Iowa Department of Human Services

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Governor

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Director

INFORMATIONAL LETTER NO.1191

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

FROM: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

DATE: November 30, 2012

SUBJECT: Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: **January 1, 2013**

1. Changes to the Preferred Drug List (PDL)[1] Effective January 1, 2013

Preferred	Non-Preferred	Recommended	Non-Recommended
Adapalene[1]	Advicor®	Lamivudine/Zidovudine	Combivir®[4]
Albuterol Sulfate 0.63mg/3ml[2]	Akne-Mycin®[1]	Nevirapine 200mg Tablets	Norvir® Tablets[8]
Alclometasone	Androgel®		Stribild™
Astelin®	Arixtra®[1]		Viramune® 200mg Tablets[4]
Benzoyl Peroxide-Erythromycin[1]	Benzamycin® Pak[1]		
BPO®[1]	Binosto™[1]		
Bromocriptine	Betaseron®[3]		
Bupropion 75mg & 100mg Tablets	Clarinex®[1]		
Calcium Acetate (phosphate binder)	Cleocin® Oral Solution 75mg/5ml		
Ciprodex®[5]	Clobetasol Propionate		
Clindamycin-Benzoyl Peroxide[1]	Combivent® Respimat®		
Clindamycin Oral Solution 75mg/5ml	Cortisporin® Otic		
Enoxaparin[1]	Coumadin®[3]		
Escitalopram	Cubicin®		

Felbamate	Derma-Smoothe/FS®		
Fondaparinux[1]	Desoximetasone		
Foradil®	Differin®[1]		
Gabapentin Oral Solution 250mg/5ml	Diprolene®		
Hydrocortisone Butyrate	Dovonex®		
Janumet®[1]	Emend®[1]		
Januvia®[1]	Felbatol®[6]		
Jentadueto®[1]	Fluocinolone		
Latuda®	Fosrenol®		
Lescol® XL	Geodon®		
Levemir®	Halog®		
Levonorgestrel & ethinyl estradiol (91 day)	Humalog® Pen[1]		
Malathion[7]	Humalog® Kwikpen™[1]		
Methylergonovine	Humalog® Kwikpen™ Mix 50/50[1]		
Metrogel®[1]	Kadian®[3]		
Metronidazole Cream[1]	Lexapro®		
Moxeza®	Lovenox®[1]		
Neomycin-Polymyxin-HC Otic	Lumigan®		
Olux®	Maxalt®[1]		
Opana® ER	Maxalt-MLT®[1]		
Oxcarbazepine Oral Suspension 300mg/5ml	MetroCream®[1]		
Moxeza®	Naratriptan[1]		
Pancreaze®	Neupro®		
Paroxetine Oral Suspension 10mg/5ml	Neurontin® Oral Solution 250mg/5ml[6]		
Patanase®	Omeclamox Pak®		
Procentra®[1]	Parcopa®		
Relpax®[1]	Parlodel®		
Tazorac®[1]	Paxil® Oral Suspension 10mg/5ml		
Tegretol® XR	Pioglitazone		
Testim®	Pioglitazone/Metformin		
Topicort®	ProAir® HFA		
Vytorin®	Rayos®[1]		
Ziprasidone	Rebif®[3]		
	Restoril® 22.5mg[1]		

	Spinosad		
	Stalevo®		
	Sumatriptan Nasal Spray[1]		
	Temazepam 22.5mg[1]		
	Trileptal® Oral Suspension 300mg/5ml[6]		
	Valurna®[1]		
	Viokace®		
	Wellbutrin® 75mg & 100mg Tablets		

[1]Clinical PA Criteria Apply
[2]Preferred for members < 2 years of age
[3]Grandfather Existing Users
[4]Select Brand Name Drug PA Required
[5]Preferred for members < 8 years of age
[6]Grandfather Existing Users with Seizure Diagnosis
[7]Requires 2 trials of a preferred topical permethrin product in past 30 days
[8]PA Required- Use Capsules

2. **New Drug Prior Authorization Criteria-** See prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.
   - **Vemurafenib (Zelboraf™):** Prior authorization is required for Zelboraf™ (Vemurafenib). Payment will be considered for patients when the following criteria are met:
     1. Patient is 18 years of age or older; and
     2. Has a diagnosis of unresectable or metastatic melanoma with $BRAF^{V600E}$ mutation as detected by an FDA-approved test; and
     3. Prescriber is an oncologist.

     If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.

3. **Changes to Existing Prior Authorization Criteria-** *Changes are italicized.* See complete prior authorization criteria posted at www.iowamedicaidpdl.com under the Prior Authorization Criteria tab.
   - **Biologicals for Arthritis:** Prior authorization is required for biologicals used for arthritis. *Patients initiating therapy with a biological agent must 1) be screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; 2) have not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; 3) not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV with an ejection fraction of 50% or less; and 4) be screened for latent TB infection, patients with latent TB infection will only be considered after one month of TB treatment and patients with active*

TB will only be considered upon completion of TB treatment. Payment will be considered under the following conditions:

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

A diagnosis of moderate to severe psoriatic arthritis (Enbrel, Humira, Remicade, Simponi)
-A trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

A diagnosis of moderate to severe juvenile idiopathic arthritis (Enbrel, Humira, Actemra, Orencia)
-A trial and inadequate response to intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

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

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

4. **Coverage of Benzodiazepines and Barbiturates by Medicare Part D: Effective January 1, 2013,** Part D will cover barbiturates (used in the treatment of epilepsy, cancer, or a chronic mental health disorder) and benzodiazepines. As a result, they will be removed from coverage by Iowa Medicaid.

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

   a. **Abilify Quantity Limits:** Tablet splitting will be required for all strengths of Abilify. Quantities above 15 tablets per 30 days will require prior authorization. Existing users of 20mg dose and above will be grandfathered.

   b. **Step Therapy Edits for Atypical Antipsychotics:** Step therapy edits will be implemented for atypical antipsychotics.
      Step 1: Preferred generic drugs
      Step 2: Preferred brand name drugs
      Step 3: Non-Preferred drugs

No manual PA will be required for preferred brand name drugs when the preferred generic trial is found in the member's pharmacy claims history in the past 12 months. All non-preferred drugs will require manual PA. Existing users will be grandfathered.

c. ProDUR age edits:

Drug Product	Age Edit
Asmanex 110mcg	PA required > 12 years of age
Brovana	PA required < 18 years of age
Clorazepate	PA required < 9 years of age
Complera	PA required < 18 years of age
Dulera	PA required < 12 years of age
Edurant	PA required < 18 years of age
Eligard	PA required < 18 years of age
Erivedge	PA required < 18 years of age
Flurazepam	PA required < 15 years of age
Foradil	PA required < 5 years of age
Inlyta	PA required < 18 years of age
Isentress 25mg Chewable Tablet	PA required > 12 years of age
Isentress 100mg Chewable Tablet	PA required > 12 years of age
Jakafi	PA required < 18 years of age
Oxazepam	PA required < 6 years of age
Perforomist	PA required < 18 years of age
Revlimid	PA required < 18 years of age
Serevent	PA required < 4 years of age
Stribild	PA required < 18 years of age
Zytiga	PA required < 18 years of age

d. ProDUR Quantity Limits: The following quantity limit edits will be implemented effective *January 1, 2013*. 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
Opana ER 5mg	60	30
Opana ER 7.5mg	60	30
Opana ER 10mg	60	30
Opana ER 15mg	60	30
Opana ER 20mg	60	30
Opana ER 30mg	60	30

e. Proper Billing of Synagis® and flu vaccines: As a reminder, Synagis® 50mg Injection and most flu vaccines should be billed as 0.5ml.

6. **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 515-256-4608 (local) to request an override for the non-preferred brand name drug with a recent status change.

7. **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 515-256-4607 (local in Des Moines) or email info@iowamedicaidpdl.com.