnosis:

Preferred Drug Trial 1: Drug Name& Dose Trial Dates: Failure Reason

Preferred Drug Trial 2: Drug Name& Dose Trial Dates: Failure Reason

Does the patient have an immunocompromised condition? If yes, diagnosis: Affected area to be treated:

Medical or contraindication reason to override trial requirements:

Attach lab results and other documentation as necessary.

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

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



Request for Prior Authorization
INSULIN, PRE-FILLED PENS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

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

Preferred

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

Non-Preferred

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

Number of Units

How Often

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

Diagnosis:

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

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

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

Other medical conditions to consider:

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

Attach lab results and other documentation as necessary.

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

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



Request for Prior Authorization ISOTRETINOIN (ORAL)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

Prior authorization is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata. 2. Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (www.ipledgeprogram.com) risk management program. Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

Preferred

Non-Preferred

- Amnesteem, Claravis, Myorisan, Zenatane, Absorica. Includes Strength, Dosage Instructions, Quantity, Days Supply.

Diagnosis: Date of Initial Treatment:

*If PA extension, please specify exact date range of last drug-free interval: From: To:

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

Please submit documentation of trial failures with systemic (not topical) antibiotic & vitamin A derivative such as topical tretinoin or Differin (adapalene) include drug names, strength, exact date ranges and failure reasons:

If female of child-bearing years, confirmed negative serum pregnancy test? Yes No. If yes, please list Prescriber: Date of pregnancy test:

Specify plan for contraception:

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

Other medical conditions to consider:

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

PLEASE ALSO FAX THE iPLEDGE CONSENT FORM(S) SIGNED BY PATIENT. THE iPLEDGE CONSENT FORM(S) CAN BE OBTAINED ONLINE AT www.ipledgeprogram.com.

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.



45. Insulin Pens, Pre-Filled

Prior authorization is required for pre-filled insulin pens. Prior authorization is granted when documentation indicates:

- ◆ The member's visual or motor skills are impaired to such that the member cannot accurately draw up the insulin, and
- ◆ There is no caregiver available to provide assistance.
- ◆ Patient does not reside in a long-term care facility.

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

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

46. 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.



47. Ivacaftor (Kalydeco™)

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

- ◆ Patient is two 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, S1251N, S1255P, S549N, S549R, and R117H as detected by an FDA-cleared cystic fibrosis mutation test; and
- ◆ Prescriber is a cystic fibrosis specialist or pulmonologist; and
- ◆ Baseline liver function tests (AST/ALT) and FEV₁, if age appropriate, are provided; and
- ◆ Patient does not have one of the following infections: *Burkholderia cenocepacia*, *Burkholderia dolosa*, or *Mycobacterium abscessus*.

If the criteria for coverage are met, an initial authorization will be given for three months. Additional approvals will be granted for six months at a time if the following criteria are met:

- ◆ Adherence to ivacaftor therapy is confirmed; and
- ◆ Response to therapy is documented by prescriber (e.g., improved FEV₁ from baseline, weight increased from baseline, decreased exacerbations, improved quality of life) or rationale for continued care; and
- ◆ Liver function tests (AST/ALT) are assessed every three months during the first year of treatment and annually thereafter.

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

48. 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



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 2 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, S549R, and R117H as detected by an FDA-cleared CF mutation test; and 3) Prescriber is a CF specialist or pulmonologist; and 4) Baseline liver function tests (AST/ALT) and FEV1, if age appropriate, are provided; and 5) Patient does not have one of the following infections documented on the most recent sputum culture: Burkholderia cenocepacia, Burkholderia dolosa, Mycobacterium abscessus. If the criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 6 months at a time if the following criteria are met: 1) Adherence to ivacaftor therapy is confirmed; and 2) Response to therapy is documented by prescriber (e.g., improved FEV1 from baseline, decreased exacerbations, improved quality of life) or rationale for continued care; and 3) Liver function tests (AST/ALT) are assessed every 3 months during the first year of treatment and annually thereafter.

[] Kalydeco™

Strength Dosage Instructions Quantity Days Supply

Diagnosis (Attach copy of FDA-cleared CF mutation test results):

Attach copy of baseline liver function test (AST/ALT) and FEV1 or indicate why not appropriate:

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)

**Request for Prior Authorization
IVACAF TOR (KALYDECO™)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Renewal Requests:

Patient is adherent to ivacaftor therapy: Yes No

Document response to therapy (improved FEV₁ from baseline, weight increased from baseline, decreased exacerbations, improved quality of life) or rationale for continued care. Please provide labs, if applicable, and specific documentation of improvement: _____

Liver function tests (AST/ALT) are assessed every 3 months during first year of treatment and annually thereafter: Yes No Most recent lab date: _____

Ivacaftor Therapy Start Date: _____

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.



- ◆ 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.

49. **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.

50. 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.

51. Linezolid (Zyvox®)

Prior authorization is required for linezolid (Zyvox®). Payment for linezolid (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.*



Request for Prior Authorization
LINEZOLID (ZYVOX®)

(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 Zyvox®. Payment for Zyvox® will be authorized when there is documentation that: Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable), AND Patient has an active infection and meets one of the following diagnostic criteria: Vancomycin-resistant Enterococcus (VRE) and no alternative regimens with documented efficacy, Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin, Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin.

Preferred

Non-Preferred

[] Linezolid (authorized generic)

[] Zyvox

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

- Diagnosis options: Vancomycin-resistant Enterococcus (VRE) and no alternative regimens with documented efficacy, Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin, Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin, Other (specify).

Is Prescriber Infectious Disease (ID) Specialist? [] Yes [] No If no, note consultation with ID Specialist: Consultation Date: Physician Name & Phone:

Pertinent Lab data:

Additional relevant information:

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.



* 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.

52. Long Acting Narcotics

Prior authorization is required for all nonpreferred 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 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.



53. Lumacaftor/Ivacaftor (Orkambi™)

Prior authorization is required for Orkambi™ (lumacaftor/ivacaftor). Dual therapy with another cystic fibrosis transmembrane conductance regulator (CFTR) potentiator will not be considered. Payment will be considered for patients when the following criteria are met:

- ◆ Patient is 12 years of age or older; and
- ◆ Has a diagnosis of cystic fibrosis; and
- ◆ Patient is homozygous for the F508del mutation in the CFTR gene as confirmed by a FDA-cleared CF mutation test; and
- ◆ Baseline live function tests (AST/ALT) and bilirubin levels are provided; and
- ◆ Baseline percent predicted forced expiratory volume (ppFEV₁) is provided and is greater than or equal (\geq) 40; and
- ◆ Prescriber is a CF specialist or pulmonologist; and
- ◆ Patient does not have one of the following infections: Burkholderia cenocepacia, Burkholderia dolosa, or Mycobacterium abscessus.

If the criteria for coverage are met, an initial authorization will be given for three months. Additional approvals will be granted for six months at a time if the following criteria are met:

- ◆ Adherence to lumacaftor/ivacaftor therapy is confirmed; and
- ◆ Response to therapy is documented by prescriber (e.g., improved ppFEV₁ from baseline, weight increased from baseline, decreased exacerbations, improved quality of life) or rationale for continued care; and
- ◆ Liver function tests (AST/ALT) and bilirubin are assessed every three months during the first year of treatment and annually thereafter.

Use form 470-5366, *Request for Prior Authorization: Lumacaftor/Ivacaftor (Orkambi™)*, to request prior authorization. Click [here](#) to see a sample of the form.



Request for Prior Authorization
LUMACAFITOR/IVACAFITOR (ORKAMBI™)

(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 Orkambi™ (lumacaftor/ivacaftor). Dual therapy with another cystic fibrosis transmembrane conductance regulator (CFTR) potentiator will not be considered. Payment will be considered for patients when the following criteria are met: 1) Patient is 12 years of age or older; and 2) Has a diagnosis of cystic fibrosis; and 3) Patient is homozygous for the F508del mutation in the CFTR gene as confirmed by a FDA-cleared CF mutation test; and 4) Baseline liver function tests (AST/ALT) and bilirubin levels are provided; and 5) Baseline percent predicted forced expiratory volume (ppFEV1) is provided and is greater than or equal to (≥) 40; and 6) Prescriber is a CF specialist or pulmonologist; and 7) Patient does not have one of the following infections: Burkholderia cenocepacia, Burkholderia dolosa, or Mycobacterium abscessus.

If the criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 6 months at a time if the following criteria are met: 1) Adherence to lumacaftor/ivacaftor therapy is confirmed; and 2) Response to therapy is documented by prescriber (e.g., improved ppFEV1 from baseline, weight increased from baseline, decreased exacerbations, improved quality of life) or rationale for continued care; and 3) Liver function tests (AST/ALT) and bilirubin are assessed every 3 months during the first year of treatment and annually thereafter.

Orkambi Dosage instructions Quantity Days supply

Initial Requests. Attach the following test results:

- Checkboxes for FDA-cleared CF mutation test, Baseline liver function tests (AST/ALT) and bilirubin, Baseline percent predicted forced expiratory volume (ppFEV1) with result lines.

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, lab results, and most recent sputum culture results.

Renewal Requests.

Is patient adherent to Orkambi? Yes No

Liver function tests (AST/ALT) and bilirubin will be assessed every 3 months during the first year of treatment and annually thereafter? Yes (attach most recent results) Date and result: No

Document response to therapy (e.g., improved ppFEV1 from baseline, weight increased from baseline, decreased exacerbations, improved quality of life) or rationale for continued care:

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.



54. Methotrexate Injection

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

- ◆ Diagnosis of severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (pJIA) and ALL of the following:
 - Prescribed by a rheumatologist; and
 - Patient has a documented trial and intolerance with oral methotrexate; and
 - Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD (hydroxychloroquine, leflunomide, minocycline or sulfasalazine); and
 - Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and
 - Patient does not reside in a long-term care facility.
- ◆ Diagnosis of severe, recalcitrant disabling psoriasis and ALL of the following:
 - Patient is 18 years of age or older; and
 - Prescribed by a dermatologist; and
 - Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy).
 - Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and
 - Patient does not reside in a long-term care facility.

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

Use form 470-5294, *Request for Prior Authorization: Methotrexate Injection*, to request prior authorization. Click [here](#) to see a sample of the form.



55. 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.

56. 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.



Request for Prior Authorization
MODIFIED FORMULATIONS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

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

- Checkboxes for: Horizant (trial of gabapentin), Invega / Paliperidone ER (trial of risperidone), Trilipix (trial of Tricor), Xopenex HFA (trial of albuterol HFA), Xopenex Nebs / levalbuterol nebs (trial of albuterol nebs)

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

- Checkboxes for: Abilify Discmelt (trial of Abilify solution), Aricept ODT (trial of Aricept tablets), Binosto (trial of alendronate tablets), Clozapine ODT / Fazaclor (trial of clozapine tablets), Lamotrigine ODT (lamotrigine chew tablets), Metozolv ODT (trial of metoclopramide solution), Remeron SolTab (trial of mirtazapine tablets), Risperdal M-Tab (trial of risperidone solution), Zyprexa Zydis (trial of Zyprexa tablets)

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

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

Failure Reason:

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

Failure Reason:

Medical Necessity for alternative delivery system:

Failure Reason of preferred alternative delivery system:

Medical or contraindication reason to override trial requirements:

Attach lab results and other documentation as necessary.

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.



57. Multiple Sclerosis-Oral Agents

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

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

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

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

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

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

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

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

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

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



58. 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.

59. 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.



60. 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.

61. 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 for counseling to:
 - Quitline Iowa program for Medicaid Fee-for-Service members, or
 - Through the Managed Care Organization program for managed care members.
- ◆ Confirmation of enrollment in the counseling program is required for approval. Continuation therapy is available only with documentation of ongoing participation in the counseling 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.

62. Nonparenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products

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

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

Requests for desmopressin nasal spray for the treatment of nocturnal enuresis will not be considered.

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. Please refer to the Selected Brand-Name Drugs prior authorization form if requesting a non-preferred brand-name product.

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.



Request for Prior Authorization
NON-PARENTERAL VASOPRESSIN DERIVATIVES OF
POSTERIOR PITUITARY HORMONE 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 non-parenteral vasopressin derivatives of posterior pituitary hormone products. Payment for preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses: 1. Diabetes Insipidus, 2. Hemophilia A, and 3. Von Willebrand's disease.

Requests for desmopressin nasal spray for the treatment of nocturnal enuresis will not be considered. Payment for non-preferred non-parenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial(s) and therapy failure with the preferred agent(s).

Preferred

- Desmopressin Nasal Solution
Desmopressin Nasal Spray
Desmopressin Tablets
Stimate Nasal Spray

Non-Preferred

- DDAVP Acetate Nasal Solution
DDAVP Acetate Nasal Spray
DDAVP Tablets

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

- Diabetes insipidus Hemophilia A
Von Willebrand's disease Other (please specify)
Nocturnal enuresis*

*If nocturnal enuresis, is patient 6 years old or older? Yes No

Please specify exact date range of last drug-free interval: From: To:

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

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

Attach lab results and other documentation as necessary.

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

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



Request for Prior Authorization
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs (nsaids) and COX-2 inhibitors. Prior authorization is not required for preferred nsaids or COX-2 inhibitors. 1. Requests for a non-preferred nsaid must document previous trials and therapy failures with at least three preferred nsaids.

Preferred (No PA required)

- Diclofenac Sod./Pot. Meloxicam (COX-2)
Diclofenac Sod. EC/DR Nabumetone (COX-2)
Etodolac 400mg/500mg Naprosyn Susp.
Flurbiprofen Naproxen
Ibuprofen Naproxen EC/ER
Ibuprofen Susp. Naproxen Sodium 550mg
Indomethacin Salsalate
Ketoprofen Sulindac

Non-Preferred (PA required for all products)

- Arthrotec Indomethacin ER* Tivorbex
Celebrex Ketoprofen ER Tolmetin Sod
Celecoxib Meclofenamate Sod Vivlodex
Diclofenac ER/XR* Naprelan Voltaren Gel
EC-Naprosyn Oxaprozin Voltaren XR
Etodolac CR/ER/XR Pennsaid Zipsor
Fenoprofen Piroxicam Zorvolex
Flector Patch Ponstel
Other (specify)

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

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

Failure Reason

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

Failure Reason

Preferred Drug Trial 3: Drug Name& Dose Trial Dates:

Failure Reason

Medical Necessity for alternative delivery system:

Medical or contraindication reason to override trial requirements:

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

Attach lab results and other documentation as necessary.

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

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



63. 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.

64. 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.



65. **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



Request for Prior Authorization
ORAL CONSTIPATION AGENTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

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

- 1) Patient is 18 years of age or older; and
2) Patient must have documentation of adequate trials and therapy failures with at least one medication from each of the following categories: saline laxative (milk of magnesia), osmotic laxative (polyethylene glycol or lactulose), and stimulant laxative (senna); and
3) Patient does not have a known or suspected mechanical gastrointestinal obstruction.

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

Non-Preferred

[] Amitiza [] Linzess [] Movantik

Strength Dosage Instructions Quantity Days Supply

Treatment failures:

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

Failure reason:

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

Trial Dates: Failure reason:

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

Failure reason:

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

**Request for Prior Authorization
ORAL CONSTIPATION AGENTS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

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

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

- Other Diagnosis:** _____

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

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

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

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



- ◆ 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.

66. 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:
 - Chronic idiopathic constipation (Amitiza® or Linzess™)
 - Irritable bowel syndrome with constipation (Amitiza® or Linzess™)
 - Opioid-induced constipation with chronic, non-cancer pain (Amitiza®)

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.

a. Chronic Idiopathic Constipation (Amitiza[®] or Linzess[™])

In addition to the above criteria being met:

- ◆ 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.

b. Irritable Bowel Syndrome with Constipation (Amitiza[®] or Linzess[™])

In addition to the above criteria being met:

- ◆ 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.



c. Opioid-Induced Constipation with Chronic, Non-Cancer Pain (Amitiza®)

In addition to the above criteria being met:

- ◆ 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.

67. Oral Immunotherapy

Prior authorization is required for sublingual allergen immunotherapy. Payment will be considered under the following conditions:

- ◆ Medication is prescribed by or in consultation with an allergist; and
- ◆ Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and
- ◆ Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines); and
- ◆ Patient has a documented intolerance to immunotherapy injections; and
- ◆ The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration).
- ◆ If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved.

Use form 470-5295, *Request for Prior Authorization: Oral Immunotherapy*, to request prior authorization. Click [here](#) to see a sample of the form.



a. Short Ragweed Pollen (Ragwitek®)

In addition to the above criteria being met:

- ◆ Patient is 18 through 65 years of age; and
- ◆ Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen.

If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen season and continued throughout the season.

b. Grass Pollen (Grastek® and Oralair®)

(1) Grastek®

In addition to the above criteria being met:

- ◆ Patient is 5 through 65 years of age; and
- ◆ Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop).

If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected season onset of each grass pollen season.

(2) Oralair®

In addition to the above criteria being met:

- ◆ Patient is 10 through 65 years of age (Oralair®); and
- ◆ Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, and Kentucky blue/June grass.

If criteria for coverage are met, authorization will be considered at least four months before the expected onset of each grass pollen season and continued throughout the grass pollen season.



68. 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.

69. PCSK9 Inhibitors

Prior authorization is required for PCSK9 Inhibitors. Payment will be considered under the following conditions:

- ◆ Patient is 18 years of age or older (or, for Homozygous Familial Hypercholesterolemia, patient is 13 years of age or older); and
- ◆ Current use of a statin and documentation of adherence to prescribed lipid lowering medications for the previous 90 days is provided (further defined below, by diagnosis); and



Request for Prior Authorization
PCSK9 INHIBITORS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

Prior authorization is required for PCSK9 Inhibitors. Payment will be considered under the following conditions: 1) Patient is 18 years of age or older (or, for Homozygous Familial Hypercholesterolemia (HoFH), patient is 13 years of age or older; and 2) Current use of a statin and documentation of adherence to prescribed lipid lowering medications for the previous 90 days is provided (further defined below, by diagnosis); and 3) Is to be prescribed as an adjunct to a low fat diet; and 4) A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; and 5) Documentation patient has been counseled on importance of abstinence from tobacco and, if a current smoker, be encouraged to enroll in a smoking cessation program; and 6) Is prescribed by a lipidologist, cardiologist, or endocrinologist. 7) The 72-hour emergency supply rule does not apply to PCSK9 Inhibitors. 8) Prescriber and dispensing pharmacy will educate the patient on proper storage and administration. Improperly stored medications will not be replaced. 9) Lost or stolen medication replacement requests will not be authorized. 10) Goal is defined as a 50% reduction in untreated baseline LDL-C. 11) Is prescribed for one of the following diagnoses: Heterozygous Familial Hypercholesterolemia (HeFH), Clinical Atherosclerotic Cardiovascular Disease (ASCVD), or HoFH. The required trials (excluding the statin trial) may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Quantity Limits:

Praluent/Repatha for HeFH or ASCVD: One syringe/pen/autoinjector per fill (requires refill every 14 days)
Repatha for HoFH only: One three-pack per month

Initial Requests (please see below for renewal requests):

HeFH or ASCVD Drug and Dose Requested:

- Praluent 75mg every 2 weeks for 8 weeks (4 doses)
Repatha 140mg every 2 weeks for 8 weeks (4 doses)

HoFH Drug and Dose Requested:

- Repatha 420mg (3x140mg autoinjectors) every month for 3 months

Is patient on a low fat diet: Yes No

Has patient experienced >= 50% reduction in untreated baseline LDL-C with current therapies?

- Yes No

Attach baseline (prior to pharmacologic therapy) and current lipid profiles.

Statin to be used as adjunct to PCSK9 inhibitor: Dose:

**Request for Prior Authorization
PCSK9 INHIBITORS**
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Has patient been counseled on importance of abstinence from tobacco? Yes No

Is patient a current smoker or tobacco user: Yes No

If yes, has patient been encouraged to enroll in smoking cessation program? Yes No

Prescriber Specialty: Lipidologist Cardiologist Endocrinologist Other: _____

Prescriber and dispensing pharmacy will educate patient on proper storage and administration?

Yes No

Heterozygous Familial Hypercholesterolemia (HeFH)

- 1) Total cholesterol > 290mg/dL or LDL-C > 190mg/dL; *and*
 - a) Presence of tendon xanthomas; *or*
 - b) In first or second degree relative, one of the following: documented tendon xanthomas, MI at age ≤ 60 years, or total cholesterol > 290mg/dL; *or*
 - c) Confirmation of diagnosis by gene or receptor testing (attach results); *and*
- 2) Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications.

Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), plus ezetimibe (Zetia) 10mg daily, plus cholestyramine daily.

Total cholesterol: _____ **Date obtained:** _____

LDL-C: _____ **Date obtained:** _____

Presence of tendon xanthomas: Yes No

Any of the following present in first degree relative:

Documented tendon xanthomas MI at age ≤ 60 years Total cholesterol > 290mg/dL

Diagnosis confirmed by gene or receptor testing? Yes (attach results) No

Statin 1 trial:

Dose: _____ Trial dates: _____

Failure reason: _____

Statin 2 trial:

Dose: _____ Trial dates: _____

Failure reason: _____

Plus concurrent ezetimibe (Zetia) trial:

Dose: _____ Trial dates: _____

Failure reason: _____

Plus concurrent cholestyramine trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

**Request for Prior Authorization
PCSK9 INHIBITORS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Clinical Atherosclerotic Cardiovascular Disease (ASCVD)

- 1) History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; *and*
- 2) Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications.

Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), plus ezetimide (Zetia) 10mg daily, plus cholestyramine daily.

History of any of the following: MI Angina
 Coronary or other arterial revascularization Stroke TIA PVD of atherosclerotic origin

Statin 1 trial:

Dose: _____ Trial dates: _____

Failure reason: _____

Statin 2 trial:

Dose: _____ Trial dates: _____

Failure reason: _____

Plus concurrent ezetimibe (Zetia) trial:

Dose: _____ Trial dates: _____

Failure reason: _____

Plus concurrent cholestyramine trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

Homozygous Familial Hypercholesterolemia (HoFH) – Repatha only

- 1) Total cholesterol and LDL-C > 600mg/dL and triglycerides within reference range; or
- 2) Confirmation of diagnosis by gene or receptor testing (attach results); and 3) Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications.

Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), plus ezetimide (Zetia) 10mg daily, plus cholestyramine daily.

Total cholesterol: _____ Date obtained: _____

LDL-C: _____ Date obtained: _____

Triglycerides within reference range? Yes No (attach results)

Diagnosis confirmed by gene or receptor testing? Yes (attach results) No

Statin 1 trial:

Dose: _____ Trial dates: _____

Failure reason: _____

Statin 2 trial:

Dose: _____ Trial dates: _____

Failure reason: _____

**Request for Prior Authorization
PCSK9 INHIBITORS**
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Plus concurrent ezetimibe (Zetia) trial:

Dose: _____ Trial dates: _____

Failure reason: _____

Plus concurrent cholestyramine trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

Renewal Requests:

HeFH or ASCVD (Praluent or Repatha)

Lipid profile required at week 8, week 24, and every 6 months thereafter (attach results).

Yes Most recent date obtained: _____ LDL-C: _____ No

Praluent:

- LDL-C at goal – continue therapy at 75mg every 2 weeks for 24 weeks
- LDL-C not at goal – increase dose to 150mg every 2 weeks for 8 weeks (4 doses) and repeat LDL-C in 8 weeks
 - o If repeat LDL-C at goal – continue therapy at 150mg every 2 weeks for 24 weeks
 - o If repeat LDL-C not at goal – discontinue treatment

Repatha:

- LDL-C at goal – continue therapy at 140mg every 2 weeks for 24 weeks
- LDL-C not at goal – discontinue treatment

Patient continues therapy with a maximally tolerated statin dose and remains at goal? Yes No

Current Statin: Drug name: _____ Dose: _____

Patient has continued compliance with a low fat diet? Yes No

HoFH (Repatha only)

Lipid profile required after 3 months (third dose) and every 6 months thereafter (attach results).

Yes Most recent date obtained: _____ LDL-C: _____ No

- LDL-C at goal – continue therapy at 420mg every month for 6 months
- LDL-C not at goal – discontinue treatment

Patient continues therapy with a maximally tolerated statin dose and remains at goal? Yes No

Patient has continued compliance with a low fat diet? Yes No

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.



- ◆ Is to be prescribed as an adjunct to a low fat diet; and
- ◆ A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; and
- ◆ Documentation patient has been counseled on importance of abstinence from tobacco and, if a current smoker, be encouraged to enroll in a smoking cessation program; and
- ◆ Is prescribed by a lipidologist, cardiologist, or endocrinologist.
- ◆ The 72-hour emergency supply rule does not apply to PCSK9 Inhibitors.
- ◆ Prescriber and dispensing pharmacy will educate the patient on proper storage and administration. Improperly stored medications will not be replaced.
- ◆ Lost or stolen medication replacement requests will not be authorized.
- ◆ Goal is defined as a 50% reduction in untreated baseline LDL-C.

Use form 470-5399, *Request for Prior Authorization: PCSK9 Inhibitors*, to request prior authorization. Click [here](#) to see a sample of the form.

PCSK9 Inhibitors are prescribed for one of the following diagnoses:

a. Heterozygous Familial Hypercholesterolemia (HeFH)

In addition to the above criteria being met:

- ◆ Total cholesterol > 290mg/dL or LDL-C > 190mg/dL; and
 - Presence of tendon xanthomas; or
 - In first or second degree relative, one of the following:
 - Documented tendon xanthomas; or
 - MI at age ≤60 years; or
 - Total cholesterol > 290mg/dL; or
 - Confirmation of diagnosis by gene or receptor testing (attach results); and
- ◆ Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), PLUS ezetimibe (Zetia) 10mg daily, PLUS cholestyramine daily.



b. Clinical Atherosclerotic Cardiovascular Disease (ASCVD)

In addition to the above criteria being met:

- ◆ History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; and
- ◆ Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), PLUS ezetimibe (Zetia) 10mg daily, PLUS cholestyramine daily.

c. Homozygous Familial Hypercholesterolemia (HoFH)-Repatha (Evolocumab) Only

In addition to the above criteria being met:

- ◆ Total cholesterol and LDL-C > 600mg/dL and triglycerides within reference range; or
- ◆ Confirmation of diagnosis by gene or receptor testing (attach results); and
- ◆ Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications. Trials are defined as concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), PLUS ezetimibe (Zetia) 10mg daily, PLUS cholestyramine daily.

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

Initial and Renewal Authorizations for HeFH or ASCVD

Initial. Praluent 75mg or Repatha 140mg every 2 weeks for 8 weeks (4 doses).



Renewal.

- ◆ Lipid profile required at week 8, week 24, and every 6 months thereafter; *and*
- ◆ Patient continues therapy with a maximally tolerated statin dose and remains at goal; *and*
- ◆ Patient has continued compliance with a low fat diet.

Quantity limits for Praluent/Repatha. A quantity limit of one syringe/pen/autoinjector per fill will apply (requires refill every 14 days).

Praluent. If LDL-C at goal, continue therapy at 75mg every 2 weeks for 24 weeks.

If LDL-C not at goal, dose increase to 150mg every 2 weeks for 8 weeks (4 doses) and repeat LDL-C in 8 weeks.

- ◆ If LDL-C not at goal, discontinue Praluent.
- ◆ If LDL-C at goal, continue therapy at 150mg every 2 weeks for 24 weeks.

Repatha. If LDL-C at goal, continue therapy at 140mg every 2 weeks for 24 weeks.

If LDL-C not at goal, discontinue Repatha.

Initial and Renewal Authorizations for HoFH (Repatha Only)

Initial. Repatha 420mg (3x140mg autoinjectors) every month for 3 months.

Renewal.

- ◆ Lipid profile required after three months (third dose) and every six months thereafter; *and*
- ◆ Continued therapy with a maximally tolerated statin dose.
 - If LDL-C at goal, continue therapy at 420mg every month for six months.
 - If LDL-C not at goal, discontinue Repatha; *and*
- ◆ Patient has continued compliance with a low fat diet.

Quantity limits for Repatha. A quantity limit of one three-pack per month.



70. 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 nonpreferred 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.

71. 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.

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72. Quantity Limit Override

a. Initial 15-Day Limit

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

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

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

b. Monthly Limits

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

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

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

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



Drug Product	Quantity	Days' Supply	Comments
Abilify 2 mg (aripiprazole)	15	30	
Abilify 5 mg (aripiprazole)	15	30	
Abilify 10 mg (aripiprazole)	15	30	
Abilify 15 mg (aripiprazole)	15	30	
Abilify 20 mg (aripiprazole)	15	30	
Abilify 30 mg (aripiprazole)	15	30	
Aceon 2 mg (perindopril)	30	30	
Aceon 4 mg (perindopril)	30	30	
Aceon 8 mg (perindopril)	60	30	
Aciphex 20 mg (rabeprazole)	60	30	
Actonel 5 mg (risedronate)	30	30	
Actonel 30 mg (risedronate)	30	30	
Actonel 35 mg (risedronate)	4	30	
Actoplus Met 15-500 mg (metformin/pioglitazone)	60	30	
Actoplus Met 15-850 mg (metformin/pioglitazone)	60	30	
Actos 15 mg (pioglitazone)	30	30	
Actos 30 mg (pioglitazone)	30	30	
Actos 45 mg (pioglitazone)	30	30	
Adalat CC 30 mg (nifedipine ER)	30	30	
Adalat CC 60 mg (nifedipine ER)	30	30	
Adalat CC 90 mg (nifedipine ER)	30	30	
Adderall 5 mg (amphetamine salt combo)	90	30	
Adderall 7.5 mg (amphetamine salt combo)	90	30	
Adderall 10 mg (amphetamine salt combo)	90	30	
Adderall 12.5 mg (amphetamine salt combo)	90	30	
Adderall 15 mg (amphetamine salt combo)	90	30	
Adderall 20 mg (amphetamine salt combo)	90	30	
Adderall 30 mg (amphetamine salt combo)	60	30	



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



Drug Product	Quantity	Days' Supply	Comments
Amaryl 1 mg (glimepiride)	30	30	
Amaryl 2 mg (glimepiride)	30	30	
Amaryl 4 mg (glimepiride)	60	30	
Ambien 5 mg (zolpidem)	30	30	
Ambien 10 mg (zolpidem)	30	30	
Ambien CR 6.25 mg (zolpidem)	30	30	
Ambien CR 12.5 mg (zolpidem)	30	30	
Ampyra 10 mg (dalfampridine)	60	30	
Androgel 1% (25 mg) gel (testosterone)	30 pkts	30	
Androgel 1% (50 mg) gel (testosterone)	60 pkts	30	
Androgel 1% pump (testosterone)	300 gm	30	
Androgel 1.62% pump (testosterone)	150 gm	30	
Arava 10 mg (leflunomide)	30	30	
Arava 20 mg (leflunomide)	30	30	
Arava 100 mg (leflunomide)	3	30	
Aricept ODT 5 mg (donepezil)	30	30	
Aricept ODT 10 mg (donepezil)	30	30	
Aricept 5 mg (donepezil)	30	30	
Aricept 10 mg (donepezil)	30	30	
Aricept 23 mg (donepezil)	30	30	
Astelin nasal spray (azelastine)	30 ml	30	
Atacand 4 mg (candesartan)	30	30	
Atacand 8 mg (candesartan)	30	30	
Atacand 16 mg (candesartan)	30	30	
Atacand 32 mg (candesartan)	30	30	
Atacand HCT 16-12.5 mg (candesartan/HCTZ)	30	30	
Atacand HCT 32-12.5 mg (candesartan/HCTZ)	30	30	
Ativan 0.5mg tablet (lorazepam)	120	30	
Ativan 1 mg tablet (lorazepam)	120	30	
Ativan 2 mg tablet (lorazepam)	120	30	



Drug Product	Quantity	Days' Supply	Comments
Atrovent HFA (ipratropium)	2 bottles (25.8 gm)	30	
Atrovent inhaler (ipratropium)	2 inhalers (28 gm)	30	
Atrovent 0.03% nasal spray (ipratropium)	2 bottles	30	
Atrovent 0.06% nasal spray (ipratropium)	2 bottles	30	
Auvi-Q (epinephrine)	2 units	30	
Avalide 150-12.5 mg (irbesartan/HCTZ)	30	30	
Avalide 300-12.5 mg (irbesartan/HCTZ)	30	30	
Avalide 300-25 mg (irbesartan/HCTZ)	30	30	
Avandaryl 4 mg/1 mg (glimepiride/rosiglitazone)	60	30	
Avandaryl 4 mg/2 mg (glimepiride/rosiglitazone)	60	30	
Avandaryl 4 mg/4 mg (glimepiride/rosiglitazone)	60	30	
Avandia 8 mg (rosiglitazone)	30	30	
Avapro 75 mg (irbesartan)	30	30	
Avapro 150 mg (irbesartan)	30	30	
Avapro 300 mg (irbesartan)	30	30	
Avinza 30 mg (morphine ER)	30	30	
Avinza 45 mg (morphine ER)	30	30	
Avinza 60 mg (morphine ER)	30	30	
Avinza 75 mg (morphine ER)	30	30	
Avinza 90 mg (morphine ER)	30	30	
Avinza 120 mg (morphine ER)	150	30	
Avonex (interferon beta-1a)	1 kit	28	
Bactroban nasal ointment	10 grams	30	
Bactroban ointment (mupirocin)	44 grams	30	
Beconase AQ (beclomethasone dipropionate)	2 inhalers (50 gm)	30	
Belsomra (suvorexant) 5 mg	30	30	
Belsomra (suvorexant) 10 mg	30	30	
Belsomra (suvorexant) 15 mg	30	30	
Belsomra (suvorexant) 20 mg	30	30	



Drug Product	Quantity	Days' Supply	Comments
Benicar 5 mg (olmesartan)	30	30	
Benicar 20 mg (olmesartan)	30	30	
Benicar 40 mg (olmesartan)	30	30	
Benicar HCT 20-12.5 mg (olmesartan/HCTZ)	30	30	
Benicar HCT 40-12.5 mg (olmesartan/HCTZ)	30	30	
Benicar HCT 40-25 mg (olmesartan/HCTZ)	30	30	
Boniva 2.5 mg (ibandronate)	30	30	
Boniva 150 mg (ibandronate)	1 tablet	30	
Boniva syr (ibandronate)	1 syringe	90	
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



Drug Product	Quantity	Days' Supply	Comments
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	
Combivent Respimat (ipratropium bromide and albuterol)	8 grams	30	
Combunox (oxycodone/ibuprofen)	28	30	
Complera (emtricitabine/rilpivirine/ tenofovir disoproxil fumarate)	30	30	
Concerta SA 18 mg (methylphenidate ER)	30	30	
Concerta SA 27 mg (methylphenidate ER)	30	30	
Concerta SA 36 mg (methylphenidate ER)	60	30	
Concerta SA 54 mg (methylphenidate ER)	60	30	
Cosopt (dorzolamide hydrochloride/ timolol maleate)	10 ml	30	
Cozaar 25 mg (losartan)	60	30	
Cozaar 50 mg (losartan)	60	30	
Cozaar 100 mg (losartan)	30	30	
Crestor 5 mg (rosuvastatin)	30	30	
Crestor 10 mg (rosuvastatin)	30	30	
Crestor 20 mg (rosuvastatin)	30	30	
Crestor 40 mg (rosuvastatin)	30	30	
Cymbalta 20 mg (duloxetine)	60	30	
Cymbalta 30 mg (duloxetine)	60	30	
Cymbalta 60 mg (duloxetine)	60	30	
Dalmane 15 mg (flurazepam)	30	30	
Dalmane 30 mg (flurazepam)	30	30	



Drug Product	Quantity	Days' Supply	Comments
Darvocet-N 50 (propoxyphene-n/ acetaminophen)	180	30	
Darvocet-N 100 (propoxyphene- n/acetaminophen)	180	30	
Daytrana 10 mg/9-hour patch (methylphenidate)	30	30	
Daytrana 15 mg/9-hour patch (methylphenidate)	30	30	
Daytrana 20 mg/9-hour patch (methylphenidate)	30	30	
Daytrana 30 mg/9-hour patch (methylphenidate)	30	30	
Dermotic (fluocinolone)	20 ml	30	
Detrol LA 2 mg (tolterodine)	30	30	
Detrol LA 4 mg (tolterodine)	30	30	
Dexedrine 5 mg SR (dextroamphetamine SR)	60	30	
Dexedrine 10 mg SR (dextroamphetamine SR)	60	30	
Dexedrine 15 mg SR (dextroamphetamine SR)	120	30	
Dexilant 30 mg (dexlansoprazole)	30	30	
Dexilant 60 mg (dexlansoprazole)	30	30	
Diastat (diazepam)	6	30	
Diazepam syringes	15 syringes	30	
Diazepam intensol 5 mg/ml (diazepam)	240 ml	30	
Diazepam oral solution 1 mg/ml (diazepam)	1200 ml	30	
Differin 0.1% cream (adapalene)	45	30	
Differin 0.1% gel (adapalene)	45	30	
Diovan 40 mg (valsartan)	30	30	
Diovan 80 mg (valsartan)	30	30	
Diovan 160 mg (valsartan)	30	30	
Diovan 320 mg (valsartan)	30	30	



Drug Product	Quantity	Days' Supply	Comments
Diovan HCT 80-12.5 mg (valsartan/HCTZ)	30	30	
Diovan HCT 160-12.5 mg (valsartan/HCTZ)	30	30	
Diovan HCT 160-25 mg (valsartan/HCTZ)	30	30	
Diovan HCT 320-12.5 mg (valsartan/HCTZ)	30	30	
Diovan HCT 320-25 mg (valsartan/HCTZ)	30	30	
Ditropan XL 5 mg (oxybutynin ER)	30	30	
Ditropan XL 10 mg (oxybutynin ER)	60	30	
Ditropan XL 15 mg (oxybutynin ER)	60	30	
Doral 7.5 mg (quazepam)	30	30	
Doral 15 mg (quazepam)	30	30	
Dulera 100/5 (mometasone furoate/formoterol fumarate)	120 inhalations	30	
Dulera 200/5 (mometasone furoate/formoterol fumarate)	120 inhalations	30	
Duoneb 3 ml vial (albuterol/ipratropium)	620 ml	30	
Duragesic 12 mcg (fentanyl)	10	30	
Duragesic 25 mcg (fentanyl)	10	30	
Duragesic 50 mcg (fentanyl)	10	30	
Duragesic 75 mcg (fentanyl)	10	30	
Duragesic 100 mcg (fentanyl)	10	30	
Edurant 25 mg (rilpivirine)	30	30	
Effexor XR 37.5 mg (venlafaxine)	30	30	
Effexor XR 75 mg (venlafaxine)	30	30	
Effexor XR 150 mg (venlafaxine)	90	30	
Embeda 20-0.8 mg (morphine/naltrexone)	60	30	
Embeda 30-1.2 mg (morphine/naltrexone)	60	30	
Embeda 50-2 mg (morphine/naltrexone)	60	30	
Embeda 60-2.4 mg (morphine/naltrexone)	60	30	
Embeda 80-3.2mg (morphine/naltrexone)	60	30	
Embeda 100-4 mg (morphine/naltrexone)	60	30	



Drug Product	Quantity	Days' Supply	Comments
EMLA (lidocaine-prilocaine)	30 grams	30	
Emsam 6 mg/24-hour patch (selegiline)	30	30	
Emsam 9 mg/24-hour patch (selegiline)	30	30	
Emsam 12 mg/24-hour patch (selegiline)	30	30	
Enablex 7.5 mg (darifenacin)	30	30	
Enablex 15 mg (darifenacin)	30	30	
Entocort 3 mg capsules (budesonide)	90	30	
Epinephrine, racemic solution 2.25% (racepinephrine)	30	15	
Epipen (epinephrine)	2 units	30	
Epipen, Jr (epinephrine)	2 units	30	
Estraderm (estradiol)	8 patches	30	
Eurax (crotamiton)	60 grams	30	
Exelon 1.5 mg (rivastigmine)	60	30	
Exelon 2 mg/ml oral solution (rivastigmine)	180 ml	30	
Exelon 3 mg (rivastigmine)	60	30	
Exelon 4.5 mg (rivastigmine)	60	30	
Exelon 6 mg (rivastigmine)	60	30	
Fanapt 1 mg (iloperidone)	60	30	
Fanapt 2 mg (iloperidone)	60	30	
Fanapt 4 mg (iloperidone)	60	30	
Fanapt 6 mg (iloperidone)	60	30	
Fanapt 8 mg (iloperidone)	60	30	
Fanapt 10 mg (iloperidone)	60	30	
Fanapt 12 mg (iloperidone)	60	30	
Fenoglide 40 mg (fenofibrate)	30	30	
Fioricet (butalbital-acetaminophen-caffeine)	60	30	
Fioricet/Codeine (butalbital-acetaminophen-caffeine-codeine)	60	30	
Fiorinal (butalbital-aspirin-caffeine)	60	30	
Fiorinal/Codeine (butalbital-aspirin-caffeine-codeine)	60	30	
Flomax 0.4 mg (tamsulosin)	60	30	
Flonase (fluticasone propionate)	2 inhalers (32 grams)	30	



Drug Product	Quantity	Days' Supply	Comments
Flovent HFA 44 mcg (fluticasone propionate)	1 inhaler (10.6 gm)	30	
Flovent HFA 110 mcg (fluticasone propionate)	1 inhaler (12 gm)	30	
Flovent HFA 220 mcg (fluticasone propionate)	2 inhalers (24 gm)	30	
Focalin 2.5 mg (dexmethylphenidate)	60	30	
Focalin 5 mg (dexmethylphenidate)	60	30	
Focalin 10 mg (dexmethylphenidate)	60	30	
Focalin XR 5 mg (dexmethylphenidate)	30	30	
Focalin XR 10 mg (dexmethylphenidate)	30	30	
Focalin XR 15 mg (dexmethylphenidate)	30	30	
Focalin XR 20 mg (dexmethylphenidate)	30	30	
Focalin XR 25 mg (dexmethylphenidate)	30	30	
Focalin XR 30 mg (dexmethylphenidate)	30	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	
Glucagon 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	



Drug Product	Quantity	Days' Supply	Comments
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	
Intuniv 1 mg (guanfacine ER)	30	30	
Intuniv 2 mg (guanfacine ER)	30	30	
Intuniv 3 mg (guanfacine ER)	30	30	
Intuniv 4 mg (guanfacine ER)	30	30	
Invega 3 mg (paliperidone)	30	30	
Invega 6 mg (paliperidone)	60	30	
Invega 9 mg (paliperidone)	30	30	
Invega Sustenna 39 mg syringe (paliperidone palmitate)	1 syringe	30	
Invega Sustenna 78 mg syringe (paliperidone palmitate)	1 syringe	30	
Invega Sustenna 117 mg syringe (paliperidone palmitate)	1 syringe	30	
Invega Sustenna 156 mg syringe (paliperidone palmitate)	1 syringe	30	
Invega Sustenna 234 mg syringe (paliperidone palmitate)	1 syringe	30	



Drug Product	Quantity	Days' Supply	Comments
Invega Trinza 273 mg syringe (paliperidone palmitate)	1 syringe	90	
Invega Trinza 410 mg syringe (paliperidone palmitate)	1 syringe	90	
Invega Trinza 546 mg syringe (paliperidone palmitate)	1 syringe	90	
Invega Trinza 819 mg syringe (paliperidone palmitate)	1 syringe	90	
Irenka 40 mg (duloxetine)	60	30	
Kadian 10 mg (morphine ER)	60	30	
Kadian 20 mg (morphine ER)	60	30	
Kadian 30 mg (morphine ER)	60	30	
Kadian 40 mg (morphine ER)	60	30	
Kadian 50 mg (morphine ER)	60	30	
Kadian 60 mg (morphine ER)	60	30	
Kadian 80 mg (morphine ER)	60	30	
Kadian 100 mg (morphine ER)	60	30	
Kalydeco (ivacaftor)	60	30	
Klonopin 0.5 mg (clonazepam)	120	30	
Klonopin 1 mg (clonazepam)	120	30	
Klonopin 2 mg (clonazepam)	120	30	
Korlym (mifepristone)	120	30	
Latuda 20 mg (lurasidone)	30	30	
Latuda 40 mg (lurasidone)	30	30	
Latuda 60 mg (lurasidone)	30	30	
Latuda 80 mg (lurasidone)	60	30	
Latuda 120 mg (lurasidone)	30	30	
Lescol 20 mg (fluvastatin)	30	30	
Lexapro 5 mg (escitalopram)	15	30	
Lexapro 10 mg (escitalopram)	15	30	
Lexapro 20 mg (escitalopram)	60	30	
Lidoderm patch (lidocaine)	90	30	Maximum of 30 patches allowed for initial fill
Lipitor 10 mg (atorvastatin)	30	30	
Lipitor 20 mg (atorvastatin)	30	30	
Lipitor 40 mg (atorvastatin)	45	30	
Liquicet (hydrocodone/acetaminophen)	2700 ml	30	
Lorazepam intensol 2 mg/ml (lorazepam)	150 ml	30	



Drug Product	Quantity	Days' Supply	Comments
Lorcet 10/650 mg (hydrocodone/ acetaminophen)	180	30	
Lorcet Plus (hydrocodone/ acetaminophen)	180	30	
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	



Drug Product	Quantity	Days' Supply	Comments
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	
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	



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



Drug Product	Quantity	Days' Supply	Comments
Phrenilin (butalbital-acetaminophen)	60	30	
Pradaxa (dabigatran)	60	30	
Pravachol 10 mg (pravastatin)	30	30	
Pravachol 20 mg (pravastatin)	30	30	
Pravachol 40 mg (pravastatin)	30	30	
Pravachol 80 mg (pravastatin)	30	30	
Premarin 0.625 mg (conjugated estrogens)	30	30	
Premarin vaginal cream (conjugated estrogens)	1 tube (30 gm)	30	
Prevacid 15 mg (lansoprazole)	30	30	Prior authorization required for more than 60 days of PPI therapy
Prevacid 30 mg (lansoprazole)	30	30	Prior authorization required for more than 60 days of PPI therapy
Prevacid SoluTabs 15 mg (lansoprazole)	30	30	
Prevacid SoluTabs 30 mg (lansoprazole)	30	30	
Prilosec 10 mg (omeprazole)	30	30	
Prilosec 20 mg (omeprazole)	30	30	
Prilosec 40 mg (omeprazole)	30	30	
Pristiq 50 mg (desvenlafaxine)	30	30	
Pristiq 100 mg (desvenlafaxine)	30	30	
Proair HFA 8.5 gm (albuterol)	3 inhalers (25.5 gm)	30	
Procardia XL 30 mg (nifedipine ER)	30	30	
Procardia XL 60 mg (nifedipine ER)	30	30	
Procardia XL 90 mg (nifedipine ER)	30	30	
Procentra 5 mg/5 ml (dextroamphetamine)	1800 ml	30	
Prosom 1 mg (estazolam)	30	30	
Prosom 2 mg (estazolam)	30	30	
Protonix 20 mg (pantoprazole)	30	30	Prior authorization required for more than 60 days of PPI therapy
Protonix 40 mg (pantoprazole)	30	30	Prior authorization required for more than 60 days of PPI therapy



Drug Product	Quantity	Days' Supply	Comments
Provigil 100 mg (modafinil)	30	30	
Provigil 200 mg (modafinil)	60	30	
Prozac 20 mg/5 ml solution (fluoxetine)	600 ml	30	
Prozac 10 mg tablet (fluoxetine)	45	30	
Prozac 10 mg capsule (fluoxetine)	30	30	
Prozac 20 mg (fluoxetine)	120	30	
Prozac 40 mg (fluoxetine)	60	30	
Pulmicort flexhaler 180 mcg/dose (budesonide)	2	30	
Qvar 40 mcg (beclomethasone dipropionate)	3 inhalers (21.9 gm)	30	
Qvar 80 mcg (beclomethasone dipropionate)	3 inhalers (21.9 gm)	30	
Remeron 15 mg (mirtazapine)	45	30	
Remeron 30 mg (mirtazapine)	30	30	
Remeron 45 mg (mirtazapine)	30	30	
Remeron SolTab 15 mg (mirtazapine ODT)	45	30	
Remeron SolTab 30 mg (mirtazapine ODT)	30	30	
Remeron SolTab 45 mg (mirtazapine ODT)	30	30	
Restoril 7.5 mg (temazepam)	30	30	
Restoril 15 mg (temazepam)	30	30	
Restoril 22.5 mg (temazepam)	30	30	
Restoril 30 mg (temazepam)	30	30	
Revlimid 2.5 mg (lenalidomide)	30	30	
Revlimid 5 mg (lenalidomide)	30	30	
Revlimid 10 mg (lenalidomide)	60	30	
Revlimid 15 mg (lenalidomide)	30	30	
Revlimid 25 mg (lenalidomide)	30	30	
Rhinocort aqua sus (budesonide)	8.6 gm	30	
Risperdal 0.5 mg M-tab (risperidone)	120	30	
Risperdal 1 mg M-tab (risperidone)	120	30	
Risperdal 2 mg M-TAB (risperidone)	90	30	
Risperdal 3 mg M-TAB (risperidone)	60	30	
Risperdal 4 mg M-TAB (risperidone)	60	30	



Drug Product	Quantity	Days' Supply	Comments
Risperdal Consta 12.5 mg syringe (risperidone)	2 syringes	28	
Risperdal Consta 25 mg syringe (risperidone)	2 syringes	28	
Risperdal Consta 37.5 mg syringe (risperidone)	2 syringes	28	
Risperdal Consta 50 mg syringe (risperidone)	2 syringes	28	
Risperdal 0.25 mg (risperidone)	120	30	
Risperdal 0.5 mg (risperidone)	120	30	
Risperdal 1 mg (risperidone)	120	30	
Risperdal 2 mg (risperidone)	90	30	
Risperdal 3 mg (risperidone)	60	30	
Risperdal 4 mg (risperidone)	60	30	
Ritalin 5 mg (methylphenidate)	90	30	
Ritalin 10 mg (methylphenidate)	90	30	
Ritalin 20 mg (methylphenidate)	90	30	
Ritalin LA 10 mg (methylphenidate ER)	30	30	
Ritalin LA 20 mg (methylphenidate ER)	30	30	
Ritalin LA 30 mg (methylphenidate ER)	60	30	
Ritalin LA 40 mg (methylphenidate ER)	30	30	
Ritalin LA 60 mg (methylphenidate ER)	30	30	
Ritalin SR 20 mg (methylphenidate ER)	90	30	
Robinul 1 mg (glycopyrrolate)	90	30	
Robinul Forte 2 mg (glycopyrrolate)	120	30	
Robitussin DM Syrup (dextromethorphan-guaifenesin 10-100 mg/5 ml)	240 ml	30	Allowed for a cumulative 90 days per 12 month period
Rozerem 8 mg (ramelteon)	30	30	
Ryzolt 100 mg (tramadol ER)	30	30	
Ryzolt 200 mg (tramadol ER)	30	30	
Ryzolt 300 mg (tramadol ER)	30	30	
Saphris 5 mg (asenapine)	60	30	
Saphris 10 mg (asenapine)	60	30	



Drug Product	Quantity	Days' Supply	Comments
Savella 12.5 mg (milnacipran)	60	30	
Savella 25 mg (milnacipran)	60	30	
Savella 50 mg (milnacipran)	60	30	
Savella 100 mg (milnacipran)	60	30	
Serax 10 mg (oxazepam)	120	30	
Serax 15 mg (oxazepam)	120	30	
Serax 30 mg (oxazepam)	120	30	
Serevent diskus 60 blisters (salmeterol)	1 package (60)	30	
Seroquel 25 mg (quetiapine)	90	30	
Seroquel 50 mg (quetiapine)	90	30	
Seroquel 100 mg (quetiapine)	90	30	
Seroquel 200 mg (quetiapine)	90	30	
Seroquel 300 mg (quetiapine)	60	30	
Seroquel 400 mg (quetiapine)	60	30	
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	



Drug Product	Quantity	Days' Supply	Comments
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	
Symbicort 80/4.5 (budesonide/formoterol fumarate)	120 inhalations	30	
Symbicort 160/4.5 (budesonide/formoterol fumarate)	120 inhalations	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	
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	



Drug Product	Quantity	Days' Supply	Comments
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 wth codeine No. 3 (acetaminophen/codeine)	390	30	
Tylenol wth 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	
Valium 2 mg (diazepam)	120	30	
Valium 5 mg (diazepam)	120	30	
Valium 10 mg (diazepam)	120	30	
Valturna 150-160 mg (aliskiren/ valsartan)	30	30	
Valturna 300-320 mg (aliskiren/ valsartan)	30	30	
Venlafaxine ER 37.5 mg tablet	30	30	
Venlafaxine ER 75 mg tablet	30	30	
Venlafaxine ER 150 mg tablet	60	30	
Venlafaxine ER 225 mg tablet	60	30	
Veregen (sinecatechins)	30 gm	28	Max 120 gm/16 weeks
Vicodin 5/500 mg (hydrocodone/ acetaminophen)	240	30	
Vicodin ES (hydrocodone/ acetaminophen)	150	30	
Vicodin HP (hydrocodone/ acetaminophen)	180	30	



Drug Product	Quantity	Days' Supply	Comments
Victoza (liraglutide)	9 mL	30	
Vigamox (moxifloxacin)	6 ml	30	
Viibryd 10 mg (vilazodone)	30	30	
Viibryd 20 mg (vilazodone)	30	30	
Viibryd 40 mg (vilazodone)	30	30	
Vimpat 50 mg (lacosamide)	60	30	
Vimpat 100 mg (lacosamide)	60	30	
Vimpat 150 mg (lacosamide)	60	30	
Vimpat 200 mg (lacosamide)	60	30	
Vivelle/Vivelle-DOT (estradiol)	8 patches	28	
Vyvanse 10 mg (lisdexamfetamine)	30	30	
Vyvanse 20 mg (lisdexamfetamine)	30	30	
Vyvanse 30 mg (lisdexamfetamine)	30	30	
Vyvanse 40 mg (lisdexamfetamine)	30	30	
Vyvanse 50 mg (lisdexamfetamine)	30	30	
Vyvanse 60 mg (lisdexamfetamine)	30	30	
Vyvanse 70 mg (lisdexamfetamine)	30	30	
Wellbutrin 75 mg (bupropion)	180	30	
Wellbutrin 100 mg (bupropion)	90	30	
Wellbutrin SR 100 mg (bupropion SR)	60	30	
Wellbutrin SR 150 mg (bupropion SR)	60	30	
Wellbutrin SR 200 mg (bupropion SR)	60	30	
Wellbutrin XL 150 mg(bupropion ER)	30	30	
Wellbutrin XL 300 mg (bupropion ER)	30	30	
Xalatan (latanoprost)	5 ml	30	
Xalkori 200 mg (crizotinib)	60	30	
Xalkori 250 mg (crizotinib)	60	30	
Xanax 0.25 mg (alprazolam)	120	30	
Xanax 0.5 mg (alprazolam)	120	30	
Xanax 1 mg (alprazolam)	120	30	
Xanax 2 mg (alprazolam)	120	30	
Xanax XR 0.5 mg (alprazolam ER)	30	30	
Xanax XR 1 mg (alprazolam ER)	30	30	



Drug Product	Quantity	Days' Supply	Comments
Xodol 5/300 mg (hydrocodone/ acetaminophen)	360	30	
Xodol 7.5/300 mg (hydrocodone/ acetaminophen)	180	30	
Xodol 10/300 mg (hydrocodone/ acetaminophen)	180	30	
Xolair sol 150 mg (omalizumab)	6	30	
Xyrem 500 mg/ml (sodium oxybate)	540 ml	30	
Zamicet (hydrocodone/ acetaminophen)	2700 ml	30	
Zavesca (miglustat)	90	30	
Zebeta 5 mg (bisoprolol)	30	30	
Zelboraf 250 mg (vemurafenib)	240	30	
Zetia 10 mg (ezetimibe)	30	30	
Zocor 5 mg (simvastatin)	30	30	
Zocor 10 mg (simvastatin)	30	30	
Zocor 20 mg (simvastatin)	30	30	
Zocor 40 mg(simvastatin)	30	30	
Zoloft 50 mg (sertraline)	45	30	
Zonalon 5% cream (doxepin)	45 m	30	
Zovirax 5% ointment (acyclovir)	30 gm	30	
Zydone 5/400 mg (hydrocodone/ acetaminophen)	240	30	
Zydone 7.5/400 mg (hydrocodone/ acetaminophen)	240	30	
Zydone 10/400 mg (hydrocodone/ acetaminophen)	180	30	
Zyprexa 2.5 mg (olanzapine)	30	30	
Zyprexa 5 mg (olanzapine)	30	30	
Zyprexa 7.5 mg (olanzapine)	30	30	
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	



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

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

- ◆ Patient is under two years of age; and
- ◆ Patient has a diagnosis of infantile spasms.

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

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

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

74. 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).

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

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



a. Atrial Fibrillation

In addition to the above criteria being met:

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

b. Treatment and Prevention of DVT or PE

In addition to the above criteria being met:

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

c. Prophylaxis of DVT Following Hip or Knee Replacement

In addition to the above criteria being met:

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



Requests will be approved for the following dosing:

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

75. 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.

76. Sedative/Hypnotics-Non-Benzodiazepine

Preferred agents are available without prior authorization. Requests for doses above the manufacturer recommended dose will not be considered.

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 previous trials and therapy failures with, at a minimum, three preferred agents. Payment for nonpreferred nonbenzodiazepine sedative/hypnotics will be considered when the following criteria are met:

- ◆ A diagnosis of insomnia.
- ◆ Medications with a side effect of insomnia (i.e., stimulants) are decreased in dose, changed to a short-acting product, and/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.

In addition to the above criteria, requests for suvorexant (Belsomra) will require documentation of a trial and therapy failure with at least one nonpreferred agent, other than suvorexant, prior to consideration of coverage.

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

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

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.

77. Select Oncology Agents

Prior authorization is required for select oncology agents. Patient must have a diagnosis that is indicated in the FDA-approved package insert or the use is for an indication supported by the compendia (including National Comprehensive Cancer Network (NCCN) compendium level of evidence 1, 2A, or 2B). The following must be submitted with the prior authorization request:

- ◆ Copies of medical records (i.e., diagnostic evaluations and recent chart notes)
- ◆ Location of treatment (provider office, facility, home health, etc.) if medication requested is not an oral agent
- ◆ Original prescription
- ◆ Most recent copies of related laboratory results



Request for Prior Authorization
SELECT ONCOLOGY 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 select oncology agents. Patient must have a diagnosis that is indicated in the FDA-approved package insert or the use is for an indication supported by the compendia (including National Comprehensive Cancer Network (NCCN) compendium level of evidence 1, 2A, or 2B).

Provider specialty: _____

Patient information: Height: _____ (in) _____ (cm) Weight: _____ (lb) _____ (kg) BSA: _____

Diagnosis: _____

Medication requested: [] New [] Continuation

Table with 6 columns: Medication, Strength, Dosage Instructions, # of Cycles, Quantity, Days Supply

Previous treatment trials:

Table with 6 columns: Medication, Strength, Dosage Instructions, # of Cycles, Quantity, Days Supply

Attach copies of the following:

- [] Medical records (i.e., diagnostic evaluations and recent chart notes)
[] Original prescription
[] Recent related laboratory results

Please indicate setting in which medication is to be administered if medication requested is not an oral agent:

- [] Home by home health [] Long-term care facility [] Other: _____

Renewal requests: Has disease progressed? [] Yes [] No Date of last office visit: _____

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.



If criteria for coverage are met, initial authorization will be given for three months. Additional authorizations will be considered for up to six month intervals when criteria for coverage are met. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued unless otherwise justified.

Use form 470-5367, *Request for Prior Authorization: Select Oncology Agents*, to request prior authorization. Click [here](#) to see a sample of the form.

78. 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](#).

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.

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79. 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.

80. 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.



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, Prescriber must complete all information above, 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
Naratriptan
Rizatriptan ODT
Rizatriptan Tablets
Sumatriptan Tablets

Non- Preferred (PA required from Day 1)

- Almotriptan
Amerge
Axert
Frova
Imitrex Tabs
Maxalt
Maxalt MLT
Relpax
Sumatriptan NS
Sumatriptan Inj
Sumavel DosePro
Treximet*
Zecuity
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.



Request for Prior Authorization
SHORT ACTING NARCOTICS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

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

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

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

Non-Preferred

- Butalbital/APAP/Caff/Codeine
Butalbital/ASA/Caff/Codeine
Combunox
Hydrocodone/APAP (5/300, 7.5/300, 10/300)
Hydrocodone/Ibuprofen
Hydromorphone Inj
Meperidine Syp/Inj
Nucynta
Opana
Oxycodone/APAP (7.5/325, 10/325)
Primlev
Roxicodone
Xodol
Other (specify)

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

Diagnosis:

Preferred Trial 1: Drug Name Strength Dosage Instructions

Trial start date: Trial end date:

Specify failure:

Preferred Trial 2: Drug Name Strength Dosage Instructions

Trial start date: Trial end date:

Specify failure:

Preferred Trial 3: Drug Name Strength Dosage Instructions

Trial start date: Trial end date:

Specify failure:

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

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

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

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



81. 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 for counseling to:
 - Quitline Iowa program for Medicaid Fee-for-Service members, or
 - Through the Managed Care Organization program for managed care members.
- ◆ Confirmation of enrollment and ongoing participation in the 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.



82. Sodium Oxybate (Xyrem®)

Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered for patients 18 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 ESS) 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® REMS 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.



Request for Prior Authorization
SODIUM OXYBATE (XYREM®)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered for patients 18 years of age or older under the following conditions: 1) A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study... 7) The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website...

Non-Preferred

[] Xyrem® Strength Dosage Instructions Quantity Days Supply

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

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

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

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

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

Medical or contraindication reason to override trial requirements:

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

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

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

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

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

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

Attach lab results and other documentation as necessary.

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

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



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 will be considered with documentation of a specific testicular or hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism.

- 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 primary hypogonadism or hypogonadotropic hypogonadism (further defined below)
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 the patient has not experienced a hematocrit > 54% or an increase in PSA > 1.4ng/mL in the past 12 months.

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

**Request for Prior Authorization
TESTOSTERONE PRODUCTS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Preferred

- Androderm
- Methyltestosterone
- Testim
- Testosterone Cypionate
- Testosterone Enanthate

Non-Preferred

- Androgel
- Android
- Aveed
- Axiron
- Depo-Testosterone
- Fortesta
- Methitest
- Natesto
- Striant
- Testosterone Gel
- Testred
- Vogelxo

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

Complete for diagnosis of hypogonadism:

- Primary Hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:
 - Cryptorchidism
 - Bilateral torsion
 - Orchitis
 - Vanishing testes syndrome
 - Orchiectomy
 - Klinefelter's syndrome
 - Chemotherapy
 - Toxic damage from alcohol or heavy metals
 - Other: _____
- Hypogonadotropic Hypogonadism:
 - Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency
 - Pituitary-hypothalamic injury from tumors, trauma, or radiation

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: _____

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: _____

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.



83. Tasimelteon (Hetlioz®)

Prior authorization is required for tasimelteon (Hetlioz®). Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered under the following conditions:

- ◆ Patient has a diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as confirmed by a sleep specialist; and
- ◆ Patient is 18 years of age or older; and
- ◆ Documentation the patient is totally blind with no perception of light is provided; and
- ◆ Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and
- ◆ Patient has a documented trial and therapy failure with ramelteon (Rozerem®).

If criteria for coverage are met, initial requests will be given for three months. Requests for continuation therapy will be considered when the patient has received three months of continuous therapy and patient has achieved adequate results with tasimelteon (Hetlioz®), such as entrainment, significant increases in nighttime sleep, and/or significant decreases in daytime sleep.

Use form 470-5296, *Request for Prior Authorization: Tasimelteon (Hetlioz®)*, to request prior authorization. Click [here](#) to see a sample of the form.

84. Testosterone Products

Prior authorization is required for testosterone products. Payment will be considered with documentation of a specific testicular or hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism. Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis.

Payment for nonpreferred 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 erectile dysfunction, infertility, and age-related hypogonadism will not be considered.



Payment will be considered under the following conditions:

- ◆ Patient is male and 18 years of age or older (or 12 years of age for testosterone cypionate); and
- ◆ Patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (attach lab results); and
- ◆ Patient has at primary hypogonadism or hypogonadotropic hypogonadism (further defined below):
 - Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:
 - Cryptorchidism
 - Bilateral torsion
 - Orchitis
 - Vanishing testes syndrome
 - Orchiectomy
 - Klinefelter's syndrome
 - Chemotherapy
 - Toxic damage from alcohol or heavy metals
 - Hypogonadotropic hypogonadism
 - Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency
 - Pituitary-hypothalamic injury from tumors, trauma, or radiation
- ◆ Patient does not have:
 - Breast or prostate cancer
 - Palpable prostate nodules or prostate-specific antigen (PSA) > 4ng/mL
 - Hematocrit > 50 percent
 - Untreated severe obstructive sleep apnea
 - Severe lower urinary tract symptoms
 - Uncontrolled or poorly controlled heart failure

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

- ◆ An updated testosterone level (attach lab result); and
- ◆ Documentation the patient has not experienced a hematocrit > 54 percent or an increase in PSA > 1.4ng/mL in the past 12 months.



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

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

85. 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 taking direct acting antiviral agents used without interferon for the treatment of chronic hepatitis C infection.
- ◆ 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 eltrombopag (Promacta[®]) for the treatment of severe aplastic anemia will only be considered under the following conditions:

- ◆ Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy; and
- ◆ Patient has a platelet count less than or equal $30 \times 10^9/L$.



If criteria for coverage are met, initial authorization will be given for 16 weeks. Documentation of hematologic response after 16 weeks of therapy will be required for further consideration. 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.

86. Topical Antifungals for Onychomycosis

Jublia[®] (efinaconazole) and Kerydin[®] (tavaborole) will be considered when the following criteria are met:

- ◆ Patient has a diagnosis of onychomycosis of the toenail(s) confirmed by a positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy (attach results) without dermatophytomas or lumula (matrix) involvement; and
- ◆ Patient is 18 years of age or older; and
- ◆ Patient has documentation of a complete trial and therapy failure or intolerance to oral terbinafine; and
- ◆ Patient has documentation of a complete trial and therapy failure or intolerance to ciclopirox 8 percent topical solution; and
- ◆ Patient is diabetic or immunosuppressed/immunocompromised.

If the criteria for coverage are met, a one-time authorization of 48 weeks will be given. Requests for reoccurrence of infection 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 470-5368, *Request for Prior Authorization: Topical Antifungals for Onychomycosis*, to request prior authorization. Click [here](#) to see a sample of the form.



Request for Prior Authorization
TOPICAL ANTIFUNGALS FOR ONYCHOMYCOSIS

(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.

Jublia® (efinaconazole) and Kerydin® (tavaborole) will be considered when the following criteria are met: 1) Patient has a diagnosis of onychomycosis of the toenail(s) confirmed by a positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy...

Non-Preferred: [] Jublia [] Kerydin

Dosage instructions: _____ Quantity: _____ Days supply: _____

Diagnosis (attach results of KOH preparation, fungal culture, or nail biopsy): _____

Dermatophytomas present? [] Yes [] No Lunula (matrix) involvement? [] Yes [] No

Oral Terbinafine trial: Dose: _____ Trial dates: _____

Failure reason: _____

Ciclopirox topical solution trial: Dose: _____ Trial Dates: _____

Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

Is the patient diabetic? [] Yes [] No

Is the patient immunosuppressed or immunocompromised? [] Yes [] No

If yes, diagnosis: _____

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
TOPICAL CORTICOSTEROIDS

(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 non-preferred topical corticosteroids. Payment will be considered for patients when there is documentation of adequate trials and therapy failures with at least two preferred, chemically distinct, topical corticosteroid agents within the same potency class or a higher potency class in the past 12 months.

Drug Name: _____ Strength: _____ Dosage Form: _____

Dosage Instructions: _____ Quantity: _____ Days Supply: _____

Diagnosis: _____

Preferred Topical Corticosteroid Trial 1:

Drug Name & Dose: _____ Trial Dates: _____

Failure Reason: _____

Preferred Topical Corticosteroid Trial 2:

Drug Name & Dose: _____ Trial Dates: _____

Failure Reason: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Table with 2 columns: Prescriber signature (Must match prescriber listed above.), Date of submission

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



Request for Prior Authorization
TOPICAL RETINOIDS FOR ACNE

(PLEASE PRINT - ACCURACY IS IMPORTANT)

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

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

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

Preferred

- Adapalene Gel, Retin-A, Differin Cream & Gel, Tazorac, Epiduo

Non-Preferred

- Adapalene, Fabior, Veltin, Atralin, Retin-A Micro, Ziana, Differin Lotion, Tretinoin

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

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

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

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

Attach lab results and other documentation as necessary.

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

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



87. Topical Corticosteroids

Prior authorization is required for non-preferred topical corticosteroids. Payment will be considered for patients when there is documentation of adequate trials and therapy failures with at least two preferred, chemically distinct, topical corticosteroid agents within the same potency class or a higher potency class in the past 12 months.

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

Use form 470-5347, *Request for Prior Authorization: Topical Corticosteroids*, to request prior authorization. Click [here](#) to see a sample of the form.

88. 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.

89. Valsartan/Sacubitril (Entresto™)

Prior authorization is required for valsartan/sacubitril (Entresto™). Requests above the manufacturer recommended dose will not be considered. Payment will be considered for patients when the following criteria are met:

- ◆ Patient is 18 years of age or older; and
- ◆ Patient has a diagnosis of NYHA Functional Class II, III, or IV heart failure; and
- ◆ Patient has a left ventricular ejection fraction (LVEF) $\leq 40\%$; and
- ◆ Patient has documentation of a previous trial and therapy failure or intolerance to an ACE inhibitor at a maximally tolerated dose; and
- ◆ Patient had documentation of a previous trial and therapy failure or intolerance to an angiotensin II receptor blocker (ARB); and
- ◆ Is to be administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB (list medications patient is currently taking for the treatment of heart failure); and
- ◆ Will not be used in combination with an ACE inhibitor or ARB; and
- ◆ Will not be used in combination with aliskiren (Tekturna) in diabetic patients; and
- ◆ Patient does not have a history of angioedema associated with the use of ACE inhibitor or ARB therapy; and



Request for Prior Authorization
VALSARTAN/SACUBITRIL (ENTRESTO)

(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 valsartan/sacubitril (Entresto). Requests above the manufacturer recommended dosing will not be considered. Payment will be considered for patients when the following criteria are met:

- 1) Patient is 18 years of age or older; and
2) Patient has a diagnosis of NYHA Functional Class II, III, or IV heart failure; and
3) Patient has a left ventricular ejection fraction (LVEF) ≤40%; and
4) Patient has documentation of a previous trial and therapy failure or intolerance to an ACE inhibitor at maximally tolerated dose; and
5) Patient has documentation of a previous trial and therapy failure or intolerance to an angiotensin II receptor blocker (ARB); and
6) Is to be administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB (list medications patient is currently taking for the treatment of heart failure); and
7) Will not be used in combination with an ACE inhibitor or ARB; and
8) Will not be used in combination with aliskiren (Tekturna) in diabetic patients; and
9) Patient does not have a history of angioedema associated with the use of ACE inhibitor or ARB therapy; and
10) Patient is not pregnant; and
11) Patient does not have severe hepatic impairment (Child Pugh Class C); and
12) Prescriber is a cardiologist or has consulted with a cardiologist (telephone consultation is acceptable).

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

If the criteria for coverage are met, initial authorization will be given for 3 months. Requests for continuation of therapy may be provided if prescriber documents adequate response to therapy.

Non-Preferred

Entresto

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

**Request for Prior Authorization
VALSARTAN/SACUBITRIL (ENTRESTO)**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Trial Information:

ACE inhibitor trial: Dose: _____ Trial dates: _____

Failure reason: _____

ARB trial: Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Medical or contraindication reason to override ACE Inhibitor/ARB trial requirements: _____

Will Entresto be used in combination with ACE inhibitor or ARB? Yes No

Does patient have a history of angioedema associated with ACE inhibitor or ARB therapy? Yes No

Provide heart failure therapies to be used in conjunction with Entresto: _____

If patient is diabetic, will Entresto be used in combination with aliskiren (Tekturna)? Yes No

Provide patient's left ventricular ejection fraction: _____ Date obtained: _____

Results: _____

If female of child-bearing years, confirmed negative serum pregnancy test? Yes No

If yes, please list Prescriber: _____ Date of pregnancy test: _____

Does patient have severe hepatic impairment (Child Pugh Class C)? Yes No

Is Prescriber a cardiologist? Yes No If no, note consultation with cardiologist:

Consultation date: _____ Physician name & phone: _____

Renewal Requests: Provide documentation of adequate response to treatment:

Attach lab results and other documentation as necessary.

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

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



- ◆ Patient is not pregnant; and
- ◆ Patient does not have severe hepatic impairment (Child Pugh Class C); and
- ◆ Prescriber is a cardiologist or has consulted with a cardiologist (telephone consultation is acceptable).

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

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

Use form 470-5398, *Request for Prior Authorization: Valsartan/Sacubitril (Entresto™)*, to request prior authorization. Click [here](#) to see a sample of the form.

90. 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.



91. Vorapaxar (Zontivity™)

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

- ◆ Patient has a history of myocardial infarction (MI) or peripheral artery disease (PAD); and
- ◆ Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and
- ◆ Patient has documentation of an adequate trial and therapy failure with aspirin plus clopidogrel; and
- ◆ Patient will use vorapaxar concurrently with aspirin and/or clopidogrel.

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

Use form 470-5331, *Request for Prior Authorization: Vorapaxar (Zontivity)*, to request prior authorization. Click [here](#) to see a sample of the form.

92. 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.



D. BASIS OF PAYMENT FOR DRUGS

The amount of payment for drugs is based on several factors, in accordance with 441 IAC 79.1(8) and upper limits in 42 CFR 447.500 to 447.520.

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

Average actual acquisition cost (average AAC) is defined as retail pharmacies' average prices paid to acquire drug products.

- ◆ Average AAC is determined by the Department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies.
- ◆ Surveys are conducted at least once every six months, or more often at the Department's discretion.
- ◆ The average AAC is calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the Department is published on the Iowa Medicaid Enterprise website.
- ◆ If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span is used.

Federal upper limit (FUL) is defined as the upper limit for multiple-source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services, as described in 42 CFR 447.514.

For drugs with no established FUL, the Department determines the allowable average actual acquisition cost in accordance with the provisions of federal drug regulation 42 CFR 447.512. This basis of payment is also applicable to compounded prescriptions.

Professional dispensing fee is added to the ingredient cost to cover the pharmacist's professional services and costs associated with transferring the drug to a Medicaid member. The dispensing fee is set based on cost of dispensing surveys of Iowa Medicaid participating pharmacies.



1. Reimbursement Effective February 1, 2013

The Medicaid program relies on information published by **Medi-Span** to classify drugs as brand or generic.

a. Generic and Nonprescription Drugs

For covered **generic** prescription drugs and for covered **nonprescription** drugs shall be the lowest of the following, as of the date of dispensing:

- ◆ Average actual acquisition cost (average AAC) plus the professional dispensing fee.
- ◆ The federal upper limit (FUL) plus the professional dispensing fee.
- ◆ The submitted charge, representing the provider's usual and customary charge for the drug.

b. Brand-Name Drugs

For covered **brand-name** prescription drugs shall be the lowest of the following, as of the date of dispensing:

- ◆ Average actual acquisition cost (average AAC) plus the professional dispensing fee.
- ◆ The submitted charge, representing the provider's usual and customary charge for the drug.

2. Drugs Subject to Federal Upper Limit (FUL)

a. FUL Development

The Centers for Medicare and Medicaid Services (CMS) establishes federal upper limits (FUL) for reimbursement for multiple-source drugs. These reimbursement levels are updated periodically and are available on the Centers for Medicare and Medicaid Services web page at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Prescription-Drugs.html>.

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b. Reimbursement for FUL Drugs

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

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

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

Prior authorization is required for selected brand-name drugs as determined by the Department for which there is available, an "A" rated bioequivalent generic product as determined by the federal Food and Drug Administration.

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

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

3. Reimbursement for Unit-Dose Packaging

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



Claim the additional reimbursement by placing a “3” in “Unit Dose Indicator” (field 429-DT) for electronic claims, as explained under [Point of Sale Claim Submission](#), or a “09” in the Basis Cost (field 14) on the paper claim form, as explained under [Paper Claim Submission](#). The additional reimbursement will be automatically added, possibly resulting in reimbursement that is higher than your submitted charge.

Credits: Payment may be made only for unit-dose-packaged drugs that are **consumed** by the patient. Any previous charges for intact unit-dose packages returned to the pharmacy must be credited to the Medicaid program. Such credits may be shown on future billings. If no additional billings are to be made, direct a refund in the drug cost component.

In accordance with state and federal law, proper crediting to Iowa Medicaid is **required** for the return of unused medications upon therapy discontinuation or a member’s discharge, transfer, or death.

Both the long-term-care pharmacy and the nursing facility are subject to financial review by the state to ensure that medications are being returned to the pharmacy when permitted by state and federal law and proper credits are applied to the Iowa Medicaid program.

4. Reimbursement for Vaccinations

Vaccines for mass immunizations, such as might occur with nursing home patients, are payable to a pharmacy. Examples are vaccines such as influenza vaccine and pneumonia vaccine.

Payment is allowed on a per-dose basis. Reimbursement is limited to the lesser of the pharmacist’s usual charge per dose or the cost of the dose plus the current professional fee. Each dose must be billed on the billing form of the patient receiving the dose. Where available, unit-dose syringes should be dispensed.

In 1995, the Department implemented the Vaccines for Children (VFC) immunization program. The VFC Program was created to meet the vaccination needs of children from birth through 18 years of age. The program is intended to help raise childhood immunization levels, especially among infants and young children.



Under the VFC program, all providers are required to follow the most current Recommended Immunization Schedule from the Advisory Committee on Immunization Practices (ACIP). The following vaccines may be ordered under the VFC program:

- ◆ DTaP
- ◆ DTaP/Hep B/IPV (Pediatrix)
- ◆ DTaP/IPV/Hib (Pentacel)
- ◆ DTaP/IPV (Kinray)
- ◆ DT (pediatric)
- ◆ Td preservative free
- ◆ Tdap
- ◆ Hib
- ◆ Hib/Hep B
- ◆ Hepatitis A
- ◆ Hepatitis B
- ◆ HPV (Gardasil)
- ◆ Influenza
- ◆ MMR
- ◆ MMR/V (ProQuad)
- ◆ Meningococcal conjugate (Menactra)
- ◆ Pneumococcal conjugate (Prevnar)
- ◆ Polio
- ◆ Rotavirus
- ◆ Varicella

For more information, see the Iowa Department of Public Health web page: <http://www.idph.iowa.gov/immtb/immunization>

As a result, pharmacists are not reimbursed for providing these vaccines when administered by the practitioner. EXCEPTIONS: Payment for immunizations administered to these persons will continue:

- ◆ Medicaid members who are enrolled in an HMO that has contracted to provide specific Medicaid services.
- ◆ When Medicare makes payment, the deductibles, coinsurance, and any Medicaid-covered services beyond the scope of Medicare are considered for coverage for Medicaid members who are dually eligible for Medicaid and Medicare.
- ◆ Pharmacies enrolled in the Vaccines for Children (VFC) Program through the Iowa Department of Public Health may administer influenza vaccines for children age 18 and under. Pharmacies will be paid for administration of influenza vaccines when the vaccine is covered under the VFC Program.

Pharmacists can be reimbursed for vaccines for patients in an institutional setting where facility staff administer the vaccine.



E. BILLING SYSTEM

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

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

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

1. Point of Sale Claim Submission

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

The Affordable Care Act (ACA) requires that providers who prescribe or are indicated as a referring provider on a Medicaid claim must be enrolled as a participating provider in the program. Pharmacy claims submitted with a National Provider Identifier (NPI) that is not enrolled with the Iowa Medicaid program will be denied. Providers may contact Provider Services at 800-338-7909 or 256-4609 (local) for questions regarding provider enrollment.

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



- ◆ **For members under age 21**, pharmacy claims may be processed through Pharmacy Point of Sale System with Iowa Medicaid as the primary insurer.
- ◆ **For members who are pregnant**, bill claims through the Pharmacy Point of Sale System with Iowa Medicaid as the primary insurer. To get a \$0.00 copayment, enter code "2" in the pregnancy indicator code field (NCPDP field 335-2C).
- ◆ For **all other** Medicaid members with other prescription insurance, that insurance is primary and Medicaid is secondary.
 - Ask the member for the primary prescription insurance card.
 - If a member has primary pharmacy insurance, submit the claim to the primary insurance first and then the copay to Medicaid last, using a "8" in the OTHER COVERAGE CODE field (field 308-C8).
 - If a member has primary pharmacy insurance and the claim is not covered by the primary insurance, submit the claim to Medicaid using a "3" in the OTHER COVERAGE CODE field (field 308-C8).
 - If a member has Iowa Medicaid pharmacy insurance only (or does not have the primary prescription insurance information), enter a "1" in the OTHER COVERAGE CODE field (field 308-C8).

a. Claims Rejected Due to Other Insurance Coverage

When a claim is submitted with a blank field or a zero in the OTHER COVERAGE CODE field but the Iowa Medicaid eligibility file has third-party liability (TPL) information, the Medicaid claim will be denied and you will receive a rejection code of 41, "Submit to Primary Payer."

The Point-of-Sale System will give the policy number and the type of coverage. Most times the insurance company name is given. However, for the less common companies, a code is given in place of the name.

Use the primary prescription insurance billing information to bill the primary insurance. If necessary, you may contact the IME Provider Services for the name and address of the health insurance company.

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After billing the other company, resubmit the claim with one of the following codes the OTHER COVERAGE CODE field:

- ◆ Use code **1** if the member states that there is no other insurance coverage. If the claim has already been rejected with a reject code of 41 "Submit to Primary Payer," Iowa Medicaid's eligibility file conflicts with the primary third-party insurance company's information. See [Correction of Insurance Information](#).
- ◆ Use code **3** if other coverage does exist but the drug is not covered under the primary insurance plan.
- ◆ Use code **8** when payment is not collected. Example: The primary third-party insurance is 100% major medical.

b. Correction of Insurance Information

The Department makes every attempt to keep current data regarding other insurance Medicaid members may have. However, if the primary insurance is no longer valid or has changed, the Department's records need to be corrected. The pharmacy can facilitate this in one of three ways:

- ◆ Instruct the client to notify the Department; or
- ◆ Complete form 470-2826, *Insurance Questionnaire*, available on the IME web site (<http://dhs.iowa.gov/ime/providers/forms>), and FAX the form to Revenue Collections at (515) 725-1352; or
- ◆ Notify the Department by e-mailing Revcoll@dhs.state.ia.us or by calling (515) 256-4619 (local) or 1-866-810-1206. The minimum information necessary for insurance carriers to verify the other insurance coverage is the following:
 - Member last name
 - Member first name
 - State identification number or social security number
 - Date of birth
 - Policy number
 - Full insurance company name

For example, if the company is Blue Cross/Blue Shield, include which state the policy is from, as most every state has a BC/BS carrier. (In Iowa, it's Wellmark.)



2. Claiming Payment for Retroactively Eligible Member

For Iowa Medicaid prescription drug claims involving claims for a member whose Medicaid eligibility was determined retroactively, call the IME Point of Sale (POS) Unit at (515) 256-4608 (local calls) or 877-463-7671. Have the following information available:

- ◆ The pharmacy's national provider identifier.
- ◆ The member's Iowa Medicaid number, name, and date of birth.
- ◆ The drug's name, strength, quantity, and dates requested for reimbursement.
- ◆ The date the pharmacy was made aware the member had Medicaid coverage for the state of Iowa.

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

3. Claim Attachment Control, Form 470-3969

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

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

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

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

Medicaid Claims
PO Box 150001
Des Moines, IA 50315

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



4. Paper Claim Submission

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

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

FIELD NAME/DESCRIPTION	INSTRUCTIONS
1 – CARDHOLDER ID	MANDATORY. Enter the member's Medicaid ID number. Copy this directly from the <i>Medical Assistance Eligibility Card</i> . It consists of seven numeric characters followed by a letter, i.e., 1234567A.
2 – GROUP ID	NOT USED. Leave blank.
3 – LAST	NOT USED. Submit information under Patient segment.
4 – FIRST	NOT USED. Submit information under Patient segment.
5 – PLAN NAME	IAMED
6 – BIN NUMBER	011933
7 – PROCESSOR CONTROL NUMBER	IAPOP
8 – CMS PART D	OPTIONAL.



FIELD NAME/DESCRIPTION	INSTRUCTIONS
PATIENT	
9 – PATIENT’S LAST NAME	REQUIRED. Must be submitted.
10 – PATIENT’S FIRST NAME	REQUIRED. Must be submitted.
11 – PERSON CODE	NOT USED.
12 – DATE OF BIRTH	REQUIRED. Enter the member’s birth date using a two-digit entry for each of the following: month, day, and year.
13 – PATIENT GENDER CODE	REQUIRED. Enter the gender.
14 – RELATIONSHIP TO CARDHOLDER	NOT USED.
15 – PATIENT RESIDENCE	OPTIONAL.
PHARMACY	
16 – DOCUMENT CONTROL NUMBER	OPTIONAL. For office use only.
17 – SERVICE PROVIDER ID	MANDATORY. Enter the pharmacy’s national provider identifier (NPI).
18 – SERVICE PROVIDER ID QUALIFIER	MANDATORY. Enter “01” for national provider identifier (NPI).
19 – PHARMACY NAME	REQUIRED. Enter the pharmacy’s name.
20 – PHONE NUMBER	OPTIONAL. Entering the pharmacy’s area code and phone number may expedite processing of the claim.
21 – ADDRESS	REQUIRED. Enter the pharmacy’s street address.
22 – CITY	REQUIRED. Enter the pharmacy’s city.
23 – STATE	REQUIRED. Enter the pharmacy’s state.
24 – ZIP	REQUIRED. Enter the pharmacy’s zip code.



FIELD NAME/DESCRIPTION	INSTRUCTIONS
PRESCRIBER	
25 – SIGNATURE OF PROVIDER	REQUIRED. Enter the signature of the representative completing the form.
26 – DATE	REQUIRED. Enter the date of the completed claim.
27 – PRESCRIBER ID	REQUIRED. Enter the national provider identifier (NPI) of the prescribing practitioner.
28 – ID QUALIFIER	01 = NPI
29 – PRESCRIBER LAST NAME	REQUIRED.
PHARMACIST	
30 – PHARMACIST ID	NOT USED.
31 – ID QUALIFIER	NOT USED.
CLAIM	
32 – PRESCRIPTION SERV. REF# (RX NUMBER)	MANDATORY. Enter the prescription number you have assigned to the prescription being billed. This number must be all numeric . No alpha characters are allowed.
33 – PRESCRIPTION SERV. REF# (RX NUMBER) QUALIFIER	1 = RX BILLING
34 – FILL #	REQUIRED. Enter “00” for a new prescription, and 01-99 for refills.
35 – DATE WRITTEN	REQUIRED. Enter the date the prescription was written using a two-digit entry for each of the following: month, day, and year. CCYYMMDD
36 – DATE OF SERVICE	MANDATORY. Enter the date the prescription was filled using a two-digit entry for each of the following: month, day, and year. CCYYMMDD
37 – SUBMISSION CLARIFICATION	OPTIONAL. Enter “20” if 340B claim. Enter “08” if compound claim.
38 – PRESCRIPTION ORIGIN	OPTIONAL.



FIELD NAME/DESCRIPTION	INSTRUCTIONS
39 – PHARMACY SERVICE TYPE	NOT USED.
40 – SPECIAL PACKAGING INDICATOR	OPTIONAL.
41 – PRODUCT/SERVICE ID	MANDATORY. Enter the national drug code (NDC) found on the drug's label. All of the numerals in the NDC, including the package size, must be current and exactly match the NDC of the product actually dispensed. Be careful to copy the NDC exactly as it appears, including leading zeros. If the product number is only three digits long, enter a leading zero. For a compound, "0" must appear in this field. List each ingredient, NDC, quantity, and charge in the COMPOUND section.
42 – PRODUCT/SERVICE ID QUALIFIER	00 = COMPOUND 03 = NDC
43 – PRODUCT DESCRIPTION	REQUIRED.
44 – QUANTITY DISPENSED	REQUIRED. Give the number of tablets, capsules, etc. or the metric measurement for liquids, creams, etc. Be sure the billed quantity, when divided by the number of days' supply, is an appropriate amount for that therapeutic class of drugs. If the quantity is a fractional amount, use a decimal point.
45 – DAYS SUPPLY	REQUIRED. Enter the number of days the prescription will last.
46 – DAW CODE (MAC OVERRIDE)	Leave blank.
47 – PRIOR AUTH # SUBMITTED	CONDITIONAL. Leave blank unless one of the following applies: 1 = 72 hour supply 4 = Pregnant 5 = Nursing facility vaccine 7 = Mental health drugs



FIELD NAME/DESCRIPTION	INSTRUCTIONS
48 – PA TYPE	CONDITIONAL. Enter code "2" if a number was entered in the "PRIOR AUTH # SUBMITTED" box. Otherwise, leave blank.
49 – OTHER COVERAGE CODE	CONDITIONAL. To determine whether the member has drug coverage under other insurance, check the member's eligibility using the Eligibility Verification System (ELVS) or the IME web portal. <ul style="list-style-type: none">◆ If a member has Iowa Medicaid pharmacy insurance only and no other primary insurance, leave this field blank or enter a zero.◆ Enter code "1" if the member states there is no other insurance but the claim has already been rejected with a reject code of 41 "Submit to Primary Payer." Iowa Medicaid's eligibility file conflicts with the primary third-party insurance company's information.◆ Enter code "3" if other coverage does exist and the drug is not covered under the primary insurance plan. NOTE: Also allowed for Part D excluded drugs.◆ Enter code "8" when billing is for patient financial responsibility. Only the indicator "06 = Patient Pay Amount" will be accepted as an other payer-patient responsibility amount qualifier.
50 – DELAY REASON	NOT USED.
51 – LEVEL OF SERVICE	NOT USED.
52 – PLACE OF SERVICE	OPTIONAL.
53 – QUANTITY PRESCRIBED	OPTIONAL.
CLINICAL	
54 – DIAGNOSIS CODE	NOT USED.
55 – DIAGNOSIS CODE QUALIFIER	NOT USED.



FIELD NAME/DESCRIPTION	INSTRUCTIONS
DUR	
56 – DUR/PPS CODE REASON	Leave blank.
57 – DUR/PPS CODE SERVICE	Leave blank.
58 – DUR/PPS CODE RESULT	Leave blank.
59 – LEVEL OF EFFORT	Leave blank.
60 – PROCEDURE MODIFIER	Leave blank.
COB OTHER PAYMENTS	
COB1 – PRIMARY	
61 – OTHER PAYER ID	REQUIRED FOR COB. Primary payer.
62 – OTHER PAYER ID QUALIFIER	REQUIRED FOR COB. Primary payer.
63 – OTHER PAYER DATE	REQUIRED FOR COB. Primary payer. If the patient has other insurance coverage, enter the date the claim was paid or rejected by the other insurer.
64 – OTHER PAYER REJECT CODES	CONDITIONAL. If the patient has other insurance coverage but the claim was rejected, enter the rejection codes assigned by the other insurer (if known).
COB1 – SECONDARY	
65 – OTHER PAYER ID	REQUIRED FOR COB. Payer ID of primary payer.
66 – OTHER PAYER ID QUALIFIER	REQUIRED FOR COB.
67 – OTHER PAYER DATE	REQUIRED FOR COB. If the patient has other insurance coverage, enter the date the claim was paid or rejected by the other insurer.
68 – OTHER PAYER REJECT CODES	CONDITIONAL. If the patient has other insurance coverage but the claim was rejected, enter the rejection codes assigned by the other insurer (if known).



FIELD NAME/DESCRIPTION	INSTRUCTIONS
COMPOUND	
69 – DOSAGE FORM DESCRIPTION CODE	MANDATORY.
70 – DISPENSING UNIT FORM INDICATOR	MANDATORY.
71 – ROUTE OF ADMINISTRATION	OPTIONAL.
72 – INGREDIENT COMPONENT COUNT	MANDATORY.
73 – PRODUCT NAME	REQUIRED. Submit for each compound component.
74 – PRODUCT ID	REQUIRED. Submit for each compound component.
75 – PRODUCT ID QUALIFIER	REQUIRED. Submit for each compound component.
76 – INGREDIENT QTY	REQUIRED. Submit for each compound component.
77 – INGREDIENT DRUG COST	OPTIONAL. Submit for each compound component.
78 – BASIS OF COST	OPTIONAL. Submit for each compound component. Enter "08" if 340B claim.
PRICING	
79 – USUAL & CUSTOMARY CHARGE	REQUIRED. Enter the usual and customary charge.
80 – BASIS OF COST DETERMINATION	CONDITIONAL. Enter code "09" to indicate unit dose drug. Enter "08" if 340B claim. Otherwise, leave blank.
81 – INGREDIENT COST SUBMITTED	REQUIRED. Enter the pharmacy's submitted product component cost of the dispensed prescription. Amount also included in the gross amount due. 340B pricing submitted in this field when applicable.
82 – DISPENSING FEE SUBMITTED	REQUIRED. Enter the pharmacy's usual and customary dispensing fee. Enter zeros if no dispensing fee is charged for the prescription.



FIELD NAME/DESCRIPTION	INSTRUCTIONS
83 – PROFESSIONAL SERVICE FEE SUBMITTED	REQUIRED. Enter the pharmacy's usual and customary dispensing fee. Enter zeros if no dispensing fee is charged for the prescription.
84 – INCENTIVE AMOUNT SUBMITTED	Leave blank.
85 – OTHER AMOUNT SUBMITTED	Leave blank.
86 – SALES TAX SUBMITTED	NOT USED.
87 – GROSS AMOUNT DUE	REQUIRED. Enter the total charge for this item. The total claim charge must be equal to the sum of the submitted ingredient cost submitted and the submitted dispensing fee.
88 – PATIENT PAID AMOUNT	Leave blank.
89 – OTHER PAYER AMOUNT PAID #1	NOT USED.
90 – OTHER PAYER AMOUNT PAID #2	NOT USED.
91 – OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT #1	REQUIRED FOR IA COB CLAIMS.
92 – OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT #2	REQUIRED FOR IA COB CLAIMS.
93 – NET AMOUNT DUE	REQUIRED. Enter the total price less the deductible amount. NOTE: If resubmitting a claim that is over 12 months old, the word "resubmit" must clearly appear on the claim to avoid denials for timely filing. This procedure can be used only if the original submission was within the last 12 months.



F. EDITS AND SPECIAL BILLING INFORMATION

1. Claims for Deceased Members

Submit claims for all Iowa Medicaid members using the dispensing date. Pharmacy claims must be billed before a member's date of death for claims processing. Failure to bill before the date of death may result in claim recoupment for any claims processed after that date of death.

2. Common Billing Errors

Medications can often be described using three measures: each, grams, and milliliters. It is important to choose the correct unit of measure when billing.

Medication	Correct Unit for Billing	Quantity	Days' Supply
Bactroban cream (mupirocin)	Grams	Varies; should be divisible by 15 grams	Varies
Bactroban ointment (mupirocin)	Grams	Varies; should be divisible by 22 grams	Varies
Byetta 5 mcg (exenatide)	MI (Submit in decimal format; do not round)	1.2 ml	30
Byetta 10 mcg (exenatide)	MI (Submit in decimal format; do not round)	2.4 ml	30
Copaxone (glatiramer)	Each	1	30
Diastat ACDL gel (diazepam)	Each (kit contains 2 syringes; bill # of kits)	1	Varies
Enbrel 25 mg	Each	1	1
Enbrel 25 mg/0.5 ml (etanercept)	MI (Submit in decimal format; do not round)	Varies claims should be divisible by 0.5 ml	30
Enbrel SureClick (etanercept)	MI (Submit in decimal format; do not round)	Varies should be divisible by .98 ml	30
Fragmin (dalteparin)	MI (Submit in decimal format; do not round)	Varies	Varies



Medication	Correct Unit for Billing	Quantity	Days' Supply
Gamunex 10% (immune globulin)	MI (Each vial is 10 ml)	Varies	Varies
Humira (adalimumab)	Each (kit contains 2 syringes)	2	30
Influenza vaccines	MI (Submit in decimal format; do not round)	0.5 ml	1
Kineret (anakinra)	MI (Submit in decimal format; do not round)	Varies; should be divisible by 0.67	30
Lovenox (enoxaparin)	MI (Submit in decimal format; do not round)	Varies	Varies
Miacalcin NS (calcitonin)	MI (Submit in decimal format; do not round)	3.7	30
Nascobal (cyanocobalamin)	MI (Submit in decimal format; do not round)	Varies; claims should be divisible by 2.3 ml	30
Neupogen 400 mcg (filgrastim)	MI (Submit in decimal format; do not round)	Varies; claims should be divisible by 1.6 ml	30
Neupogen 600 mcg (filgrastim)	MI (Submit in decimal format; do not round)	Varies; claims should be divisible by 0.5 ml	30
Pegasys (peginterferon Alfa-2a)	Each (kit contains 4 syringes)	1	28
Peranex HC (lidocaine/hydrocortisone)	Each	1	Varies
Proair HFA (albuterol)	Grams	8.5 grams	30
Proventil HFA (albuterol)	Grams	6.7 grams	30
Rebif pack (interferon Beta-1a)	MI (Submit in decimal format; do not round)	4.2 ml	30
Rebif syringe (interferon Beta-1a)	MI (Submit in decimal format; do not round)	6 ml	30
Remicade (infliximab)	Each	1	Varies
Restasis (cyclosporine)	Each	32/64	30
Risperdal Consta (risperidone)	Each	2	28



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

3. Compounded Prescriptions

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

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

4. Coverage of Non-Drug Products

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

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



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



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



8. Prospective Drug Utilization Review (Pro-DUR)

The goal of Prospective DUR is to identify potential drug therapy concerns to allow the pharmacist to use professional judgment regarding the need for intervention, such as whether or not to contact the prescribing physician. The following prospective DUR edits will cause claims to deny:

Edit	Number and Message	Reason for the Denial	* Override Provided
Age Edits	75 -PRIOR AUTHORIZATION REQUIRED	Certain medications are payable only for specific age groups.	PA required.
Cost Effectiveness	75 -PRIOR AUTHORIZATION REQUIRED	Certain strengths should be substituted with more cost-effective strengths of the same medication.	PA required.
Dosage Form	75 -PRIOR AUTHORIZATION REQUIRED Additional text: NONPREFERRED	Certain dosage forms should be substituted with more cost-effective dosage forms of the same medication.	PA required.
Excessive Days Supply	19 -M/I DAYS SUPPLY Additional text: EXCEEDS ALLOWABLE DAYS SUPPLY	The supply submitted is more than 31 days.	Request an exception to policy if there is a valid reason why a supply more than 31 days is required.
15-Day Initial Prescription Supply Limit	76 -PLAN LIMITS EXCEEDED	The supply submitted is more than 15 days on select drugs.	PA required. See Quantity Limit Override .
Gender Edits	70 –PRODUCT/ SERVICE NOT COVERED – GENDER-SPECIFIC DRUG	Certain medications are payable only for a specific gender.	PA required.



Edit	Number and Message	Reason for the Denial	* Override Provided
High Dollar Claims	78 - COST EXCEEDS MAXIMUM Additional text: CLAIM EXCEEDS \$10,000.00, PLEASE CALL POS HELPDESK	All claims submitted in excess of \$10,000 will be rejected. After verifying that the quantity and days' supply of the claim are correct, contact the Pharmacy POS Help Desk. See below.	A one-time override will be granted if quantity and days' supply are accurate and consistent. Additional medical documentation is required for longer overrides.
Hospice Edits	75 - PRIOR AUTHORIZATION REQUIRED – NOT COVERED FOR HOSPICE MEMBER	If member has hospice coverage and medication is required to be paid by hospice.	Override may be considered if hospice does not provide payment. Call POS Helpdesk.
Quantity Limits	76 - PLAN LIMITS EXCEEDED	If the quantity submitted exceeds the established quantity limit.	PA required. See Quantity Limit Override .
Refill Too Soon	79 - REFILL TOO SOON Additional text: RX NUMBER/FILL DATE/NPI OR NABP/DATE FOR NEXT FILL	If less than 90% of the previously paid claim for that medication has not been used. See Refill Too Soon .	If there is a change in dose; lost, stolen or destroyed drug; or travel.
Step Therapy Edits	75 - PRIOR AUTHORIZATION REQUIRED	Certain therapeutic drug classes are subject to step therapy edits as designated on the Preferred Drug List.	PA required.
Tablet Splitting	19 - M/I DAYS SUPPLY Additional text: MUST SPLIT TABLETS	Certain medications that are scored and easily halved should be split to facilitate more cost-effective use of the drugs.	PA required.



Edit	Number and Message	Reason for the Denial	* Override Provided
Therapeutic Duplication	88 - DUR REJECT MESSAGE Additional text: SITUATIONAL	If a second claim submitted is a therapeutic duplication of a drug already submitted and reimbursed.	PA required.

* Always verify that the quantity and days' supply on the claim are correct; then for an override contact: Pharmacy POS Help Desk at 877-463-7671 or (515) 256-4608 (local)

a. Age Edits

Certain medications are payable only for specific age groups:

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



Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
Edurant	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Eligard	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Erivedge	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Femara (letrozole)	Payable for members 50 years of age and older.	PA is required for member under 50 years of age.
Flurazepam	Payable for members 15 years of age and older.	PA is required for members under 15 years of age.
Foradil	Payable for members 5 years of age and older.	PA is required for members under 5 years of age.
Inlyta	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Isentress 25 mg and 100 mg chewable tablets	Payable for members less than 12 years of age.	PA is required for members 12 years of age and older.
Jakafi	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Nuvigil (armodafinil)	Payable with a PA for members 17 years of age and older	PA is required for members under 17 years of age.
OTC Polyethylene glycol 3350 powder	Payable for members 0 to 12 years of age. PA required for members 13 to 18 years of age. Not covered for members 19 years of age or over.	PA is required for members 13-18 years of age.



Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
Oxazepam	Payable for members 6 years of age and older.	PA is required for members under 6 years of age.
Perforomist	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Provigil (modafinil)	Payable for members 16 years of age and older	PA is required for members under 16 years of age and 21 years of age and older
Revlimid	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Serevent	Payable for members 4 years of age and older.	PA is required for members under 4 years of age.
Singulair 4 mg granules	Payable for members less than 2 years of age	PA is required for members 2 years of age and older.
Stribild	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Veregen (sinecatechins)	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Zytiga	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.



b. Cost Effectiveness Edit

Drug	Dosage	Alternative
Bupirone tablet	30 mg	Deny. Use two bupirone 15 mg tablets.
Clindamycin capsule	300 mg	Deny. Use multiples of clindamycin 150 mg capsule.
Hydroxyzine pamoate capsules	100 mg	Deny. Use hydroxyzine pamoate 50 mg capsules.
Imipramine pamoate capsules		Deny. Use imipramine HCL tablets.
Prozac or fluoxetine HCL capsules	40 mg	Deny. Use two fluoxetine HCL 20 mg capsules.
Rheumatrex		Deny. Use methotrexate.

c. Dosage Form Edits

Form	Drug	Dosage	Alternative
Prozac tablets	fluoxetine	20 mg	Deny. Use the capsule dosage form.
Zantac capsules	ranitidine	150 mg	Deny. Use the tablet dosage form.
Zantac capsules	ranitidine	300 mg	Deny. Use the tablet dosage form.

d. Excessive Days Supply

The claim will be rejected if the supply submitted is more than 31 days. If there is a valid reason why a supply of more than 31 days is required, request an exception to policy.

e. Gender Edits

Drug Name/Class	Gender Edit
Prenatal vitamins	Payable for female members



f. High-Dollar Claims

All claims in excess of \$10,000 submitted through the pharmacy point of sale system will be rejected with a denial message stating, "Claim exceeds \$10,000, please call POS Help Desk at 877-463-7671 or (515) 256-4608 locally."

After verifying that the quantity and days' supply on the claim are correct, contact the Pharmacy POS Help Desk for consideration of an override. A technician or pharmacist will review the information submitted and determine if an override shall be issued.

As a part of this process, the Iowa Medicaid Program Integrity Unit may request additional medical documentation regarding the case from the prescriber or pharmacy. This policy is intended to help ensure that proper billing procedures are being followed.

g. Hospice Edits

For members enrolled in hospice, medications in the following therapeutic categories should be submitted to hospice for coverage consideration. If hospice does not provide payment for a medication in one of the below categories, or if the member is no longer enrolled in hospice, the pharmacy may call the POS Helpdesk for coverage consideration.

Analgesics — non-narcotic

Analgesics — opioid

Antianxiety agents

Antidiarrheals

Antiemetics

Antihistamines

Antispasmodics

Cough/Cold/Allergy

Hypnotics

Laxatives

Muscle relaxant combinations

Ophthalmic agents

h. Refill Too Soon

The claim will be denied if not enough time has elapsed for the member to use 90% of the supply issued under previously paid claim for that medication. An override will be considered if:

- ◆ There is a change in dose;
- ◆ The previously issued supply has been lost, stolen or destroyed; or
- ◆ The member is traveling and will not be able to pick up the next refill at the normal time.



i. Step Therapy Edits

Certain therapeutic drug classes are subject to step therapy edits as designated on the Preferred Drug List. Antipsychotics-Atypicals:

Step 1: Preferred generic drugs. No PA required.

Step 2: Preferred brand name drugs. No PA required if a preferred generic trial is found in the paid claims system in the past 12 months.

Step 3: Nonpreferred drugs. PA required.

j. Tablet Splitting

Certain medications that are scored and easily halved should be split to facilitate more cost-effective use of the drugs.

Drug Product	Quantity	Days' Supply	Comments
Abilify 2 mg	15	30	
Abilify 5 mg	15	30	Use 10 mg tablets to obtain 5 mg daily dose
Abilify 10 mg	15	30	Use 20 mg tablets to obtain 10 mg daily dose
Abilify 15 mg	15	30	Use 30 mg tablets to obtain 15 mg daily dose
Abilify 20 mg	15	30	
Abilify 30 mg	15	30	
Lexapro 5 mg	15	30	Use 10 mg tablets to obtain 5 mg daily dose
Lexapro 10 mg	15	30	Use 20 mg tablets to obtain 10 mg daily dose



k. Therapeutic Duplication

If a second claim submitted is a therapeutic duplication of a drug already submitted and reimbursed, overlapping claims will be considered on an individual basis.

Deny regardless of prescriber	
Antipsychotics	After 12 weeks (84 days) of concomitant oral and injectable antipsychotic medication use, provide prescriber verified documentation of the necessity in the treatment plan.
Nonsteroidal anti-inflammatory drugs (NSAIDs)	After 60 days of concomitant use, provide prescriber verified documentation of the necessity of the duplication in the treatment plan.

9. Status Change for Preferred Brand Name Drugs

When the status of a previously preferred brand-name drug changes to nonpreferred, pharmacies are given a transition period of up to 30 days to allow utilization of existing stock of the brand-name product.

If additional stock remains beyond this period, pharmacies may call the Point of Sale (POS) Helpdesk at 877-463-7671 or 515-256-4608 (local) to request an override for the nonpreferred brand-name drug with a recent status change.

10. Travel or Vacation Supplies of Medication

Requests of medications for travel or vacation should be planned well in advance of the departure date.

The pharmacy can process the first month's prescriptions as usual, and then may call the Point of Sale (POS) Helpdesk at 877-463-7671 or 515-256-4608 (local) to obtain up to a one-month supply of medications to total up to a 60-day supply of medication.

Exceptions to policy will not be granted if other sources for payment are available.

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11. 340B Drug Pricing Program

In order to become eligible to participate in the 340B Program, the provider must submit a request to the Office of Pharmacy Affairs (OPA) within the Health Resources and Services Administration (HRSA). The OPA website is <http://www.hrsa.gov/opa/>. The request form is listed at the following link: <ftp://ftp.hrsa.gov/bphc/pdf/opa/PrgmReg.pdf>.

It is very important that the OPA has accurate and up-to-date information, particularly your exact name and street address. It your responsibility to:

- ◆ Contact the OPA with any changes in your information; and
- ◆ Tell your wholesaler or manufacturer that you are registered for 340B discount prices when you place an order.

Providers must enroll with Iowa Medicaid in order to bill and receive reimbursement for self-administered drugs purchased through the 340B Program.

a. Covered Entity (CE)

The covered entity (CE) has full responsibility and accountability for compliance with all requirements to prevent diversion of covered drugs to individuals other than patients of the CE, and to prevent situations in which a drug is subject to both the 340B discount and a Medicaid rebate claim.

Use of a contract pharmacy arrangement (single or multiple) does not lessen a CE's duty to ensure that the 340B Program is being administered in compliance with the statute and HRSA guidelines.

It is imperative that all CEs participating in the 340B Program not only comply with program requirements but also be able to document compliance with those requirements in the event of an audit.

To prevent duplicate discounts, HRSA requires CEs to indicate on OPA website if they purchase drugs at 340B pricing for Medicaid patients (Medicaid Exclusion File), so Medicaid does not bill for rebates. HRSA directs CEs to follow state guidelines when billing for 340B drugs. CEs may not use a contracted pharmacy unless it has reached an agreement with the state Medicaid agency on a method to prevent duplicate discounts.



b. Iowa Medicaid Billing/Reimbursement for CE Outpatient In-House Pharmacy or Contracted Pharmacy

340B requirements below are reviewed through a postpayment review. Overbillings are subject to recoupment.

(1) 340B Covered Entities

All 340B CEs that use 340B drugs and serve Medicaid FFS members must do one of the following:

◆ Medicaid **CARVE OUT** all prescriptions from the 340B program:

- Use non-340B drugs for all Medicaid members you serve.
- Bill Medicaid only for drugs purchased outside the 340B program billed in accordance with existing state Medicaid reimbursement methodologies, allowing rebates to be collected where appropriate.
- Do not list the 340B entity's NPI on the HRSA Medicaid Exclusion File.

This allows rebates to be collected by Medicaid where appropriate.

◆ Medicaid **CARVE IN** all prescriptions into the 340B program:

- Use 340B drugs for all Medicaid members you serve.
- Inform OPA at the time of 340B enrollment that you intend to purchase and dispense 340B drugs for Medicaid members.
- Do not bill Medicaid for 340B acquired drugs if your NPI is not listed on the HRSA Medicaid Exclusion File.
- Purchase all drugs billed to Medicaid on the CE's NPI under 340B unless the product is not eligible for 340B pricing.

This ensures these claims are excluded from Medicaid rebate.



◆ Billing:

Submit pharmacy claims for 340B-acquired drugs to Medicaid at your 340B AAC and with values of "08" in Basis of Cost Determination field 423-DN **OR** in Compound Ingredient Basis of Cost Determination field 490-UE **AND** also insert "20" in the Submission Clarification Code field 420-DK.

If the product is not eligible for 340B pricing do not include the basis of cost determination or submission clarification code values and bill at the regular Medicaid rate.

(2) 340B Contract Pharmacies

Contract pharmacies may not submit claims to Medicaid FFS for 340B-acquired drugs. A 340B contract pharmacy must **carve out** Medicaid FFS from its 340B operation.

12. Interpreter Services

Translation and interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for your pharmacy. The services must facilitate access to Medicaid covered services.

In order for translation and interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- ◆ Provided by interpreters who provide only interpretive services.
- ◆ Interpreters may be employed or contracted by the billing provider.
- ◆ The interpretive services must facilitate access to Medicaid-covered services.

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services. Reimbursable time may include the interpreter's travel and wait time.

a. Documentation of the Service

The billing provider must document in the patient's record the:

- ◆ Interpreter's name or company,
- ◆ Date and time of the interpretation,
- ◆ Service duration (time in and time out), and
- ◆ The cost of providing the service.



b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org)

The following are instructions for billing interpretive services when that service is provided by an outside commercial translation service.

- ◆ Bill code T1013 on the professional CMS-1500 claim form:
 - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at \$1.70 per minute.
 - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- ◆ Enter the number of minutes actually used for the provision of the service.
- ◆ Special note: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is NOT used and the units exceed 24 will be paid at 24 units.

G. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting. To view a sample of this form on line, click [here](#).

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid claims and denied claims:

- ◆ **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- ◆ **Denied** represents all processed claims for which no reimbursement is made.



Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit less the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

A detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one’s understanding of the *Remittance Advice*, it is sometimes necessary to contact IME Provider Services with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Field Descriptions

	Field Name	Field Description
A	R.A. No.	<i>Remittance Advice</i> number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME for the mailing of <i>Remittance Advice</i> and paper checks
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the <i>Remittance Advice</i> was created
G	Date Paid	Date the <i>Remittance Advice</i> was mailed and check was released



	Field Name	Field Description
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this <i>Remittance Advice</i>
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Total Billed Amt.	Total amount billed to Iowa Medicaid for claims in this status section
R	Total Other Sources	Third party insurance payment or spenddown amount applied for claims in this status section
S	Total Paid by Mcaid	Total amount paid by Medicaid for claims in this status section
T	Copay Amt.	Members' copayment amount (applied per date of service, when applicable) for claims in this status

1	Patient Name	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Dispense Date	Date of service
5	National Drug Code	11-digit NDC number
6	Sub Units	Number of units billed
7	Rx No.	Prescription number
8	Billed Amt.	Total amount billed to Iowa Medicaid for this claim
9	Other Sources	Third party insurance payment or spenddown amount applied to this claim



	Field Name	Field Description
10	Paid by Mcaid	Total amount paid by Medicaid on this claim
11	Copay Amt.	Member's copay amount (applied per date of service, when applicable)
12	S	<p>Source of payment. Allowed charge source codes are as follows:</p> <ul style="list-style-type: none"> A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced T EPSDT partial under 18 U Gynecology fee V Obstetrics fee W Child fee X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR



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	Field Name	Field Description
13	EOB	Explanation of benefits (EOB) code, if denied. A description of the code can be found on the summary page of the <i>Remittance Advice</i> (Field O).
14	Practitioner	Name of prescribing provider
15	Drug Name	Name and dosage of drug dispensed
16	Adj-R	Reason code indicating the reason for the adjustment
17	TCN-to-Credit	17-digit TCN number of the claim being credited