STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

INFORMATIONAL LETTER NO. 857

To: Iowa Medicaid Physician, Dentist, Advanced Registered Nurse Practitioner, Therapeutically Certified Optometrist, Podiatrist, Pharmacy, Home Health Agency, Rural Health Clinic, Clinic, Nursing Facilities, Community Mental Health Center, Residential Care Facility, ICF MR State and Community Based ICF/MR Providers

From: Iowa Department of Human Services, Iowa Medicaid Enterprise

Date: December 1, 2009

Subject: Iowa Medicaid Pharmacy Program Changes

Effective: **January 1, 2010**

1. Changes to the Preferred Drug List (PDL)[1] Effective January 1, 2010

Preferred	Non-Preferred	Recommended	Non-Recommended
Acular® PF	Actoplus Met®	Bicalutamide	Casodex®[2]
Acyclovir 200mg/5ml Suspension	Actos® 30mg & 45mg[4]		Intelence™
Apriso™	Acuvail™		Leuprolide
Bisoprolol Fumarate	Adalat CC®		Melphalan Injection
Bupropion XL	Adcirca™[1]		Tacrolimus
Butalbital/ASA/Caffeine 50-325-40mg Capsules	Advair Diskus® 14 pack		
OTC Calcium Carbonate Chew Tablet 500mg, 750mg, 1000mg[1]	Asacol® HD		
OTC Calcium Carbonate-Vitamin D Tablet 600mg-400unit[1]	Astepro® 0.15% Spray[1]		
Cimzia®[1] (prefilled syringe)	Augmentin XR®		
Combigan®	Avandamet®[6]		
Creon®[1]	Avandaryl®[6]		
Desogestrel & Eth Estradiol Tab 0.15mg-30mcg	Avandia®[6]		
Dextroamphetamine 5mg Tablets[1]	Besivance™		
Diclofenac Potassium Tab	Caduet®		
Fortical®	Calcipotriene		
Humalog® Mix 50/50™	Calcium Acetate		
Humalog® Mix 50/50™ Pen[1]	Clindamycin/Benzoyl Peroxide Gel[1]		
Humalog® Pen[1]	Colcrys™		
Ipratropium Bromide/Albuterol	Depo-Provera® Contraceptive& SubQ 104		
Letairis®[1]	Dexmethylphenidate[1]		
LoSeasonique™	Duetact®[6]		
Medroxyprogesterone Acetate IM	DuoNeb®		
Metformin 750mg SR Tablet	Edluar™[1]		
Multaq®	Effexor XR®[5]		

Nifedipine ER	Effient™		
Norethindrone & Eth Estradiol Tab 1mg-35mcg	Embeda™		

Preferred	**Non-Preferred**	**Recommended**	**Non-Recommended**
Norethindrone &Eth Estradiol Tab (10/11)	Epiduo™[1]		
Ofloxacin Otic Solution	Extavia®		
Omnitrope®[1]	Fazaclo®[3]		
Ranitidine Syrup	Fiorinal®		
Ribavirin	Floxin® Otic		
Seasonique®	Floxin® Otic Singles®		
Sumatriptan[1]	Fosamax Plus D™		
Topiramate	Imipramine Pamoate		
Twinject®	Imitrex®[1]		
Venlafaxine ER	Invega® Sustenna™[1]		
Zymar®	Kadian® 80mg & 200mg		
	Lialda®		
	Midazolam Injection		
	Nateglinide		
	Norgestimate- Eth Estradiol Tab		
	Omnicef®		
	Onglyza™		
	Onsolis™[1]		
	Opium Tincture		
	Ortho-Cept®		
	Ortho-Novum® 1/35		
	PegIntron®[3], PegIntron® Redipen®[3]& PegIntron® Redipen® Pak[3]		
	Pentasa® 500mg		
	Protriptyine		
	Rebetol®		
	Relpax®[1]		
	Solaraze™		
	Spiriva® HandiHaler® 5 pack		
	Suprax®		
	Tofranil-PM™		
	Treximet®[1]		
	Tyvaso™[1]		
	Veramyst®		
	Vivactil®		
	Wellbutrin XL®[5]		
	Zantac® Syrup[5]		
	Zebeta®		
	Zipsor™[1]		

[1] Clinical PA Criteria Apply
[2] Selected Brand Name Drug PA Required
[3] Grandfather Existing Users
[4] Use multiples of Actos® 15mg
[5] Effective 3/1/10
[6] Grandfather Existing Users if Prior Actos® use or CHF diagnosis

2. **Synagis® Coverage 2009-10 RSV Season**

Prior authorization requests for Synagis® may now be submitted to the Iowa Medicaid Pharmacy Prior Authorization Unit. Prior authorizations will be approved for a **maximum of five doses per member.** No allowances will be made for a sixth dose. Please refer to the Palivizumab (Synagis®) Prior Authorization criteria and form located at www.iowamedicaidpdl.com.

3. **Changes to Existing Prior Authorization Criteria-** See complete prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.

- **Antihistamines:** Patients 21 years of age and older must have *three* unsuccessful trials with antihistamines that do not require prior authorization, prior to the approval of a non-preferred first generation of preferred second generation antihistamine. *Two* of the trials must be with *cetirizine and loratadine.*

  Patients 20 years of age and younger must have unsuccessful trials with *cetirizine and loratadine* prior to approval of a non-preferred first generation or preferred second generation prescription antihistamine.

- **Fentanyl, Short Acting Oral Products:** The addition of *Onsolis*™ to this prior authorization.

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

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

4. **OTC Drug Payable List:** Please refer to the OTC Payable List by NDC located at www.iowamedicaidpdl.com for a complete listing of payable NDCs for OTC drugs covered by Iowa Medicaid.

- **Additions to the OTC Drug List:** Effective January 1, 2010, the following drugs will be added to the list of OTC payable drugs by Iowa Medicaid:
  i. Calcium Carbonate Chew Tablet 500mg, 750mg, & 1000mg (PA required)
  ii. Calcium Carbonate- Vitamin D Tablet 600mg-400unit (PA required)

5. **Age Edit for Brand Fluoroquinolone Ophthalmic Products:** Effective January 1, 2010, brand fluoroquinolone ophthalmic products will be non-preferred for members under 18 years of age.

6. **Point of Sale (POS) Billing Issues:**

a). ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *January 1, 2010*. A comprehensive list of all quantity limit edits appears on our website, www.iowamedicaidpdl.com under the heading, "Quantity Limits".

Drug Product	Quantity	Days Supply
Remeron SolTab® 15mg	45	30
Remeron SolTab® 30mg	30	30
Remeron SolTab® 45mg	30	30
Savella® 12.5mg	60	30
Savella® 25mg	60	30
Savella® 50mg	60	30
Savella® 100mg	60	30
Topiramate 25mg	60	30

Topiramate 50mg	60	30
Topiramate 100mg	60	30
Toviaz® 4mg	30	30
Toviaz® 8mg	30	30
Twinject®	4 units	30
Venlafaxine ER 37.5mg	30	30
Venlafaxine ER 75mg	30	30
Venlafaxine ER 150mg	60	30
Venlafaxine ER 225mg	60	30

b). Proper Billing of Synagis® and flu vaccines: As a reminder, Synagis® 50mg Injection and all flu vaccine injections should be billed as 0.5ml.

c). Proper Crediting of Unused Medications: Iowa Medicaid Long Term Care Pharmacy Providers and Nursing Home Facilities who serve Iowa Medicaid Members are to be reminded that proper credit to Iowa Medicaid is required for the return of unused medications upon therapy discontinuation, member discharge, transfer, or death in accordance with State law. The Iowa Medicaid Prescribed Drugs Provider Manual states, "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." Please refer to Informational Letter 497 for additional information.

7. **Changes Regarding Remittance Advice, Payment, and Informational Letters:** Iowa Medicaid Enterprise (IME) will require electronic processes exclusively for the transmission of remittance advice statements, provider payments, and informational letters in the near future. Please be aware, July 1, 2010 forward, informational letters will only be available electronically. Providers may access informational letters at www.iowamedicaidpdl.com under the Informational Letters tab. Providers can go to a local public library to access this information if internet access is not available to them. Please refer to Informational Letter No. 847 on the website under the Informational Letters tab for more information regarding this transition.

8. **Listserv:** A Listserv is now available to communicate the latest news regarding the Iowa Medicaid Pharmaceutical and Therapeutics (P&T) Committee meetings. Announcements from the Listserv will notify subscribers of postings to the iowamedicaidpdl.com website such as meeting agendas, drug monographs, informational letters, preferred drug lists, and reports. Please visit www.iowamedicaidpdl.com under the Listserv tab to register for these notices.

9. **Preferred Brand Name Drugs on the PDL-Pharmacy Clarification**
   - When a status change occurs for a previously preferred brand name drug to non-preferred status, up to a *minimum* of 30 days transition period is given to pharmacies to help utilize existing brand name product in stock in an effort to decrease a pharmacy's remaining brand name drug inventory (see PDL comment section regarding transition periods exceeding 30 days).
   - If additional stock remains beyond this time period, pharmacies may call the POS Helpdesk at 877-463-7671 or 515-725-1107 (local) to request an override for the non-preferred brand name drug with a recent status change.

10. **DUR Update:** The latest issue of the Drug Utilization Review (DUR) Digest is located at the Iowa DUR website, www.iadur.org. under the "Newsletters" link.

    We encourage providers to go to the website at **www.iowamedicaidpdl.com** to view all recent changes to the PDL. If you have questions, please contact the Pharmacy Prior Authorization Helpdesk at 877-776-1567 or 515-725-1106 (local in Des Moines) or e-mail info@iowamedicaidpdl.com.