STATE OF IOWA

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DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

INFORMATIONAL LETTER NO. 471

To: Iowa Medicaid Participating Pharmacies

From: Iowa Department of Human Services

Date: **September 12, 2005**

Subject: **Prescription Benefit Updates**

Effective: **Various, see below**

1. Rule Change IAC 441-78.1(2)*d&f* – Maintenance Drugs Effective October 1, 2005

Under current rules, the following maintenance drugs may be prescribed in 90-day quantities: oral contraceptives, cardiac drugs, hypotensive agents, vasodilating agents, anticonvulsants, diuretics, anticoagulants, thyroid and antithyroid agents, antidiabetic agents, and nonprescription maintenance drugs.

Effective October 1, 2005, the Rule has been changed to eliminate the provision for 90-day supplies of maintenance drugs, except for oral contraceptives, so that all other drugs will be limited to a 30-day supply

2. Drug Prior Authorization Effective October 17, 2005

A. New Prior Authorization Drugs and/or Categories of drugs

Effective October 17, 2005 the following drugs and/or categories of drugs will require prior authorization.

- Regranex®
- Spiriva®
- Urospecific Alpha-Blockers (Flomax®, Uroxatral®)
- Xolair®
- Zyvox®

The criteria for these drugs and/or categories of drugs are attached (refer to attachment 1). For a complete criteria chart, visit www.iowamedicaidpdl.com. The new PA forms are also available on that site or by calling the PA Provider Help Desk at 877-776-1567 or 725-1106 (local calls)

B. Changes to existing Drug Prior Authorization Categories

Effective October 17, 2005 the following category of drugs will have changes applied to the prior authorization criteria.

- Anti-Thrombotics, Injectable - preferred products will now require a prior authorization after **10** consecutive days of therapy, instead of after 30 days.

The new criterion for this category of drugs is attached (refer to attachment 1).

3. Days Supply Limitation Addition Effective October 17, 2005

- **Tamiflu®** - Prior authorization is required for Tamiflu® for quantities exceeding 14 units per 30 days effective October 17, 2005.

4. Prescription Drug Co-payment Effective July 1, 2005

The prescription co-payment structure for Iowa Medicaid was revised as follows:

- $1.00 for all covered generic and preferred brand name drugs
- $1.00 for all covered non-preferred brand-name drugs for which the cost to the state is up to and including $25.00
- $2.00 for all covered non-preferred brand-name drugs for which the cost to the state is $25.01 to $50.00
- $3.00 for all covered non-preferred brand name drugs for which the cost to the state is $50.01 or more

5. SMAC List Amended Effective July 1, 2005

The FUL/SMAC list located at www.mslciowa.com now includes the OTC products and their MAC rates. We have done this for the convenience of the providers so the combined lists are in one place.

6. OTC Payable List Deletions Effective July 1, 2005

Based on the most recent CMS rebate data the following products are no longer available from manufacturers participating in the CMS rebate program and have been removed from the OTC Payable List.

- Acetaminophen Elixir 120 mg/5ml
- Benzoyl Peroxide Wash 5%
- Calcium Citrate-Vitamin D Tab 1500 mg-200 unit
- Diphenhydramine HCl Liquid 6.25 mg/5ml
- Ferrous Fumarate Tab 300 mg
- Ferrous Gluconate 300 mg/5ml
- Ferrous Gluconate tab 320 mg

A complete list of the OTC Payable medications can be found at www.iowamedicaidpdl.com.

7. Pharmacy Dispensing Fee Increase Effective July 1, 2005

The Legislature appropriated changes in reimbursement rates to several Medicaid provider types **effective July 1, 2005.** The new pharmacy dispensing fee is $4.39

DHS is submitting a state plan amendment that will seek official CMS approval, including reimbursement, that would be applied retroactively back to July 1, 2005. The Iowa Medicaid Enterprise staff will be sending out a letter to all Iowa Medicaid pharmacies providing more details on the dispensing fee increase.

8. Paper Claim Submission Effective October 17, 2005

Effective October 17, 2005 paper claims must be submitted on the new universal claim forms (UCFs) as noted in Informational Letter 419. **Traditional universal claim forms will no longer be accepted after this date.** An example of the claim form was sent with informational letter 419 and may be viewed online at http://www.ime.state.ia.us/docs/SFX38FF.pdf.

The new universal claim forms can be ordered by calling Moore North America's Customer Service at 800-635-9500. The form number is UCF L1.

Please call Tiffany Nichols at (515) 725-1125 if you have any questions about this Informational Letter or if you need more information. Thank you.

ATTACHMENT: **1). PA Chart Additions/Changes**

Attachment 1

PA Criteria Chart Additions/Changes

Anti-Thrombotics, Injectable	Prior authorization is required for use of any preferred injectable anti-thrombotic agent longer than 10 consecutive days. Prior authorization will be required for all non-preferred injectable anti-thrombotic agents as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred anti-thrombotic injectable agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment for usage of injectable anti-thrombotic agents beyond this limit will be authorized for cases in which there is a clinical diagnosis of: 1. Pregnancy or planned pregnancy 2. Cancer-associated thromboembolic disease 3. Anti-thrombin III deficiency 4. Warfarin allergy 5. History of thrombotic event while on therapeutic anticoagulant therapy.
Regranex®	Prior authorization is required for Regranex®. Payment for new prescriptions will be authorized for ten weeks for patients who meet the following criteria: 1. Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond 2. Inadequate response to 2 weeks of wound debridement and topical moist wound dressing Longer than 10 weeks will be authorized for patients who meet the following criteria: Wound has decreased in size by 30% after 10 weeks
Spiriva®	Prior authorization is required for Spiriva®. Payment will be authorized for patients who meet all the following criteria: 1. Diagnosis of mild, moderate or severe Chronic Obstructive Pulmonary disease according to the GOLD criteria 2. Symptomatic with documented pulmonary test showing obstruction 3. Treatment failure or compliance failure with ipratropium therapy Regularly scheduled ipratropium therapy is discontinued when Spiriva® therapy begins
Urospecific Alpha-Blockers (Flomax®, Uroxatral®)	Prior authorization is required for urospecific alpha-blockers. Payment will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred alpha1-adrenergic blocker or for patients who meet any of the following criteria: 1. History of postural hypotension or hypotension 2. Use of antihypertensive or other medication that may exacerbate hypotension
Xolair®	Prior authorization is required for Xolair®. Payment for Xolair® will be authorized for patients 12 and older when there is a diagnosis of moderate to severe persistent asthma and documentation of previous trial(s) and therapy failure(s) with therapeutic doses of inhaled steroids.
Zyvox®	Prior authorization is required for Zyvox®. Payment for Zyvox® will be authorized when there is documentation that: 1. Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable). 2. Patient is being treated for one of the following diagnoses: • Vancomycin-resistant Enterococcus (VRE) and no alternatice regimens with documented efficacy are available and VRE is not in lower urinary tract**. • Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin* • Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin* *Severe intolerance to vancomycin is defined as: – Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration – Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine) **VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.