The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Acute Migraine Treatments *Use Acute Migraine Treatments PA form*	No prior authorization (PA) is required for preferred acute migraine treatments, as indicated on the Preferred Drug List (PDL). PA is required for acute migraine treatments under the following conditions: 1. A diagnosis of acute migraine; and 2. Patient meets the FDA approved age for requested agent; and 3. For preferred acute migraine treatments where PA is required, as indicated on the PDL, documentation of previous trials and therapy failures with two preferred agents that do not require PA; and/or 4. For non-preferred acute migraine treatments, documentation of previous trials and therapy failures with two preferred agents that do not require PA. Requests for non-preferred CGRP inhibitors will also require documentation of a trial and therapy failure with a preferred CGRP inhibitor; and/or 5. For quantities exceeding the established quantity limit for each agent, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications; and/or 6. For non-preferred combination products, documentation of separate trials and therapy failures with the individual ingredients, in addition to the above criteria for preferred or non-preferred acute migraine treatments requiring PA. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
ADD/ADHD/ NARCOLEPSY AGENTS *Use CNS Stimulants and Atomoxetine PA form*	*See CNS Stimulants and Atomoxetine Prior Authorization (PA) Criteria.*

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors *Use Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors PA form*	Prior authorization (PA) is required for adenosine triphosphate-citrate lyase (ACL) inhibitors. Payment will be considered under the following conditions: 1. Patient meets the FDA approved age; and 2. Documentation of adherence to prescribed lipid lowering medications (including a maximally tolerated statin), prior to ACL inhibitor therapy, for the previous 90 days is provided (further defined below, by diagnosis); and 3. Documentation is provided that medication will be used in combination with a maximally tolerated statin; 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. Patient will continue to follow an appropriate low fat diet; and 6. Is prescribed by or in consultation with a lipidologist, cardiologist, or endocrinologist; and 7. If patient is taking in combination with: a. Simvastatin, dose does not exceed 20mg per day; or b. Pravastatin, dose does not exceed 40mg per day; and 8. Concurrent use with a PCSK9 inhibitor will not be considered; and 9. Goal is defined as a 50% reduction in untreated baseline LDL-C; and 10. Is prescribed for one of the following diagnoses: a. Heterozygous Familial Hypercholesterolemia (HeFH): i. Documentation is provided verifying diagnosis (attach documentation/results), as evidenced by: 1. Clinical manifestations of HeFH (e.g. tendon xanthomas, cutaneous xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma) or: 2. Confirmation of diagnosis by gene or receptor testing; and ii. Documentation of untreated LDL-C ≥ 190 mg-dL; and iii. Patient is unable to reach LDL-C goal 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 (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily; or b. Clinical Atherosclerotic Cardiovascular Disease (ASCVD): i. History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; and ii. Patient is unable to reach LDL-C goal 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 (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily, If criteria for coverage are met, requests will be approved for 3 months. Additional authorizations will be considered at yearly intervals under the following conditions: a. Patient continues therapy with a maximally tolerated statin dose and remains at goal; and b. Patient continues to follow an appropriate low fat diet; and c. Documentation of LDL reduction is provided. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Age Edit Override – Codeine or Tramadol *Use Age Edit Override-Codeine or Tramadol PA form*	An age edit override for codeine or tramadol is required for patients under 18 years of age. Payment will be considered under the following conditions: 1. Member is 12 years of age or older; and 2. Medication is not being prescribed to treat pain after surgery following tonsil and/or adenoid procedure for members 12 to 18 years of age; and 3. If member is between 12 and 18 years of age, member is not obese (BMI greater than 30kg/m^2), does not have obstructive sleep apnea, or severe lung disease.
Alpelisib (Vijoice) *Use Alpelisib (Vijoice) PA form*	Prior authorization (PA) is required for alpelisib (Vijoice). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and *2.* Patient has a diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) confirmed by genetic testing demonstrating a *PIK3CA* mutation; and 3. Patient's condition is severe or life-threatening requiring systemic therapy as determined by treating prescriber: and 4. Patient has at least one target lesion identified on imaging. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by a reduction in sum of measurable lesion volume across 1 to 3 target lesions.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Alpha$_1$-Proteinase Inhibitor Enzymes *Use Alpha$_1$-Proteinase Inhibitor Enzymes PA form*	Prior authorization (PA) is required for Alpha$_1$-Proteinase Inhibitor enzymes. Payment for a non-preferred Alpha$_1$-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: 1. Patient has a diagnosis of congenital alpha$_1$-antitrypsin (AAT) deficiency; with a pretreatment serum concentration of AAT less than 11µM/L or a. 80mg/dl if measured by radial immunodiffusion, or b. 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 (FEV_1); 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 FEV_1 rate of decline; and 2. Patient continues to be a non-smoker; and 3. Patient continues supportive therapy for obstructive lung disease.
Amylino Mimetic (Symlin) *Use Amylino Mimetic (Symlin) PA form*	Prior authorization (PA) is required for amylino mimetics (Symlin). Payment will be considered under the following conditions: 1. Diagnosis of Type 1 or Type 2 diabetes mellitus, 2. Concurrent use of insulin therapy, 3. Documentation of blood glucose monitoring three or more times daily, 4. Inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin dosing regiments. Initial authorizations will be approved for six months; additional PAs will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial PA period.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Antidepressants *Aplenzin* *Auvelity* *Fetzima* *Use Antidepressants PA form*	Prior authorization (PA) is required for non-preferred antidepressants subject to clinical criteria. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; and 3. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and 4. Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant; and 5. Documentation of a previous trial and therapy failure at a therapeutic dose with vilazodone; and 6. Documentation of a previous trial and therapy failure at a therapeutic dose with vortioxetine; and 7. Documentation of a previous trial and therapy failure at a therapeutic dose with an antidepressant plus adjunct; and 8. If the request is for dextromethorphan and bupropion extended-release tablet (Auvelity), one of the trials must include a previous trial and inadequate response at a therapeutic dose with an extended-release bupropion agent; and 9. If the request is for an isomer, prodrug or metabolite of the requested medication, 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.
Anti-Diabetics, Non-Insulin Agents *Use Anti-Diabetics, Non-Insulin PA form*	Prior authorization (PA) is required for select preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. For the treatment of Type 2 Diabetes Mellitus, a current A1C is provided; and 3. Requests for non-preferred antidiabetic, non-insulin agents subject to clinical criteria, will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. Additionally, requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document previous trials and therapy failures with at least 3 preferred agents from 3 different drug classes at maximally tolerated doses. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Requests for weight loss are not a covered diagnosis of use and will be denied.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents *Use Antiemetic-5HT3 Receptor Antagonists/ Substance P Neurokinin Agents form*	Prior authorization (PA) is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the following dosage limits per month. 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. PA will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/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. Aprepitant (N)/Emend (P): 4 – 125mg capsules 8 – 80mg capsules Dolasetron (N)/Anzemet (N): 5 – 50mg/100mg tablets 4 vials (100mg/5mL) 8 ampules (12.5mg/0.625mL) Granisetron (N): 8 – 1mg tablets 8 vials (1mg/mL) 2 vials (4mg/mL) Akynzeo (N): 2 – 300/0.5mg capsules Ondansetron (P)/Zofran (N): 60 – 4mg tablets 60 – 8mg tablets 4 – 24mg tablets 4 – 20mL vials (2mg/mL) 8 – 2mL vials (2mg/mL) Ondansetron ODT (P)/Zofran ODT (N): 60 – 4mg tablets 60 – 8mg tablets Ondansetron Oral Solution (N)/ Zofran Oral Solution (N) 50mL/month – oral solution (4mg/5mL)
Anti-Fungal- Oral / Injectable *Use Anti-Fungal PA form*	Prior authorization (PA) is not required for preferred antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. PA will be required for all non-preferred antifungal therapy beginning the first day of therapy. Payment for a non-preferred antifungal will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Payment for any antifungal therapy beyond a cumulative 90 days of therapy per 12-month period per patient will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This PA requirement does not apply to nystatin.
Antihistamines *Use Antihistamine PA form*	Prior authorization (PA) is required for all non-preferred oral antihistamines. Patients 21 years of age and older must have three unsuccessful trials with antihistamines that do not require PA, prior to the approval of a non-preferred oral 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 the approval of a non-preferred oral antihistamine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Apremilast (Otezla) *Use Apremilast (Otezla) PA form*	Prior authorization (PA) is required for apremilast (Otezla). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and 2. Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints); with a. 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); or 3. Patient has a diagnosis of plaque psoriasis; with a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; or 4. Patient has a diagnosis of Behçet disease; with a. Documentation of active oral ulcers associated with Behçet disease; and b. Documentation of a previous trial and inadequate response, at a therapeutic dose, to colchicine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Aripiprazole Tablets with Sensor (Abilify MyCite) *Use Aripiprazole Tablets with Sensor (Abilify MyCite) PA form*	Prior authorization is required for aripiprazole tablets with sensor (Abilify MyCite). Payment will be considered under the following conditions: 1. Patient has a diagnosis of Schizophrenia, Bipolar I Disorder, or Major Depressive Disorder; and 2. Patient meets the FDA approved age for use of the Abilify MyCite device; and 3. Dosing follows the FDA approved dose for the submitted diagnosis; and 4. Documentation of patient adherence to generic aripiprazole tablets is less than 80% within the past 6 months (prescriber must provide documentation of the previous 6 months' worth of pharmacy claims for aripiprazole documenting non-adherence); and 5. Documentation all the following strategies to improve patient adherence have been tried without success: a. Utilization of a pill box b. Utilization of a reminder device (e.g. alarm, application, or text reminder) c. Involving family members or friends to assist d. Coordinating timing of dose with dosing of another daily medication; and 6. Documentation of a trial and intolerance to a preferred long-acting aripiprazole injectable agent; and 7. Prescriber agrees to track and document adherence of Abilify MyCite through the web-based portal for health care providers and transition member to generic aripiprazole tablets after a maximum of 4 months use of Abilify MyCite. Initial approvals will be given for one month. Prescriber must review member adherence in the web-based portal and document adherence for additional consideration. If non-adherence continues, prescriber must document a plan to improve adherence. If adherence is improved, consideration to switch member to generic aripiprazole tablets must be considered. Note, the ability of Abilify MyCite to improve patient compliance has not been established, 8. Requests will not be considered for patients in long-term care facilities. 9. A once per lifetime approval will be allowed. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Baclofen *Use Baclofen PA form*	Prior authorization (PA) is required for non-preferred baclofen dosage forms. Payment for a non-preferred agent will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Patient has a diagnosis of spasticity resulting from multiple sclerosis (relief of flexor spasms and concomitant pain, clonus, and muscular rigidity) or spinal cord injuries/diseases; and 2. Patient meets the FDA approved age; and 3. Documentation of a patient-specific, clinically significant reason (beyond convenience) why the member cannot use baclofen oral tablets, even when tablets are crushed and sprinkled on soft food or liquid. Presence of a nasogastric (NG) tube/J-tube alone are not reasons for approval; and 4. Request does not exceed the maximum dosage of 80mg daily.
Benzodiazepines *Use Benzodiazepine PA form*	Prior authorization (PA) is required for non-preferred benzodiazepines. Payment for non-preferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determine if the use of a benzodiazepine is appropriate for this member. PA will be approved for up to 12 months for documented: 1. Generalized anxiety disorder. 2. Panic attack with or without agoraphobia. 3. Seizure. 4. Non-progressive motor disorder. 5. Dystonia. PA requests will be approved for up to a three-month period for all other diagnoses related to the use of benzodiazepines. For patients taking concurrent opioids, the prescriber must document the following: 1. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and 2. Documentation as to why concurrent use is medically necessary is provided; and 3. A plan to taper the opioid or benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Biologicals for Arthritis *Use Biologicals for Arthritis PA form*	Prior authorization (PA) is required for biologicals used for arthritis. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. 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. Payment will be considered under the following conditions: 1. Patient has a diagnosis of rheumatoid arthritis (RA); with a. Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (hydroxycholoroquine, sulfasalazine, or leflunomide may be used if methotrexate is contraindicated); or 2. Patient has a diagnosis of moderate to severe psoriatic arthritis; with a. Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 3. Patient has a diagnosis of juvenile idiopathic arthritis with oligoarthritis; with a. Documentation of a trial and inadequate response to intraarticular glucocorticoid injections and methotrexate at a maximally tolerated dose (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 4. Patient has a diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis (pJIA); with a. Documentation of a trial and inadequate response to methotrexate at a maximally tolerated dose (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or 5. Patient has a diagnosis of systemic juvenile idiopathic arthritis (sJIA). The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Biologicals for Axial Spondyloarthritis *Use Biologicals for Axial Spondyloarthritis PA form*	Prior authorization (PA) is required for biologicals used for axial spondyloarthritis conditions. Request must adhere to all approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment will be considered under the following conditions: 1. Patient has a diagnosis of: a. ankylosing spondylitis (AS) or b. nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and 2. Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least one month in duration; and 3. Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment 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; and 4. Requests for non-preferred biologicals for axial spondyloarthritis conditions will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents that are FDA approved or compendia indicated for the submitted diagnosis, when applicable. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Biologicals for Inflammatory Bowel Disease *Use Biologicals for Inflammatory Bowel Disease PA form*	Prior authorization (PA) is required for biologicals used for inflammatory bowel disease. Request must adhere to all FDA approved labeling. Payment for non-preferred 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. Payment will be considered under the following conditions: 1. Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and 2. Patient has been 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; and 3. Patient has a diagnosis of Crohn's Disease – Payment will be considered following an inadequate response to two preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate; or 4. Patient has a diagnosis of Ulcerative Colitis (moderate to severe) – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates and azathioprine/6-mercaptopurine; and In addition to the above: Requests for TNF Inhibitors: 1. Patient has 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; and 2. Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less; and Requests for Interleukins: 1. Medication will not be given concurrently with live vaccines. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Biologicals for Hidradenitis Suppurativa *Use Biologicals for Hidradenitis Suppurativa PA form*	Prior authorization (PA) is required for biologicals FDA approved or compendia indicated for the treatment of Hidradenitis Suppurativa (HS). Payment for non-preferred biologic agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred biologic agent. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease; and 3. Patient has at least three (3) abscesses or inflammatory nodules; and 4. Patient has documentation of adequate trials and therapy failures with the following: a. Daily treatment with topical clindamycin; b. Oral clindamycin plus rifampin; c. Maintenance therapy with a preferred tetracycline. If criteria for coverage are met, initial requests will be given for 4 months. Additional authorizations will be considered upon documentation of clinical response to therapy. Clinical response is defined as at least a 50% reduction in total abscess and inflammatory nodule count with no increase in abscess count and no increase in draining fistula count from initiation of therapy. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Biologicals for Plaque Psoriasis *Use Biologicals for Plaque Psoriasis PA form*	Prior authorization (PA) is required for biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for non- preferred 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. Payment will be considered under the following conditions: 1. Patient has a diagnosis of moderate to severe plaque psoriasis; and Patient has documentation of an inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Calcifediol (Rayaldee) *Use Calcifediol (Rayaldee) PA form*	Prior authorization (PA) is required for calcifediol (Rayaldee). Initial requests will be considered for patients when the following criteria are met: 1. Patient is 18 years of age or older; and 2. Patient is being treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) as documented by a current glomerular filtration rate (GFR); and 3. Patient is not on dialysis; and 4. Patient has a serum total 25-hydroxyvitamin D level less than 30 ng/mL and a serum corrected total calcium below 9.8 mg/dL within the past 3 months; and 5. Patient has documentation of a previous trial and therapy failure at a therapeutic dose with a preferred vitamin D analog for a minimum of 3 months. 6. Initial requests will be considered for a dose of 30 mcg once daily for 3 months. Continuation of therapy will be considered when the following criteria are met: 1. Patient continues to need to be treated for secondary hyperparathyroidism associated with a diagnosis of stage 3 or stage 4 chronic kidney disease (CKD) documented by a current glomerular filtration rate (GFR); and 2. Patient has a serum total 25-hydroxyvitamin D level between 30 and 100 ng/mL, a serum corrected total calcium below 9.8 mg/dL, and a serum phosphorus below 5.5 mg/dL.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Cholic Acid (Cholbam) *Use Cholic Acid (Cholbam) PA form*	Prior authorization (PA) 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: a. 3-beta-hydroxy-delta-5C27-steroid oxidoreductase deficiency (3β-HSD), b. aldo-keto reductase 1D1 (AKR1D1), c. alpha-methylacyl-CoA racemase deficiency (AMACR deficiency), d. sterol 27-hydroxylase deficiency (cerebrotendinous xanthomatosis [CTX]), e. cytochrome P450 7A1 (CYP7A1), f. 25-hydroxylation pathway (Smith-Lemli-Opitz); OR 3. 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 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: 1. Body weight has increased by 10% or is stable at $\geq 50^{th}$ percentile, 2. Alanine aminotransferase (ALT) or aspartate aminotransferase (AST) < 50 U/L or baseline levels reduced by 80%, 3. Total bilirubin level reduced to ≤1mg/dL.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

CNS Stimulants and Atomoxetine	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 website. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for CNS stimulants and atomoxetine will be considered when patient has an FDA approved or compendia indication for requested drug under the following conditions: 1. 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 improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. Adults (≥ 21 years of age) are limited to the use of long-acting agents only. If a supplemental dose with a short-acting agent is needed for an adult in the mid to late afternoon, requests will be considered under the following circumstances: the dose of the long-acting agent has been optimized, documentation is provided a short-acting agent of the same chemical entity is medically necessary (e.g. employed during the day with school in the evening, and will be limited to one unit dose per day. Children (< 21 years of age) are limited to the use of long-acting agents with one unit of a short acting agent per day. Use of an amphetamine agent plus a methylphenidate agent will not be considered for a diagnosis of 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. 4. Binge Eating Disorder (Vyvanse only) a. Patient is 18 to 55 years of age; and b. Patient meets DSM-5 criteria for Binge Eating Disorder (BED); and c. 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 d. 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; and e. Prescription is written by a psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and f. Patient has a BMI of 25 to 45; and g. Patient does not have a history of cardiovascular disease; and h. Patient has no history of substance abuse; and i. Is not being prescribed for the treatment of obesity or weight loss; and j. Doses above 70mg per day will not be considered. k. Initial requests will be approved for 12 weeks. l. Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week. <u>DSM-5 Criteria</u> i. 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 overeating; and ii. The binge eating episodes are marked by at least three of the following:

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use CNS Stimulants and Atomoxetine or Binge Eating Disorder Agents PA form	1. Eating more rapidly than normal 2. Eating until feeling uncomfortably full 3. Eating large amounts of food when not feeling physically hungry 4. Eating alone because of embarrassment by the amount of food consumed 5. Feeling disgusted with oneself, depressed, or guilty after overeating; and iii. Episodes occur at least 1 day a week for at least 3 months; and iv. No regular use of inappropriate compensatory behaviors (e.g. purging, fasting, or excessive exercise) as are seen in bulimia nervosa; and v. Does not occur solely during the course of bulimia nervosa or anorexia nervosa. <u>Moderate to Severe BED</u> Based on the number of binge eating episodes per week: Moderate - 4 to 7 Severe – 8 to 13 Extreme – 14 or more Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. *If a non-preferred long-acting medication is requested, a trial with the preferred 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.
Crisaborole (Eucrisa) *Use Crisaborole (Eucrisa) PA form*	Prior authorization (PA) is required for Eucrisa (crisaborole). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of mild to moderate atopic dermatitis; and 3. Patient has failed to respond to good skin care and regular use of emollients; and 4. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and 5. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and 6. Patient will continue with skin care regimen and regular use of emollients. 7. Quantities will be limited to 60 grams for use on the face, neck, and groin and 100 grams for all other areas, per 30 days. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia) *Use Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia) PA form*	Prior authorization (PA) is required for cyclosporine 0.1% ophthalmic emulsion (Verkazia). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe vernal keratoconjunctivitis (VKC); and 3. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical dual-acting mast cell stabilizer/topical antihistamine (e.g., olopatadine, azelastine); and 4. Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical ophthalmic corticosteroid (e.g., dexamethasone, prednisolone, fluorometholone, loteprednol); and 5. Is prescribed by or in consultation with an ophthalmologist or optometrist; and 6. Is not prescribed in combination with other ophthalmic cyclosporine products. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Initial requests will be approved for 6 months. Additional authorizations will be considered upon documentation of clinical response to therapy.
Cystic Fibrosis Agents, Oral *Kalydeco* *Orkambi* *Symdeko* *Trikafta* *Use Cystic Fibrosis Agents, Oral PA form*	Prior authorization (PA) is required for oral cystic fibrosis agents. Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of cystic fibrosis; and 3. Patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by an FDA-cleared CF mutation test (attach test results) for which the requested drug is indicated; and 4. Prescriber is a CF specialist or pulmonologist; and 5. Baseline liver function tests (AST, ALT, and bilirubin) are provided; and 6. Requests for Trikafta will not be considered for patients with severe hepatic impairment (Child-Pugh Class C); and 7. Will not be used with other CFTR modulator therapies. If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met: 1. Adherence to oral cystic fibrosis therapy is confirmed; and 2. Liver function tests (AST, ALT, and bilirubin) are assessed every 3 months during the first year of treatment and annually thereafter.
Dalfampridine (Ampyra) *Use Dalfampridine (Ampyra™) PA form*	Prior authorization (PA) is required for dalfampridine (Ampyra). Payment will be considered under the following conditions: 1. For patients that have a gait disorder associated with MS. 2. Initial authorizations will be approved for 12 weeks with a baseline Timed 25-foot Walk (T25FW) assessment. 3. Additional PAs will be considered at 6 month intervals after assessing the benefit to the patient as measured by a 20% improvement in the T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained. PAs will not be considered for patients with a seizure diagnosis or in patients will moderate to severe renal impairment.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Deferasirox (Exjade) *Use Deferasirox (Exjade) PA form*	Prior authorization (PA) is required for deferasirox. Requests will only be considered for FDA approved dosing. 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. **Transfusional Iron Overload** 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 overlaod; and 4. Serum ferritin is consistently > 1000 mcg/L (attach lab results dates within the past month); and 5. Starting dose does not exceed: Exjade- 20mg/kg/day or Jadenu- 14mg/kg/day. Calculate dose to the nearest whole tablet. 6. Initial requests will be considered for up to 3 months. Continuation of Therapy 1. Serum ferritin has been measured within 30 days of continuation of therapy request (attach documentation); and 2. Ferritin levels are > 500mcg/L; and 3. Dose does not exceed: Exjade- 40mg/kg/day or Jadenu- 28mg/kg/day. **Non-Transfusional Iron Overload** 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; and 5. LIC are > 5mg Fe/g dw; and 6. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 20mg/kg/day (if LIC is > 15mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is ≤ 15mg Fe/g dw), or 14mg/kg/day (if LIC is > 15mg Fe/g dw). 7. Initial authorization will be considered for up to 6 months. Continuation of Therapy 1. Serum ferritin and LIC have been measured within 30 days of continuation of therapy request; and 2. Serum ferritin levels are ≥ 300mcg/L; and 3. LIC is ≥ 3mg Fe/g dw; and 4. Dose does not exceed: Exjade- 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw) or Jadenu- 10mg/kg/day (if LIC is 3 to 7 mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw).

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Deucravacitinib (Sotyktu) *Use Deucravacitinib (Sotyktu) PA form*	Prior authorization (PA) is required for deucravacitinib (Sotyktu). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of plaque psoriasis; and a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine is provided; and b. Documentation of a trial and inadequate response to the preferred adalimumab agent; and c. Will not be combined with any of the following systemic agents: biologic DMARD, Janus kinase inhibitor, phosphodiesterase 4 (PDE4) inhibitor, or potent immunosuppressant. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Dextromethorphan and Quinidine (Nuedexta) *Use Dextromethorphan and Quinidine (Nuedexta) PA form*	Prior authorization (PA) is required for Nuedexta. Payment will be considered under the following conditions: 1. Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to a neurological condition. 2. A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI; and 3. Patient has documentation of a current EKG (within the past 3 months) without QT prolongation. 4. Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire. 5. Subsequent prior authorizations will be considered at 6 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.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Direct Oral Anticoagulants *Use Direct Oral Anticoagulants PA form*	Prior authorization (PA) is not required for preferred direct oral anticoagulants (DOACs). PA is required for non-preferred DOACs. Requests will be considered for FDA approved dosing and length of therapy for submitted diagnosis. Requests for doses outside of the manufacturer recommended dose will not be considered. Payment will be considered for FDA approved or compendia indications for the requested drug under the following conditions: 1. Patient is within the FDA labeled age for indication; and 2. Patient does not have a mechanical heart valve; and 3. Patient does not have active bleeding; and 4. For a diagnosis of atrial fibrillation or stroke prevention, patient has the presence of at least one additional risk factor for stroke, with a CHA_2DS_2-VASc score ≥1; and 5. A recent creatinine clearance (CrCl) is provided; and 6. A recent Child-Pugh score is provided; and 7. Patient's current body weight is provided; and 8. Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred DOACs; and. 9. For requests for edoxaban, when prescribed for the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE), documentation patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin) is provided. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Dornase Alfa (Pulmozyme) *Use Miscellaneous PA form*	Prior authorization (PA) is required for Pulmozyme. Payment will be authorized only for cases in which there is a diagnosis of cystic fibrosis.

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Updated 10/01/2024

Dupilumab (Dupixent)	Prior authorization (PA) is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient's current weight in kilograms (kg) is provided; and 3. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and a. Is prescribed by or in consultation with a dermatologist, allergist, or immunologist; and b. Patient has failed to respond to good skin care and regular use of emollients; and c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and d. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and e. Patient will continue with skin care regimen and regular use of emollients; and 4. Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) or with oral corticosteroid dependent asthma; and a. Is prescribed by or in consultation with an allergist, immunologist, or pulmonologist; and b. Has a pretreatment forced expiratory volume in 1 second (FEV_1) ≤ 80% predicted in adults; < 90% predicted in adolescents 12 to 17 years of age; and < 95% predicted in children 6 to 11 years of age; and c. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long acting beta $_2$ agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and d. Patient must have one of the following, in addition to the regular maintenance medications defined above: i. One (1or more exacerbations in the previous year or ii. Require daily oral corticosteroids for at least 3 days; or 5. Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and a. Documentation dupilumab will be used as an add-on maintenance treatment; and b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories: i. Nasal corticosteroid spray; and ii. Oral corticosteroid; or 6. Patient has a diagnosis of eosinophilic esophagitis (EoE); and

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use Dupilumab (Dupixent) PA form	a. Is prescribed by, or in consultation with, an allergist, gastroenterologist, or immunologist; and b. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and c. Patient has signs and symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain, heartburn regurgitation, chest pain and/or, odynophagia); and d. Documentation of previous trials and therapy failures with all of the following: i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension): and iii. Dietary therapy; or 7. Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and a. Is prescribed by, or in consultation with an allergist, immunologist, or dermatologist; and b. Patient has experienced severe to very severe pruritits, as demonstrated by a current Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7; and c. Patient has ≥ 20 nodular lesions (attach documentation); and d. Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; and 8. Dose does not exceed the FDA approved dosing for indication. If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Duplicate Therapy Edits **Antipsychotics** **NSAIDs** *Use Duplicate Therapy Edit Override PA form*	Designated therapeutic classes are subject to duplicate therapy edits. Providers should submit a Prior Authorization request for override consideration.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Eluxadoline (Viberzi) *Use Eluxadoline (Viberzi) PA form*	Prior authorization (PA) is required for eluxadoline. Only FDA approved dosing will be considered. Payment will be considered under the following conditions: 1. Patient meets the FDA approved age. 2. Patient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D). 3. Patient does not have any of the following contraindications to therapy: a. Patient is without a gallbladder. b. Known or suspected biliary duct obstruction, or sphincter of Oddi disease/dysfunction. c. Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than 3 alcoholic beverages per day. d. A history of pancreatitis or structural diseases of the pancreas (including known or suspected pancreatic duct obstruction). e. Severe hepatic impairment (Child-Pugh Class C). f. Severe constipation or sequelae from constipation. g. Known or suspected mechanical gastrointestinal obstruction. 4. Patient has documentation of a previous trial and therapy failure at a therapeutic dose with both of the following: a. A preferred antispasmodic agent (dicyclomine or hyoscyamine). b. A preferred antidiarrheal agent (loperamide). If criteria for coverage are met, initial authorization will be given for 3 months to assess the response to treatment. Requests for continuation of therapy will require the following: 1. Patient has not developed any contraindications to therapy (defined above). 2. Patient has experienced a positive clinical response to therapy as demonstrated by at least one of the following: a. Improvement in abdominal cramping or pain. b. Improvement in stool frequency and consistency. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Eplerenone (Inspra) *Use Miscellaneous PA form*	Prior authorization (PA) is required for Inspra. Payment will be authorized only in cases where there is documented trial and therapy failure on spironolactone or documented cases of gynecomastia from spironolactone therapy.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Erythropoiesis Stimulating Agents *Use Erythropoesis Stimulating Agent PA form*	Prior authorization (PA) is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for non-preferred 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 PA for the use of erythropoiesis stimulating agents: 1. 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. 2. 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. 3. For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy. 4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.
Extended Release Formulations *Use Extended Release Formulations PA form*	Payment for a non-preferred extended release formulation will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. 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 3. 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 (PA) is required for the following extended release formulation(s): Adoxa, Amoxicillin ER, Astagraf XL, Augmentin XR, Cardura XL, Carvedilol ER, Coreg CR, Doryx, Elepsia XR, Envarsus XR, Glumetza, Gocovri, Gralise, Kapspargo, Keppra XR, Lamictal XR, Luvox CR, Memantine ER, Mirapex ER, Motpoly XR, Moxatag, Namenda XR, Oleptro, Osmolex ER, Oxtellar XR, Pramipexole ER, Pregabalin ER, Prozac Weekly, Qudexy XR, Rayos, Requip XL, Rythmol SR, Solodyn ER, Topiramate ER, Trokendi XR, Ximino.
Fentanyl, Short Acting Products *Use Short Acting Fentanyl Products PA form*	Prior authorization (PA) is required for short acting fentanyl products. Payment will be considered only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. These products carry a **Black Box Warning**. Short acting fentanyl products: 1. Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain. 2. 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 in opioid non-tolerant patients.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Fifteen Day Initial Prescription Supply Limit *Use Fifteen Day Initial Prescription Supply Limit PA form*	Designated drugs are limited to a fifteen day initial supply. 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. Providers must submit a prior authorization (PA) request for override consideration. Documentation of medical necessity, excluding patient convenience, is required for consideration of the fifteen day initial supply override.
Finerenone (Kerendia) *Use Finerenone (Kerendia) PA form*	Prior authorization (PA) is required for finerenone (Kerendia). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling, including age, dosing, contraindications, warnings and precautions, and drug interactions; and 2. Patient has a diagnosis of chronic kidney disease (CKD) associated with Type 2 Diabetes (T2D); and 3. Patient is currently receiving a maximally tolerated dose of an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB); and 4. Patient is currently receiving a maximally tolerated dose of a sodium-glucose co-transporter 2 (SGLT2) inhibitor indicated to reduce the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, and hospitalization for heart failure in adults with chronic kidney disease [i.e., dapagliflozin (Farxiga)]; and 5. Patient has the following baseline tests prior to initiation of treatment with finerenone: a. Serum potassium is ≤5.0 mEq/L; and b. Estimated glomerular filtration rate (eGFR) is ≥ 25 mL/min/1.73m^2; and c. Urine albumin to creatinine ration (UACR) is ≥ 30 mg/g. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Initial authorizations will be approved for six months. Additional PAs will be considered with the following documentation: 1. Patient's serum potassium is < 5.5 mEq/L; and 2. Patient's eGFR is ≥ 25 mL/min/1.73m2; and 3. Patient remains on a maximally tolerated dose of an ACEi or ARB; and 4. Patient remains on a maximally tolerated dose of an SGLT2 inhibitor.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

GLP-1 Agonist/Basal Insulin Combinations *Use GLP-1 Agonist/Basal Insulin Combinations PA form*	Prior authorization (PA) is required for GLP-1 agonist receptor/basal insulin combination products. Payment will be considered for patients when the following criteria are met: 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; and 4. Documentation of an adequate trial and inadequate response with at least one preferred GLP-1 receptor agonist and one preferred long-acting insulin agent concurrently; and 5. Will not be used concurrently with prandial insulin; and 6. Clinical rationale is provided as to why the patient cannot use a preferred GLP-1 receptor agonist and a preferred long-acting insulin agent concurrently; and 7. Medication will be discontinued and alternative antidiabetic products will be used if patients require a daily dosage of: a. Soliqua below 15 units or over 60 units, or b. Xultophy persistently below 16 units or over 50 units.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral *Use Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral PA form*	Prior authorization (PA) is required for oral gonadotropin-releasing hormone (GnRH) antagonists. Payment for non-preferred oral GnRH antagonists may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent. Payment will be considered for patients when the following is met: 1. Pregnancy has been ruled out; and 2. Patient does not have osteoporosis; and 3. Request adheres to all FDA approved labeling for requested drug, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 4. Requests for elagolix (Orilissa) or relugolix, estradiol, norethindrone acetate (Myfembree) will be considered under the following conditions: a. Patient has a diagnosis of moderate to severe pain associated with endometriosis; and b. Patient has documentation of a previous trial and therapy failure with at least one preferred oral NSAID and at least one preferred 3-month course of a continuous hormonal contraceptive taken concurrently; and c. Patient has documentation of a previous trial and therapy failure with a preferred GnRH agonist. d. Initial requests will be considered for 3 months. Additional requests will be considered upon documentation of improvement of symptoms; and e. Requests will be considered based on drug, dose, and length of therapy: i. Orilissa- maximum duration of therapy of 24 months for the 150mg dose and six (6) months for the 200mg dose; or ii. Myfembree- maximum duration of therapy of 24 months; or 5. Requests for elagolix, estradiol, and norethindrone acetate; elagolix (Oriahnn) or relugolix, estradiol, norethindrone acetate (Myfembree) will be considered under the following conditions: a. Patient is premenopausal; and b. Patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids); and c. Patient has documentation of a previous trial and therapy failure with at least one preferred 3-month course of a continuous hormonal contraceptive; and d. Patient has documentation of a previous trial and therapy failure with tranexamic acid. e. Initial requests will be considered for 6 months. Additional requests will be considered upon documentation of improvement of symptoms. f. Requests will be considered for a maximum duration of therapy of 24 months. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Granulocyte Colony Stimulating Factor Agents *Use Granulocyte Colony Stimulating Factor PA form*	Prior authorization (PA) 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 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: 1. Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy. 2. Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant. 3. Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy. 4. Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients. On current chemotherapy drug(s) that would cause severe neutropenia.
Growth Hormone	Prior authorization (PA) is required for therapy with growth hormones. Requests will only be considered for FDA approved dosing. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. 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). Payment will be considered under the following conditions: Children with Growth Hormone Deficiency 1. Standard deviation of 2.0 or more below mean height for chronological age; and 2. No expanding intracranial lesion or tumor diagnosed by MRI; and 3. Growth rate below five centimeters per year; and 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter; and 5. Annual bone age testing is required. A Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 6. Epiphyses open. Pediatric Chronic Kidney Disease 1. Is prescribed by or in consultation with a nephrologist; and 2. Standard deviation of 2.0 or more below mean height for chronological age; and 3. No expanding intracranial lesion or tumor diagnosed by MRI; and 4. Growth rate below five centimeters per year; and 5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 6. Epiphyses open. Turner's Syndrome 1. Chromosomal abnormality showing Turner's syndrome; and 2. Prescribed by or in consultation with an endocrinologist; and 3. Standard deviation of 2.0 or more below mean height for chronological age; and 4. No expanding intracranial lesion or tumor diagnosed by MRI; and 5. Growth rate below five centimeters per year; and 6. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 7. Epiphyses open.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use Growth Hormone PA form	Prader Willi Syndrome 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; and 3. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 4. Epiphyses open. Noonan Syndrome 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; and 3. Standard deviation of 2.0 or more below mean height for chronological age; and 4. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 5. Epiphyses open. SHOX (Short stature Homeobox) 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and 2. Prescribed by or in consultation with an endocrinologist; and 3. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and 4. Epiphyses open. Adults with Growth Hormone Deficiency 1. Patients who were growth hormone deficient during childhood (childhood onset) and who have a continued deficiency; or 2. Patients who have growth hormone deficiency (adult onset) as a result of pituitary or hypothalamic disease (e.g., panhypopituitarism, pituitary adenoma, trauma, cranial irradiation, pituitary surgery); and 3. Failure of at least one growth hormone stimulation test as an adult with a peak growth hormone value of ≤ 5 mcg/L after stimulation. Adults with AIDS Wasting/Cachexia 1. Greater than 10% of baseline weight loss over 12 months that cannot be explained by a concurrent illness other than HIV infection; and 2. Patient is currently being treated with antiviral agents; and 3. Patient has documentation of a previous trial and therapy failure with an appetite stimulant (i.e. dronabinol or megestrol). Short Bowel Syndrome If the request is for Zorbtive [somatropin (rDNA origin) for injection] approval will be granted in patients receiving specialized nutritional support. Zorbtive therapy should be used in conjunction with optimal management of Short Bowel Syndrome. PA will be considered for a maximum of 4 weeks. If the criteria for coverage is met, initial requests will be given for 12-month periods, unless otherwise stated above. Additional PAs will be considered upon documentation of clinical response to therapy and patient continues to meet the criteria for the submitted diagnosis.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Hematopoietics/ Chronic ITP *Use Hematopoietics/Chronic ITP PA form*	Prior authorization (PA) is required for hematopoietics/chronic ITP agents. Request must adhere to all FDA approved labeling. Payment for a non-preferred hematopoietic/chronic ITP agent will be considered following documentation of a recent trial and therapy failure with a preferred hematopoietic/ITP agent, when applicable, unless such a trial would be medically contraindicated. Payment will be considered under the following conditions: 1. A diagnosis of thrombocytopenia with chronic immune thrombocytopenia (ITP) (Doptelet, Promacta, Nplate, Tavalisse) a. Patient has documentation of an insufficient response to a corticosteroid, immunoglobulin, or splenectomy. 2. A diagnosis of severe aplastic anemia (Promacta) a. Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy; and b. Patient has a platelet count less than or equal 30 x 10^9/L. c. 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. 3. A diagnosis of thrombocytopenia with chronic liver disease in patients who are scheduled to undergo a procedure with the following documentation (Doptelet, Mulpleta): a. Pre-treatment platelet count; and b. Scheduled dosing prior to procedure; and c. Therapy completion prior to scheduled procedure; and d. Platelet count will be obtained before procedure.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Hepatitis C Treatments, Direct Acting Antivirals *Use Hepatitis C Treatments, Direct Acting Antivirals PA form*	Prior authorization (PA) is required for hepatitis C direct-acting antivirals (DAA). Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. 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 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. Patient's prior HCV DAA treatment history is provided (treatment naïve or treatment experienced); and 5. DAAs approved for pediatric use will be considered for those under the age of 18 when used in accordance with current AASLD guidelines and patient's weight is provided; and 6. Patient does not have limited life expectancy (less than 12 months) due to non-liver related comorbid conditions. 7. 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 length of therapy for the particular treatment. 8. The 72-hour emergency supply rule does not apply to DAAs. Requests for treatment-experienced patients (with previous DAA) will be considered under the following conditions: 1. Patient must meet all criteria for treatment approval above; and 2. The requested therapy is FDA approved as therapy for treatment-experienced patients and follows current AASLD guidelines; and 3. HCV retreatment is prescribed by or in consultation with a digestive disease, liver disease, or infectious disease provider practice; and 4. Patient has not been previously treated with and failed the requested DAA therapy; and 5. Documentation is provided patient has a documented presence of detectable HCV RNA at least 12 weeks after completing previous DAA treatment.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

High Dose Opioids	Prior authorization (PA) is required for use of high-dose opioids ≥ 90 morphine milligram equivalents (MME) per day (See CDC Guideline for Prescribing Opioids for Chronic Pain at https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/index.html). Patients undergoing active cancer treatment or end-of-life care will not be subject to the criteria below. Payment will be considered when the following is met: 1. Requests for non-preferred opioids meet criteria for coverage (see criteria for Long-Acting Opioids and/or Short-Acting Opioids); and 2. Patient has a diagnosis of severe, chronic pain with a supporting ICD-10 code. Requests for a diagnosis of fibromyalgia or migraine will not be considered; and 3. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 4. Patient has tried and failed at least two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants; and 5. There is documentation demonstrating an appropriate upward titration or an appropriate conversion from other opioid medications; and 6. Pain was inadequately controlled at the maximum allowed dose without prior authorization for the requested opioid(s); and 7. Pain was inadequately controlled by 2 other chemically distinct preferred long-acting opioids at the maximum allowed dose without prior authorization; and 8. Chart notes from a recent office visit or telehealth visit for pain management are included documenting the following: a. Treatment plan – including all therapies to be used concurrently (pharmacologic and non-pharmacologic); and b. Treatment goals; and 9. Patient has been informed of the risks of high-dose opioid therapy; and 10. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that use of high-dose opioid therapy is appropriate for this patient; and 11. The patient's risk for opioid addiction, abuse and misuse has been reviewed and prescriber has determined the patient is a candidate for high-dose opioid therapy; and 12. A signed chronic opioid therapy management plan between the prescriber and patient dated within 12 months of this request is included; and 13. The requested dosing interval is no more frequent than the maximum FDA-approved dosing interval; and 14. Patient has documentation of receipt of an opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP of dispensation [attach documentation] within the prior 24 months of high dose opioid request for the emergency treatment of an opioid overdose; and 15. Patient has been educated on opioid overdose prevention; and 16. Patient's household members have been educated on the signs of opioid overdose and how to administer an opioid reversal agent; and

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use High Dose Opioids PA form	17. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with initial and subsequent requests; and 18. A documented dose reduction is attempted at least annually. If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of high-dose opioid therapy will be considered every 6 months with the following: 1. High-dose opioid therapy continues to meet treatment goals, including sustained improvement in pain and function; and 2. Patient has not experienced an overdose or other serious adverse event; and 3. Patient is not exhibiting warning signs of opioid use disorder; and 4. The benefits of opioids continue to outweigh the risks; and 5. A documented dose reduction has been attempted at least annually, and the prescriber has determined the dose cannot be reduced at this time; and 6. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that continued use of high-dose opioid therapy is appropriate for this patient; and 7. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with subsequent requests. 8. Patient has documentation of receipt of an opioid reversal agent (e.g. as seen in pharmacy claims or documentation from the Iowa PMP [attach documentation] within 24 months of high dose opioid request for the emergency treatment of an opioid overdose; and 9. Patient has been reeducated on opioid overdose prevention; and 10. Patient's household members have been reeducated on the signs of opioid overdose and how to administer an opioid reversal agent.

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Updated 10/01/2024

IL-5 Antagonists *Fasenra* *Nucala*	Prior authorization is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of severe asthma with an eosinophilic phenotype, and a. Patient has a pretreatment blood eosinophil count of ≥ 150 cells/mcL within the previous 6 weeks or blood eosinophils ≥ 300 cells/mcL within 12 months prior to initiation of therapy; and b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and c. Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and d. A pretreatment forced expiratory volume in 1 second (FEV_1) < 80% predicted in adults and < 90% in adolescents; or 3. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis, and a. Patient has documentation of an adequate trial and therapy failure with systemic glucocorticoids; and b. One of the following: i. Eosinophil count > 1000 cells/mcL; or ii. Eosinophil count > 10% of the total leukocyte count; and 4. Patient has a diagnosis of hypereosinophilic syndrome (HES); and a. Patient has been diagnosed with HES for ≥ 6 months prior to starting treatment; and b. Documentation that non-hematologic secondary causes of HES have been ruled out; and c. Documentation patient does not have FIP1L1-PDGFRα kinase-positive HES: and d. Documentation of ≥ 2 HES flares within the previous 12 months while on stable HES therapy (e.g., chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy); and e. Patient has a blood eosinophil count ≥ 1,000 cells/mcL; and f. Medication will be used in combination with stable doses of at least one other HES therapy; and 5. Patient has a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP); and a. Documentation mepolizumab will be used as an add-on maintenance treatment with a nasal corticosteroid spray; and

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Updated 10/01/2024

Use IL-5 Antagonists PA form	b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories: i. Nasal corticosteroid; and ii. Oral corticosteroid; and 6. Prescribed by or in consultation with an allergist, hematologist, immunologist, otolaryngologist, pulmonologist, or rheumatologist. If criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis or 6 months for a diagnosis of hypereosinophilic syndrome or CRSwNP to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met: Severe Asthma with an Eosinophilic Phenotype: 1. Patient continues to receive therapy with an ICS, LABA and LTRA; and 2. Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or 3. Patient has experienced a decrease in administration of rescue medication (albuterol); or 4. Patient has experienced a decrease in exacerbation frequency; or 5. Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline. Eosinophilic Granulomatosis with Polyangiitis 1. Patient has demonstrated a positive clinical response to therapy (increase in remission time). Hypereosinophilic Syndrome: 1. Patient has demonstrated positive clinical response to therapy (improvement of symptoms and/or reduction in the number of flares); and 2. Medication continues to beused in combination with stable doses or at least one other HES therapy. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) 1. Patient has demonstrated positive clinical response to therapy (improvement in symptoms); and 2. Continues to receive medication as add-on maintenance therapy with a nasal corticosteroid spray. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Immunomodulators-Topical *Elidel* *Protopic* *Use Immunomodulators-Topical PA form*	Prior authorization (PA) is required for topical immunomodulators. Payment for non-preferred topical immunomodulator products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. 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 one preferred topical corticosteroid, except on the face or groin. 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. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Updated 10/01/2024

Initial Days' Supply Limit Override *Use Initial Days' Supply Limit Override PA form*	Requests for medications exceeding the initial days' supply limit require prior authorization. Payment will be considered under the following conditions: 1. Patient has an FDA approved or compendia indication for the requested drug; and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3. Medical rationale for exceeding the initial days' supply limit is provided; and 4. Requests for opioids exceeding the 7 day initial supply limit will be considered: a. For patients with active cancer, patients experiencing acute sickle cell crises, end-of-life/palliative care, or on an individual case-by-case basis based on medical necessity documentation provided; and b. Request must meet all other opioid requirements (quantity limits, morphine milligram equivalents (MME), and the preferred drug list (PDL). If requests do not comply with these requirements, separate, additional, prior authorization is required. Please reference and use the following prior authorization (PA) forms at www.iowamedicaidpdl.com where appropriate: i. Quantity Limit Override Form (exceeds established quantity limit) ii. High Dose Opioid PA Form (exceeds established MME limit) iii. Short-Acting Opioids PA Form (non-preferred short-acting opioids) iv. Long-Acting Opioids PA Form (non-preferred long-acting opioids); or 5. Requests for benzodiazepines exceeding the 7 day initial supply limit will be considered: a. For patients with active cancer, end-of-life/palliative care, seizure disorder, or on an individual case-by-case basis based on medical necessity documentation provided; and b. For patients taking concurrent opioids, the prescriber must document the following: i. The risks of using an opioid and benzodiazepine concurrently have been discussed with the patient; and ii. Documentation is provided as to why concurrent use is medically necessary; and iii. A plan to taper the opioid is provided, if appropriate; and c. Request must meet all other benzodiazepine requirements (quantity limit, PDL, etc). If requests do not comply with these requirements, separate, additional prior authorization is required. Please use the following PA forms at www.iowamedicaidpdl.com where appropriate: i. Benzodiazepines (non-preferred benzodiazepine) ii. Quantity Limit Override (as posted at www.iowamedicaidpdl.com under Billing/Quantity Limits); and 6. Requests for drugs or drug classes subject to the initial days' supply limit not listed above, will be considered on an individual case-by-case basis, based on medical necessity documentation provided.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Isotretinoin (Oral) *Use Oral Isotretinoin PA form*	Prior authorization (PA) is required for oral isotretinoin therapy. Payment will be considered for preferred oral isotretinoin products for moderate to severe acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative (tretinoin or adapalene) therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative therapy are not required for approval for treatment of acne conglobata; and 2. Prescriber attests patient has enrolled in and meets all requirements of the iPLEDGE 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 24 weeks. A minimum of 8 weeks without therapy is required to consider subsequent authorizations. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Ivabradine (Corlanor) *Use Ivabradine (Corlanor) PA form*	Prior authorization (PA) is required for ivabradine. Only FDA approved dosing will be considered. Payment will be considered under the following conditions: 1. Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV); and a. Patient is 18 years of age or older; and b. Patient has documentation of a left ventricular ejection fraction ≤35%; and c. Patient is in sinus rhythm with a resting heart rate of ≥70 beats per minute; and d. Patient has documentation of blood pressure ≥90/50 mmHg; or 2. Patient has a diagnosis of stable symptomatic heart failure (NYHA/Ross class ll to lV) due to dilated cardiomyopathy, and a. Pediatric patient age 6 months and less than 18 years old; and b. Patient has documentation of a left ventricular ejection fraction ≤45%; and b. Patient is in sinus rhythm with a resting heart rate (HR) defined below; i. 6 to 12 months – HR ≥ 105 bpm ii. 1 to 3 years- HR ≥ 95 bpm iii. 3 to 5 years- HR ≥ 75 bpm iv. 5 to 18 years- HR ≥ 70 bpm; and 3. Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g. carvedilol 50mg daily, metoprolol succinate 200mg daily, or bisoprolol 10mg daily) or weight appropriate dosing for pediatric patients, or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and 4. Patient has documentation of a trial and continued use with a preferred angiotensin system blocker at a maximally tolerated dose. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Janus Kinase Inhibitors	Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug, excluding requests for the FDA approved indication of alopecia areata, vitiligo, or other excluded medical use(s), as defined in Section 1927 (d)(2) of the Social Security Act, State Plan, and Rules when the following conditions are met: 1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3. Patient has a diagnosis of: a. Moderate to severe rheumatoid arthritis; with i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR b. Psoriatic arthritis; with i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR c. Moderately to severely active ulcerative colitis; with i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and ii. A documented trial and inadequate response with a preferred TNF inhibitor; and iii. If requested dose is for tofacitinib 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit; OR d. Moderately to severely active Crohn's disease upadacitinib); with i. A documented trial and inadequate response to two preferred conventional therapies including aminosalicylates (sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate; and ii. A documented trial and inadequate response with a preferred TNF inhibitor; OR e. Polyarticular Course Juvenile Idiopathic Arthritis; with i. A documented trial and inadequate response to intraarticular glucocorticoid injections; and ii. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use Janus Kinase Inhibitor PA form	iii. A documented trial and inadequate response with a preferred TNF inhibitor; OR f. Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis); with i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR g. Atopic dermatitis; with i. Documentation patient has failed to respond to good skin care and regular use of emollients; and ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and iv. For mild to moderate atopic dermatitis: a. A documented trial and therapy failure with crisaborole; and b. Affected area is less than 20% of body surface area (BSA); and c. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or v. For moderate to severe atopic dermatitis: a. A documented trial and therapy failure with cyclosporine or azathioprine; and b. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Ketorolac *Use Ketorolac PA form*	Prior authorization (PA) is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short term (up to five days) management of moderately severe, acute pain. 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 (5) days. Payment will be considered under the following conditions: 1. For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given. 2. Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40mg/day. Maximum IV/IM dose is 120mg/day. Maximum intranasal dose is 126mg/day. Maximum combined duration of therapy is 5 days per month. 3. 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 non-steroidal anti-inflammatory drugs at therapeutic doses.

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Letermovir (Prevymis) *Use Letermovir (Prevymis) PA form*	Prior authorization (PA) is required for oral letermovir. Requests for intravenous letermovir should be directed to the member's medical benefit. Payment will be considered under the following conditions: 1. Medication is to be used for the prophylaxis of cytomegalovirus (CMV) infection and disease; and 2. Patient or donor is CMV-seropositive R+ (attach documentation); and 3. Patient has received an allogeneic hematopoietic stem cell transplant (HSCT) within the last 28 days (provide date patient received HSCT); and 4. Is prescribed by or in consultation with a hematologist, oncologist, infectious disease or transplant specialist; and 5. Patient is 18 years of age or older; and 6. Dose does not exceed: a. 240mg once daily when co-administered with cyclosporine; b. 480mg once daily; and 7. Patient must not be taking the following medications: a. Pimozide; or b. Ergot alkaloids (e.g., ergotamine, dihydroergotamine); or c. Rifampin; or d. Atorvastatin, lovastatin, pitavastatin, simvastatin, or repaglinide when co-administered with cyclosporine; and 8. Patient does not have severe (Child-Pugh Class C) hepatic impairment (provide score); and 9. Therapy duration will not exceed 100 days post-transplantation.
Lidocaine Patch (Lidoderm) *Use Lidocaine Patch (Lidoderm) PA form*	Prior authorization (PA) is required for topical lidocaine patches. Payment will be considered only for cases in which there is a diagnosis of pain associated with post-herpetic neuralgia. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Linezolid (Zyvox) *Use linezolid (Zyvox) PA form*	Prior authorization (PA) is required for linezolid. Payment for linezolid will be authorized when there is documentation that: 1. The patient has an active infection and meets one of the following diagnostic criteria: a. Vancomycin-resistant Enterococcus (VRE); or b. Methicillin-resistant Staph aureus (MRSA); or c. Methicillin-resistant Staph epidermis (MRSE); or d. Other multiply resistant gram positive infection (e.g. penicillin resistant Streptococcus spp); and 2. Patient meets ONE of the following criteria: a. Patient is severely intolerant to vancomycin with no alternative regimens with documented efficacy available*, or b. VRE in a part of the body other than lower urinary tract**, or c. Patient discharged on linezolid and requires additional quantity (up to 10 days oral therapy will be allowed). 3. A current culture and sensitivity report is provided documenting sensitivity to linezolid. *Severe intolerance to vancomycin is defined as: 1. Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration 2. 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.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Long-Acting Opioids *Use Long-Acting Opioids PA form*	Prior authorization (PA) is required for all non-preferred long-acting opioids. PA is also required for members when the total daily opioid use (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). Payment will be considered under the following conditions: 1. Patient has a diagnosis of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment; and 2. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 3. Patient has tried and failed at least two nonopioid pharmacologic therapies (e.g., acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants); and 4. There is documentation of previous trial and therapy failure with one preferred long-acting opioid at maximally tolerated dose; and 5. A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization; and 6. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and determine if use of a long-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and. 7. Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids. 8. Requests for long-acting opioids will only be considered for FDA approved dosing intervals. As-needed (PRN) dosing will not be considered; and 9. For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met: 1. Patient has experienced improvement in pain control and level of functioning; and 2. Prescriber has reviewed the patient's use of controlled substances on the Iowa PMP and has determined continued use of a long-acting opioid is appropriate for this member; and 3. For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Mannitol Inhalation Powder (Bronchitol) *Use Mannitol Inhalation Powder (Bronchitol) PA form*	Prior authorization is required for mannitol inhalation powder (Bronchitol). Payment will be considered when the following criteria are met: 1. Patient has a diagnosis of cystic fibrosis; and 2. Patient meets the FDA approved age; and 3. Prescriber is a cystic fibrosis specialist or pulmonologist; and 4. Documentation is provided that patient has successfully completed the Bronchitol tolerance test (BTT); and 5. Patient will pre-medicate with a short-acting bronchodilator; and 6. Dose does not exceed the FDA approved dose. If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met: 1. Adherence to mannitol inhalation powder (Bronchitol) therapy is confirmed; and 2. Patient has demonstrated improvement or stability of disease symptoms, such as improvement in FEV_1, decrease in pulmonary exacerbations, decrease in hospitalizations, or improved quality of life.
Maralixibat (Livmarli) *Use Maralixibat (Livmarli) PA form*	Prior authorization (PA) is required for maralixibat (Livmarli). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of Alagille syndrome (ALGS) confirmed by genetic testing demonstrating a *JAG1* or *NOTCH2* mutation or deletion; and 3. Patient has cholestasis with moderate to severe pruritis; and 4. Is prescribed by or in consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in ALGS; and 5. Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents: a. Ursodeoxycholic acid (ursodiol) b. Cholestyramine c. Rifampin; and 6. Patient's current weight in kilograms (kg) is provided. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. If criteria for coverage are met, initial authorizations will be given for 6 months to assess the response to treatment. Request for continuation of therapy will required documentation of an improvement in pruritis symptoms and patient's current wright in kg.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Mavacamten (Camzyos) *Use Mavacamten (Camzyos) PA form*	Prior authorization (PA) is required for mavacamten (Camzyos). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and 3. Patient exhibits symptoms of New York Heart Association (NYHA) class ll or lll symptoms; and 4. Is prescribed by or in consultation with a cardiologist; and 5. Patient has a left ventricular ejection fraction (LVEF) ≥ 55%; and 6. Patient has a peak left ventricular outflow tract (LVOT) gradient ≥ 50 mmHg at rest or with provocation; and 7. Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following: a. Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and b. Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and c. Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by improvement in obstructive HCM symptoms.
Methotrexate Injection *Otrexup* *Rasuvo* *Use Methotrexate Injection PA form*	Prior authorization (PA) is required for non-preferred methotrexate injection. Payment will be considered under the following conditions: 1. Diagnosis of severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (PJIA) and ALL of the following: a. Prescribed by a rheumatologist; and b. Patient has a documented trial and intolerance with oral methotrexate; and c. Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD (hydroxychloroquine, leflunomide, or sulfasalazine); and d. 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 e. Patient does not reside in a long-term care facility. 2. Diagnosis of severe, recalcitrant, disabling psoriasis and ALL of the following: a. Patient is 18 years of age or older; and b. Prescribed by a dermatologist; and c. 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). d. 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 e. 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.

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The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment *Use Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment PA form*	Prior Authorization (PA) is required for miconazole-zinc oxide-white petrolatum (Vusion) Ointment. Payment will only be considered 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.
Mifepristone (Korlym) *Use Mifepristone (Korlym) PA form*	Prior authorization (PA) is required for mifepristone (Korlym). Payment will be considered for patients when the following is met: 1. The patient is 18 years of age or older: and 2. Has a diagnosis of endogenous Cushing's Syndrome with hyperglycemia secondary to hypercortisolism in patients with Type 2 Diabetes or glucose intolerance: and 3. Patient must have failed surgery or is not a candidate for surgery: and 4. Prescriber is an endocrinologist: and 5. Female patients of reproductive age must have a negative pregnancy test confirmed within the last 7 days and must use a non-hormonal method of contraception during treatment and for one month after stopping treatment.
Modified Formulations *Use Modified Formulations PA form*	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. The required trials may be overridden when documented evidence is provided that use of these preferred agent(s) would be medically contraindicated. Prior authorization is required for the following modified dosage forms: Abilify Discmelt, Adlarity, Alkindi, Aricept ODT, Aspruzyo, Binosto, Dartisla, Drizalma, Elyxyb, Eprontia, Exservan, Ezallor, FazaClo, Gimoti, Horizant, Lamotrigine ODT, Likmez, Metoclopramide ODT, Norliqva, Remeron SolTab, Risperidone ODT, Sertraline Caps, Sitavig, Spritam, Sympazan, Tramadol Oral Solution, Trilipix, Valsartan Oral Solution, Xopenex, Zyprexa Zydis.

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Updated 10/01/2024

Multiple Sclerosis Agents-Oral *Use Multiple Sclerosis Agents-Oral PA form*	For patients initiating therapy with a preferred oral multiple sclerosis agent, a manual prior authorization (PA) is not required if a preferred injectable interferon or non-interferon agent is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided: 1. A diagnosis of relapsing forms of multiple sclerosis; and 2. Request must adhere to all FDA approved labeling, including indication, age, dosing, contraindications, and warnings and precautions; and 3. Documentation of a previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis. Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Muscle Relaxants *Use Muscle Relaxant PA form*	Prior authorization (PA) is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures 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 dose of 4 tablets per day when the criteria for coverage are met. * If a non-preferred 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.
Narcotic Agonist-Antagonist Nasal Sprays *Use Narcotic Agonist/Antagonist Nasal Spray PA form*	Prior authorization (PA) is required for narcotic agonist-antagonist nasal sprays. For consideration, the diagnosis must be supplied. 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 non-preferred 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.
New to Market Drugs *Use New to Market Drugs PA form*	Prior authorization (PA) is required for newly marketed drugs. Payment will be considered for patients when the following criteria are met: 1. Patient has an FDA approved or compendia indication for the requested drug; and 2. If the requested drug falls in a therapeutic category/class with existing prior authorization criteria, the requested drug must meet the criteria for the same indication; or 3. If no clinical criteria are established for the requested drug, patient has tried and failed at least two preferred drugs, when available, from the Iowa Medicaid Preferred Drug List (PDL) for the submitted indication; and 4. Request must adhere to all FDA approved labeling. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Once newly marketed drugs are reviewed by the Pharmaceutical & Therapeutics Committee, they will be placed on the PDL which will dictate ongoing PA criteria, if applicable.

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Nocturnal Polyuria Treatments *Use Nocturnal Polyuria Treatments PA form*	Prior authorization (PA) is required for nocturnal polyuria treatments. Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of nocturnal polyuria as confirmed by a 24-hour collection which notes the presence of greater than 33% of 24- hour urine productions occurring at night; and 3. Patient wakens at least 2 times at night to void; and 4. Patient has attempted fluid restriction in the evenings without improvement in nocturnal polyuria; and 5. Patient is not taking a diuretic in the evening; and 6. Patient does not have any of the following contraindications: a) Current or previous history of hyponatremia; and b) Primary nocturnal enuresis; and c) Polydipsia; and d) Concomitant use with loop diuretics, systemic or inhaled glucocorticoids; and e) Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion; and f) Estimated glomerular filtration rate < 50 mL/min.1.73m^2; and g) Illnesses that can cause fluid or electrolyte imbalance; and h) New York Heart Association (NYHA) Class ll-lV congestive heart failure; and i) Uncontrolled hypertension. Initial requests will be considered for 3 months. Requests for continuation of therapy will require the following: 1. Patient continues to meet above criteria; and 2. Patient has experienced a decrease in nocturnal voiding; and 3. There is no evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalances).
Non-Biologic Agents for Ulcerative Colitis *Use Non-Biologic Agents for Ulcerative Colitis PA form*	Prior authorization is required for select non-biologicals for ulcerative colitis (UC). Payment for non-preferred select non-biologics for UC may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent(s). Payment will be considered under the following conditions: 1. Patient has a diagnosis of moderately to severely active ulcerative colitis (UC) and 2. Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and 3. A documented trial and inadequate response to two preferred conventional therapies (immunomodulators) including aminosalicylates and azathioprine/6-mercaptopurine; and 4. A documented trial and inadequate response with a preferred biological DMARD; and 5. Will not be taken concomitantly with immunomodulators or biologic therapies. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products *Use Non-Parenteral Vasopressin Deriv. of Posterior Pituitary Hormone Products PA form*	Prior authorization (PA) is required for non-parenteral vasopressin derivatives of posterior pituitary hormone products. No PA is required for members 6 years of age or older when dosed within established quantity limits for desmopressin acetate tablets. 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. 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 and therapy failure with the preferred agent. Please refer to the Selected Brand-Name Drugs prior authorization form is requesting a non-preferred brand-name product.
Non-Preferred Drug *Use Non-Preferred Drug PA form*	Prior authorization (PA) is required for non-preferred drugs as specified on the Iowa Medicaid Preferred Drug List. Payment for a non-preferred medication will be considered for an FDA approved or compendia indicated diagnosis only for cases in which there is documentation of previous trial and therapy failure with the preferred agent(s), unless evidence is provided that use of these agents would be medically contraindicated. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations.
Nonsteroidal Anti-inflammatory Drugs *Use Non-Steroidal Anti-inflammatory Drug PA form*	Prior authorization (PA) is required for all non-preferred nonsteroidal anti-inflammatory drugs (NSAIDs). Payment for a non-preferred NSAID will be considered under the following conditions: 1. Documentation of previous trials and therapy failures with at least three preferred NSAIDs; and 2. Requests for a non-preferred extended release NSAID must document previous trials and therapy failures with three preferred NSAIDs, one of which must be the preferred immediate release NSAID of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Odevixibat (Bylvay) *Use Odevixibat (Bylvay) Drug PA form*	Prior authorization (PA) is required for odevixibat (Bylvay) Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling including age, dosing, contraindications, warnings and precautions, and drug interactions; and 2. Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) type 1 or 2; and a. Genetic testing does not indicate PFIC type 2 with ABCB 11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and b. Patient has moderate to severe pruritis associated with PFIC; or 3. Patient has a diagnosis of Alagille Syndrome (ALGS) confirmed by genetic testing demonstrating a JAGI or NOTCH2 mutation or deletion; and a. Patient has cholestasis with moderate to severe pruritis; and b. Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents: i. Ursodeoxycholic acid (ursodiol) ii. Cholesytramine iii. Rifampin; and 4. Patient's current weight in kg is provided; and

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	5. Is prescribed by or in consultation with a hepatologist, gastroenterologist, or a prescriber who specializes in PFIC or ALGS Initial authorizations will be approved for 3 months for initial treatment or after a dose increase. Additional authorizations will be considered when the following criteria are met: 1. Patient's current weight in kg is provided; and 2. Documentation is provided the patient has responded to therapy and pruritis has improved. If there is no improvement in pruritis after 3 months of treatment with the maximum 120 mcg/kg/day dose, further approval of odevixibat will not be granted.
Omalizumab (Xolair)	Prior authorization (PA) is required for omalizumab (Xolair) prefilled syringe. Requests for omalizumab (Xolair) lyophilized powder for reconstitution will not be considered through the pharmacy benefit. Payment for omalizumab (Xolair) prefilled syringe will be considered for FDA approved and compendia indications under the following conditions: 1. Patient meets the FDA approved age; and 2. Therapy will be initiated in a healthcare setting, under the guidance of a healthcare provider, where the patient can be closely observed for anaphylaxis and safety of therapy has been established after a minimum of 3 doses of omalizumab; and 3. The healthcare provider has determined self-administration with omalizumab is appropriate based on careful assessment of risk for anaphylaxis and mitigation strategies, as outlined in the label; and 4. Dose follows the FDA approved dosing for indication; and 5. Prescriber is an allergist, dermatologist, immunologist, otolaryngologist or pulmonologist; and 6. Patient has access to an epinephrine injection to treat allergic reactions that may occur after administration of omalizumab (Xolair); and 7. Prescriber and dispensing pharmacy will educate patient on proper storage and administration. Improperly stored medications will not be replaced. <u>Moderate to Severe Persistent Asthma</u> 1. Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and 2. Pretreatment IgE level is within the following range: a. Adults and adolescent patients 12 years of age or older - 30 IU/mL to 700 IU/mL; or b. Pediatric patients 6 to less than 12 years of age - 30 IU/mL to 1300 IU/mL; and 3. Patient's weight is within the following range: a. Adults and adolescent patients 12 years of age or older - 30 kg to 150 kg; or b. Pediatric patients 6 to less than 12 years of age - 20 kg to 150 kg; and 4. History of positive skin or RAST test to a perennial aeroallergen; and 5. Patient is currently using a high dose inhaled corticosteroid, long-acting beta-agonist, AND a leukotriene receptor antagonist, and is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy; and 6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances.

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Use Omalizumab (Xolair) PA form	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 omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a high dose corticosteroid, long-acting beta-agonist, and leukotriene receptor antagonist. <u>Chronic Idiopathic Urticaria</u> 1. Patient has a diagnosis of moderate to severe chronic idiopathic urticaria; and 2. Patient has documentation of a trial and therapy failure with at least one preferred second-generation antihistamine, one of which must be cetirizine at a dose up to 20 mg per day; and 3. Patient has documentation of a trial and therapy failure with at least one preferred first-generation antihistamine; and 4. Patient has documentation of a trial and therapy failure with at least one preferred potent H1 receptor antagonist (hydroxyzine and/or doxepin); and 5. Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first- or second-generation antihistamine. If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to omalizumab (Xolair) therapy. <u>Nasal Polyps</u> 1. Patient has a diagnosis of nasal polyps; and 2. Pretreatment IgE level is within the following range: a. Adults and adolescent patients 12 years of age or older - 30 IU/mL to 1500 IU/mL; and 3. Patient's weight is within the following range: a. Adults and adolescent patients 12 years of age or older - 30 kg to 150 kg; and 4. Patient has documentation of an adequate trial and inadequate response with at least two nasal corticosteroids at a maximally tolerated dose; and 5. Will be used concurrently with a nasal corticosteroid; and 6. Is dosed according to manufacturer labeling based on pretreatment serum IgE and body weight. Note: according to the label, there is insufficient data to recommend a dose for certain pretreatment serum IgE levels and body weight. PA requests will be denied in these instances. If criteria for coverage are met, the initial authorization will be given for 24 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 omalizumab (Xolair) therapy and for patients who do not continue concurrent use with a nasal corticosteroid. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Ophthalmic Agents for Presbyopia *Use Ophthalmic Agents for Presbyopia PA form*	Prior authorization (PA) is required for ophthalmic agents indicated for presbyopia. Requests will be considered when patient has an FDA approved or compendia indication for the requested drug. Payment for a non-preferred agent will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a documented diagnosis of presbyopia; and 3. Patient is aged 40-55 years old at start of therapy; and 4. Is prescribed by or in consultation with an ophthalmologist or optometrist; and 5. Patient has documentation of a therapeutic failure with corrective lenses (eyeglasses or contact lenses), unless contraindicated or clinically significant intolerance. If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered under the following conditions: 1. Patient has a documented improvement in presbyopia defined as the patient gained 3 lines or more is mesopic, high contrast, binocular distance corrected near vision acuity (DCNVA), without losing more than 1 line (5 letters) of corrected distance visual acuity (CDVA); and 2. Patient is not experiencing adverse effects from the drug.
Oral Constipation Agents	Prior authorization (PA) is required for oral constipation agents subject to clinical criteria. Payment for non-preferred oral constipation agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred oral constipation agent. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient must have documentation of adequate trials and therapy failures with the following: a. Member 18 years of age or older: i. Stimulant laxative (senna) plus saline laxative (milk of magnesia); and ii. Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose); or b. Member 17 years of age or younger: i. Polyethylene glycol; and ii. One other preferred generic laxative, such as lactulose or senna; and 3. Patient does not have a known or suspected mechanical gastrointestinal obstruction; and 4. Patient has one of the following diagnoses: a. A diagnosis of chronic idiopathic constipation (Amitiza, Linzess, Motegrity, Trulance) i. Patient has less than 3 spontaneous bowel movements (SBMs) per week; and ii. Patient has two or more of the following symptoms within the last 3 months: 1. Straining during at least 25% of bowel movements; 2. Lumpy or hard stools for at least 25% of bowel movements; and 3. Sensation of incomplete evacuation for at least 25% of bowel movements; and

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	iii. Documentation the patient is not currently taking constipation causing therapies; or b. A diagnosis of irritable bowel syndrome with constipation (Amitiza, Ibsrela, Linzess, or Trulance) i. Patient is female (Amitiza only); and ii. Patient has recurrent abdominal pain on average at least 1 day per week in the last 3 months associated with two (2) or more of the following: 1. Related to defecation; 2. Associated with a change in stool frequency; and/or 3. Associated with a change in stool form; or c. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza, Movantik, Relistor, or Symproic) i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and ii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following: 1. Hard to very hard stool consistency; 2. Moderate to very severe straining; and/or 3. Having a sensation of incomplete evacuation; or d. A diagnosis of functional constipation (Linzess) i. Patient has less than 3 SBMs per week; and 1 or more of the following criteria at least once per week for at least 2 months: 1. History of stool withholding or excessive voluntary stool retention; 2. History of painful or hard bowel movements; 3. History of large diameter stools that may obstruct the toilet; 4. Presence of a large fecal mass in the rectum; 5. At least 1 episode of fecal incontinence per week.
Use Oral Constipation Agents PA form	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 and patient continues to meet the age for indication.
Oral Glucocorticoids for Duchenne muscular dystrophy Agamree Deflazacort Emflaza *Use Oral Glucocorticoids for Duchenne muscular dystrophy PA form*	Prior authorization (PA) is required for oral glucocorticoids used for the treatment of Duchenne muscular dystrophy (DMD). Payment will be considered for patients when the following criteria are met: 1. Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene; and 2. Patient is within the FDA labeled age; and 3. Patient experienced onset of weakness before 5 years of age; and 4. Is prescribed by or in consultation with a physician who specializes in treatment of Duchenne muscular dystrophy; and 5. Patient has documentation of an adequate trial and therapy failure, intolerance, or significant weight gain (significant weight gain defined as 1 standard deviation above baseline percentile rank weight for height) while on prednisone at a therapeutic dose; and 6. Is dosed based on FDA approved dosing. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Oral Immunotherapy *Grastek* *Oralair* *Ragwitek* *Use Oral Immunotherapy PA form*	Prior authorization (PA) is required for sublingual allergen immunotherapy. Payment will be considered when patient has an FDA or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Medication is prescribed by or in consultation with an allergist or immunologist; and 3. Patient has documentation of an adequate trial and therapy failure with an intranasal corticosteroid and oral or nasal antihistamine used concurrently; and 4. Patient has a documented intolerance to immunotherapy injections; and 5. 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). 6. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved. Short Ragweed Pollen (Ragwitek®) In addition to the above criteria being met: 1. Patient is diagnosed with short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis; and and 2. Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen. 3. 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. Grass Pollen (Grastek and Oralair) In addition to the above criteria being met: 1. Request is for Oralair; and a. Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and b. 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. c. If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season. 2. Request is for Grastek; and a. Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and b. 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). c. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of grass pollen season as follows: ▪ Seasonally, through the end of the grass pollen season, or ▪ For sustained effectiveness, up to three consecutive years (including the intervals between grass pollen seasons) for one grass pollen season after cessation of treatment. Authorizations would be given in 12-month intervals up to three consecutive years with one grass pollen season. House Dust Mite (Odactra) In addition to the above criteria being met: 1. Patient is diagnosed with house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis; and 2. Patient has a positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites; and 3. If criteria for coverage are met, authorization will be considered for 12 months.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Ospemifene (Osphena) *Use Ospemifene (Osphena) PA form*	Prior authorization (PA) is required for ospemifene (Osphena). Requests for a diagnosis of moderate to severe dyspareunia are considered not medically necessary and will be denied. Payment will be considered under the following conditions: 1. Patient is a post-menopausal woman with a diagnosis is moderate to severe vaginal dryness due to vulvar and vaginal atrophy; and 2. Patient has documentation of an adequate trial and therapy failure with a preferred vaginal estrogen agent; and 3. Patient does not have any contraindications to ospemifene as listed in the FDA approved label; and 4. Will not be used with estrogens, estrogen agonist/antagonists, fluconazole, or rifampin; and 5. Patient does not have severe hepatic impairment (Child-Pugh Class C); and 6. Patient will be evaluated periodically as clinically appropriate to determine if treatment is still necessary as ospemifene should be used for the shortest duration consistent with treatment goals and risks for the individual woman; and 7. Dose does not exceed the FDA approved dose. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated. Initial requests will be approved for 3 months. Additional Pas will be considered upon documentation of clinical response to therapy.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Palivizumab (Synagis) *Use Palivizumab PA form*	Respiratory Syncytial Virus (RSV) surveillance is tracked by the national respiratory and enteric virus surveillance system (NREVSS) on the centers for disease control and prevention of the United States department of health and human services website. 1. Medicaid will use Iowa virology data reported to the NREVSS, as documented under RSV state trends. 2. Medicaid will provide coverage of prescription drugs that protect against RSV consistent with the current American Academy of Pediatrics (AAP) Guidelines for Infants and Children at Risk for Severe Illness due to RSV Infection. 3. The RSV season in Iowa is predefined as November 1st through March 31st of each RSV season. Prescribers and dispensing pharmacies should monitor state specific virology data and hold administration of palivizumab if data indicates RSV is not prevalent at the beginning of the predefined Iowa RSV season. Consideration of use of palivizumab during interseasonal spread of RSV may be considered by Medicaid with widespread RSV circulation. Prior authorization (PA) is required for therapy with palivizumab. Pas will be approved for administration during the 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 in the prior 5 months 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: <u>Chronic Lung Disease (CLD) of Prematurity</u> 1. 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). 2. 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 6-month period before the start of the second RSV season. <u>Prematurity (without CLD of Prematurity or Congenital Heart Disease)</u> 1. Patient is less than 12 months of age at start of therapy with a gestational age of less than 29 weeks. <u>Neuromuscular Disorders or Anatomic Pulmonary Abnormalities</u> 1. 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. <u>Hemodynamically Significant Congenital Heart Disease (CHD)</u> 1. Patient is less than 12 months of age at start of therapy and has hemodynamically significant CHD further defined by any of the following: Acyanotic heart disease receiving medication to control congestive heart failure and will require cardiac surgical procedures, moderate to severe pulmonary hypertension, or cyanotic heart defects with documentation of consultation with a pediatric cardiologist that recommends palivizumab prophylaxis. <u>Immunocompromised Children</u> 1. 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).

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

PCSK9 Inhibitors *Praluent* *Repatha*	Prior authorization (PA) is required for PCSK9 Inhibitors. Payment for a non-preferred PCSK9 Inhibitor will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1. Patient meets the FDA approved age for indication; AND 2. Dosing follows the FDA approved dose for the submitted diagnosis; AND 3. 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 4. Is to be prescribed as an adjunct to a low fat diet; AND 5. A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; AND 6. 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. 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: <u>Diagnosis of Heterozygous Familial Hypercholesterolemia (HeFH)</u> 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: i. Documented tendon xanthomas; or ii. MI at age ≤60 years; or iii. 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 one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Use PCSK9 Inhibitors PA form	intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. Diagnosis of 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 one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. Diagnosis of Primary Hyperlipidemia (not associated with ASCVD or HeFH) 1. Baseline LDL-C ≥ 190 mg/dL; and 2. Unable to reach goal LDL-C < 100 mg/dL while on high-intensity statin therapy (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. Diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) 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 one high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) used in combination with ezetimibe 10mg daily. If patient is unable to tolerate high-intensity statin therapy, a trial with a moderate-intensity statin (e.g., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, pravastatin 40-80 mg, lovastatin 40-80 mg, fluvastatin 80mg, pitavastatin 1-4 mg, simvastatin 20-40 mg) used in combination with ezetimibe. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Initial requests will be approved for 6 months. Additional requests will be considered under the following conditions: 1. Documentation of positive clinical response to PCSK9 Inhibitor therapy (current LDL-C lab provided); and 2. Patient continues therapy with a maximally tolerated statin; and 3. Patient has continued compliance with a low-fat diet.

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Updated 10/01/2024

Peanut Allergen Powder-dnfp (Palforzia) *Use Peanut Allergen Powder-dnfp (Palforzia) PA form*	Prior authorization (PA) is required for Peanut (*Arachis hypogaea*) Allergen Powder-dnfp (Palforzia). Payment will be considered under the following conditions: 1. Patient has a confirmed diagnosis of peanut allergy, as documented by a skin prick test to peanut ≥ 3 mm compared to control or a peanut-specific serum IgE ≥ 0.35 kUA/L (kilos of allergen-specific units per liter); and 2. Patient is 4 to 17 years of age at initiation of therapy or 4 years of age and older for continued up-dosing and maintenance therapy; and 3. Prescribed by or in consultation with an allergist or immunologist; and 4. Patient has access to injectable epinephrine; and 5. Will be used in conjunction with a peanut-avoidant diet; and 6. Patient does not have any of the following: a. Uncontrolled asthma; and/or b. A history of eosinophilic esophagitis or other eosinophilic gastrointestinal disease; and 8. The initial dose escalation and the first dose of each new up-dosing level is administered under the supervision of a health care professional in a health care setting with the ability to manage potentially severe allergic reactions, including anaphylaxis. Initial dose escalation and the first dose of all up-dosing levels is not to be billed to the Iowa Medicaid outpatient pharmacy program as the initial dose escalation is administered in the provider office and should be billed via the medical benefit and the first dose of all up-dosing levels is provided via the Office Dose Kit; and 9. Follows FDA approved dosing; and 10. PA is required for all up-dosing dose levels (dose 1 through 11); and 11. Maintenance dosing will be considered with documentation patient has successfully completed all dose levels of up-dosing.

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Pegcetacoplan (Empaveli) *Use Pegcetacoplan (Empaveli) PA form*	Prior authorization (PA) is required for pegcetacoplan (Empaveli). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling including age, dosing, contraindications, and warnings and precautions; and 2. Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH); and 3. Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or ≥ 10% PNH cells; and 4. History of at least one red blood cell transfusion in the previous 12 months; and 5. Documentation of hemoglobin < 10.5 g/dL; and 6. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris), unless the patient is in a 4 week period of cross-titration between eculizumab (Soliris) and pegcetacoplan (Empaveli); and 7. Is prescribed by or in consultation with a hematologist; and 8. Medication will be administered in the member's home; and 9. Member or member's care giver has been properly trained in subcutaneous infusion and prescriber has determined home administration is appropriate. Initial authorizations will be approved for 4 weeks if within cross-titration period with eculizumab (Soliris) to verify eculizumab has been discontinued, or for 6 months otherwise. Additional authorizations will be considered when the following criteria are met: 1. Documentation of a positive clinical response to therapy (e.g., increased or stabilization or hemoglobin levels or reduction in transfusions); and 2. Is not prescribed concurrently with eculizumab (Soliris) or ravulizumab (Ultomiris).
Pirfenidone (Esbriet) / Nintedanib (Ofev)	Prior authorization (PA) 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 meets the FDA approved age; and 2. Is prescribed by a pulmonologist; and 3. Patient does not have hepatic impairment as defined below: a. Nintedanib- Patient does not have moderate or severe hepatic impairment (Child Pugh B or C) or b. Pirfenidone- Patient does not have severe hepatic impairment (Child Pugh C); and 4. Patient does not have renal impairment as defined below: a. Nintedanib- Patient does not have severe renal impairment (CrCl <30ml/min) or end-stage renal disease or b. Pirfenidone- Patient does not have end-stage renal disease requiring dialysis; and 5. Patient does not utilize non-prescribed inhalants, such as vaping or other inhaled tobacco products, prior to initiating therapy and has been instructed to avoid tobacco products while using pirfenidone or nintedanib; and 6. Patient has a diagnosis of idiopathic pulmonary fibrosis (nintedanib or pirfenidone) as confirmed by one of the following (attach documentation): a. Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or b. A surgical lung biopsy demonstrating usual interstitial pneumonia (UIP); and c. Prescriber has excluded other known causes of interstitial lung disease (ILD) such as domestic and occupational exposures, connective tissue disease, and drug toxicity; and

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Use Pirfenidone (Esbriet) / Nintedanib (Ofev) PA form	d. Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC) ≥50% predicted; and e. Patient has a carbon monoxide diffusion capacity (%Dlco) of ≥30% predicted; or 7. Patient has a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) (nintedanib) as confirmed by the following (attach documentation): a. Documentation of a chest high resolution computed tomography (HRCT) scan showing fibrosis affecting ≥ 10% of the lungs; and b. Patient has documented pulmonary function tests within the prior 60 days showing FVC ≥ 40% predicted; and c. Patient has a carbon monoxide diffusion capacity (%Dlco) of ≥ 30-89% predicted; or 8. Patient has a diagnosis of chronic fibrosing interstitial lung disease with a progressive phenotype (nintedanib) as confirmed by the following (attach documentation): a. Documentation of a chest high resolution computed tomography (HRCT) scan showing fibrosis affecting ≥ 10% of the lungs; and b. Patient has documented pulmonary function tests within the prior 60 days showing FVC ≥ 45% predicted; and c. Patient has a carbon monoxide diffusion capacity (%Dlco) of ≥ 30-79% predicted; and d. Patient has at least one sign of clinical progression for interstitial lung disease within the last 24 months despite standard treatment with an agent other than nintedanib or pirfenidone: i. A relative decline in the FVC of at least 10% predicted; or ii. A relative decline in the FVC of 5-9% predicted combined with at least one of the following: 1. Worsening respiratory symptoms; or 2. Increased extent of fibrosis on HRCT; or iii. Worsening of respiratory symptoms and an increased extent of fibrotic changes on HRCT only. 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. Adherence to pirfenidone (Esbriet) or nintedanib (Ofev) is confirmed; and 2. Documentation of a positive response to therapy, defined as meeting at least one of the following: a. Rate of lung function decline slowed; or b. Improved or no worsening of symptoms of cough, shortness of breath; and 3. Documentation is provided that the patient has remained tobacco-free; and 4. ALT, AST, and bilirubin are assessed periodically during therapy.
Proton Pump Inhibitors	Prior authorization (PA) is not required for 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 will be considered for the following diagnoses with additional documentation regarding the medical necessity: 1. Barrett's esophagus, Erosive esophagitis, or Peptic stricture (Please fax a copy of the scope results with the initial request); or 2. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, and multiple endocrine adenomas); or 3. Recurrent peptic ulcer disease; or

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

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Use Proton Pump Inhibitor PA form	4. Gastroesophageal reflux disease will be considered after documentation of a therapeutic trial and therapy failure with the requested PPI at maximal dose within the established quantity limit of one per day. Requests for PPIs exceeding one unit per day will be considered on a short term basis (up to 3 months). After the three month period, a dose reduction to 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; or 5. Helicobacter pylori will be considered for up to 14 days of treatment with documentation of active infection. Payment for a non-preferred proton pump inhibitor will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred products.
Pulmonary Arterial Hypertension Agents *Use Pulmonary Arterial Hypertension Agents PA form*	Prior Authorization (PA) is required for agents used to treat pulmonary hypertension. Payment will be approved under the following conditions: 1. Diagnosis of pulmonary arterial hypertension
Quantity Limit Override *Use Quantity Limit Override PA form*	Designated drugs are limited to 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. Providers should submit a Prior Authorization (PA) request for override consideration.
Repository Corticotropin Injection (H.P. Acthar Gel) *Use Repository Corticotropin Injection (H.P. Acthar Gel) PA form*	Prior authorization (PA) is required for repository corticotropin injection. Payment will be considered under the following conditions: 1. Patient is under two years of age and 2. Patient has a diagnosis of infantile spasms. Treatment of compendia indicated steroid-responsive conditions will only be considered upon documented contraindications or intolerance to corticosteroids not expected to occur with the use of repository corticotropin injection. If criteria for coverage are met, authorization will be provided for up to 30 days of treatment for all indications.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Rifaximin (Xifaxan) *Use Rifaximin (Xifaxan) PA form*	Prior authorization (PA) is required for rifaximin. Only FDA approved dosing will be considered. Payment will be considered under the following conditions: 1. A diagnosis of travelers' diarrhea: a. Patient is 12 years of age or older; and b. Patient has a diagnosis of travelers' diarrhea not complicated by fever or blood in the stool or diarrhea due to pathogens other than *Escherichia coli*; and c. Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with a preferred generic fluoroquinolone or azithromycin. d. A maximum 3 day course of therapy (9 tablets) of the 200mg tablets per 30 days will be allowed. 2. A diagnosis of hepatic encephalopathy: a. Patient is 18 years of age or older; and b. Patient has a diagnosis of hepatic encephalopathy; and c. Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with lactulose. 3. A diagnosis of irritable bowel syndrome with diarrhea: a. Patient is 18 years of age or older; and b. Patient has a diagnosis of irritable bowel syndrome with diarrhea; and c. Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with a preferred antispasmotic agent (dicyclomine, hyoscyamine); and d. Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with amitriptyline and loperamide. e. If criteria for coverage are met, a single 14-day course will be approved. f. Subsequent requests will require documentation of recurrence of IBS-D symptoms. A minimum 10 week treatment-free period between courses is required. g. A maximum of 3 treatment courses of rifaximin will be allowed per lifetime. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Risdiplam (Evrysdi) *Use Risdiplam (Evrysdi) PA form*	Prior authorization (PA) is required for risdiplam (Evrysdi). Payment will be considered under the following conditions: 1. Patient has a diagnosis of spinal muscular atrophy (SMA); and 2. Patient meets the FDA approved age for diagnosis; and 3. Dosing follows FDA approved dose for age and weight; and 4. A negative pregnancy test for females of reproductive potential prior to initiating treatment; and 5. Female patients of reproductive potential have been advised to use effective contraception during treatment and for at least one month after last dose and male patients of reproductive potential have been counseled on the potential effects on fertility; and 6. Patient does not have impaired liver function; and 7. Will not be prescribed concomitantly with other SMA treatments, such as Spinraza (nuninersen), Zolgensma (onasemnogene abeparvovec), or any other new products that are approved by the FDA and released; and 8. Documentation of previous SMA therapies and response to therapy is provided; and a. For patients currently on Spinraza, documentation Spinraza will be discontinued is provided, including date of last dose, and the appropriate interval based on the dosing frequency of the other drug has been met (i.e. 4 months from the last dose when on maintenance therapy); or b. For patients treated with Zolgensma, requests will not be considered; and 9. Is prescribed by or in consultation with a neurologist; and 10. Pharmacy will educate the member, or member's caregiver, on the storage and administration of Evrysdi, as replacements for improper storage or use will not be authorized. If the criteria for coverage are met, requests will be approved for 1 year. Requests for continuation of therapy will require documentation of a positive response to therapy including stabilization or improved function unless intercurrent event (fracture, illness, other) affects functional testing.
Roflumilast (Daliresp) *Use Roflumilast (Daliresp) PA form*	Prior authorization (PA) is required for roflumilast (Daliresp). Payment will be considered for patients 18 years of age or older when the following is met: 1. A diagnosis of severe COPD with chronic bronchitis as documented by spirometry results, and 2. A smoking history of ≥ 20 pack-years, and 3. Currently on a long-acting bronchodilator in combination with an inhaled corticosteroid with documentation of inadequate control of symptoms, and 4. 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.

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Updated 10/01/2024

Sapropterin (Kuvan) *Use Sapropterin (Kuvan) PA form*	Prior authorization (PA) is required for sapropterin (Kuvan). Requests for doses above the FDA approved dose will not be considered. Initial requests will be considered for patients when the following criteria are met: 1. Patient has a diagnosis of phenylketonuria (PKU); and 2. Patient is on a phenylalanine (Phe) restricted diet prior to therapy and will continue throughout therapy; and 3. Patient has a baseline blood Phe level ≥360 micromol/L while following a Phe restricted diet, obtained within 2 weeks of initiation of sapropterin therapy (attach lab results); and 4. Patient's current weight is provided; and 5. Request is for an FDA approved starting dose (10mg/kg/day for patients 1 month to 6 years and 10-20mg/kg/day for patients 7 years and older); and 6. Blood Phe levels will be measured after 1 week of therapy and at least one other time during the first month of therapy. Initial requests will be considered for 1 month to assess response to therapy. Continuation of therapy will be considered when the following criteria are met: 1. Patient's current weight is provided; and 2. Patient continues on a Phe restricted diet; and 3. For patients initiated at a dose of 10mg/kg/day and the blood Phe level did not decrease from baseline, dose may be increased to 20mg/kg/day. Approval will be given for 1 month to assess response to therapy. 4. For patients initiated at a dose of 20mg/kg/per day or those increased to this dose after 1 month of therapy at 10mg/kg/day, an updated blood Phe level must be provided documenting response to therapy, defined as at least a 30% reduction in blood Phe level. If blood Phe level does not decrease after 1 month at 20mg/kg/day, the patient is considered a non-responder and no further requests will be approved. 5. Maintenance dose requests will be considered for patients that have responded to therapy, based on the above criteria, at 6 month intervals. Documentation of compliance to diet and updated blood Phe levels documenting continued response to therapy are required for further consideration.
Satralizumab (Enspryng) *Use Satralizumab (Enspryng) PA form*	Prior authorization (PA) is required for satralizumab (Enspryng). Payment will be considered under the following conditions: 1. Patient has a diagnosis of neuromyelitis optica spectrum disorder (NMOSD); and 2. Patient is anti-aquaporin 4 (AQP4) seropositive (attach documentation); and 3. Patient meets the FDA approved age and dosing; and 4. Patient has a history of at least 1 relapse in the previous 12 months prior to initiation of therapy; and 5. Patient has been tested for tuberculosis prior to the initiation of therapy and does not have active or untreated latent tuberculosis; and 6. Patient has been tested for hepatitis B virus (HBV) prior to the initiation of therapy and confirmed negative for active HBV; and 7. Prescribed by a neurologist. If criteria for coverage are met, initial requests will be given for 1 year. Additional authorizations will be considered upon documentation of clinical response to therapy (i.e. a reduction in the frequency of relapse).

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Sedative/Hypnotics-Non-Benzodiazepine *Use Sedative/Hypnotics-Non-Benzodiazepine PA form*	Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits. PA is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trials and therapy failures with, at a minimum, three (3) preferred agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. A diagnosis of insomnia; and 3. Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued; and 4. Enforcement of good sleep hygiene is documented; and 5. All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses; and 6. Will not be used concurrently with a benzodiazepine sedative/hypnotic agent. 7. In addition to the above criteria, requests for an orexin receptor antagonist will require documentation of a trial and therapy failure with at least one non-preferred agent prior to consideration of coverage. 8. Non-preferred 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.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Select Anticonvulsants *Diacomit* *Epidiolex* *Fintepla* *Ztalmy* *Use Select Anticonvulsants PA form*	Prior authorization (PA) is required for select anticonvulsants. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations: and 2. Patient has an FDA approved or compendia indicated diagnosis, for requested drug, of seizures associated with Lennox-Gastaut syndrome, Dravet syndrome, tuberous sclerosis complex, or cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder with documentation of an adequate trial and inadequate response with at least two preferred concomitant antiepileptic drugs (AEDs), if available; and 3. Is prescribed by or in consultation with a neurologist; and 4. Patient's current weight is provided; and 5. The total daily dose does not exceed the following: a. Cannabidiol i. Lennox-Gastaut syndrome or Dravet syndrome: 20 mg/kg/day: or ii. Tuberous sclerosis complex: 25 mg/kg/day; or b. Fenfluramine i. With concomitant stiripentol (plus clobazam): 0.4 mg/kg/day with a maximum of 17 mg per day; or ii. Without concomitant stiripentol: 0.7 mg/kg/day with a maximum of 26 mg per day; or c. Stiripentol i. Prescribed concomitantly with clobazam; and ii. 50 mg/kg/day with a maximum of 3,000 mg/day; or d. Ganaxolone i. Weight ≤ 28 kg: 63mg/kg/day; or ii. Weight > 28 kg: 1800 mg/day. The required trials may be overridden when documented evidence is provided that use of these agents would medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Select Preventative Migraine Treatments	Prior authorization (PA) is required for select preventative migraine agents. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred, select preventative migraine agent. Payment will be considered under the following conditions: 1. Patient has one of the following diagnoses: a. Chronic Migraine, defined as: i. ≥ 15 headache days per month for a minimum of 3 months; and ii. ≥ 8 migraine headaches days per month for a minimum of 3 months; or b. Episodic Migraine, defined as: i. 4 to 14 migraine days per month for a minimum of 3 months; or c. Episodic Cluster Headache, defined as: i. Occurring with a frequency between one attack every other day and 8 attacks per day; and ii. With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods ≥3 months; and iii. Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting <3 months, for at least 1 year); and 2. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; and 3. The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and 4. Patient has been evaluated for and does not have medication overuse headache; and 5. For Episodic and Chronic Migraine, patient has documentation of two trials and therapy failures, of at least 3 months per agent, at a maximally tolerated dose with two different migraine prophylaxis drug classes (i.e. anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]); or 6. For Episodic Cluster Headache, patient has documentation of a. A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy. 7. Lost, stolen, or destroyed medication replacement requests will not be authorized. Initial requests will be approved for 3 months. Additional Pas will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency). The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Select Oncology Agents *Use Select Oncology Agents PA form*	Prior authorization (PA) 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 PA 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, the original prescription, and the most recent copies of related laboratory results. If criteria for coverage are met, initial authorization will be given for three (3) months. Additional authorizations will be considered for up to six (6) 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.
Select Topical Psoriasis Agents *Use Select Topical Psoriasis Agents PA form*	Prior authorization (PA) is required for select topical psoriasis agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of plaque psoriasis with involvement estimated to affect ≤ 20% of the body surface area; and 3. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Selected Brand Name Drugs *Use Selected Brand Name PA forms*	Prior authorization (PA) 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 (PDL). For PA to be considered, the prescriber must submit a completed Selected Brand Name PA form and Iowa Medicaid MedWatch form with: 1. 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. 2. 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 or vomiting, to the generic drug 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.

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Updated 10/01/2024

Short Acting Opioids *Use Short Acting Opioids PA form*	Prior authorization (PA) is required for all non-preferred short acting opioids. PA is also required for members when the total daily dose (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). Payment will be considered under the following conditions: 1. Patient has pain severe enough to require opioid treatment; and 2. Patient has tried and failed at least two non-pharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and 3. Patient has tried and failed at least two non-opioid pharmacologic therapies (e.g. acetaminophen or NSAIDs); and 4. Patient has documentation of previous trials and therapy failures with three (3) chemically distinct preferred short acting opioids (based on opioid ingredient only) at therapeutic doses; and 5. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and has determined that use of a short-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and 6. Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids; and 7. For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met: 1. Patient has experienced improvement in pain control and level of functioning; and 2. Prescriber has reviewed the patient's use of controlled substances on the Iowa PMP website and has determined continued use of a short-acting opioid is appropriate for this member; and 3. For patients taking concurrent benzodiazepines, the prescriber must document the following: b. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and c. Documentation as to why concurrent use is medically necessary is provided; and d. A plan to taper the benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents and/or non-pharmacologic therapies would be medically contraindicated.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

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Updated 10/01/2024

Sodium Oxybate Products *Xyrem* *Xywav* *Use Sodium Oxybate Products PA form*	Prior authorization (PA) is required for sodium oxybate (Xyrem). Payment will be considered under the following conditions: 1. A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including PSG, MSLT, and ESS) and previous trial and therapy failure with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline; or 2. A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant; and 3. Patient meets the FDA approved age; and 4. Is prescribed within the FDA approved dosing; and 5. Patient and prescriber are enrolled in the Xyrem® REMS Program; and 6. Patient has been instructed to not drink alcohol when using Xyrem; and 7. Patient has been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence; and 8. Requests for patients with concurrent use of a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered. 9. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website prior to requesting PA. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
Step Therapy Requirements *Use Non-Preferred Drug PA form*	Designated therapeutic drug classes are subject to step therapy edits. For these therapeutic drug classes, drugs are assigned to numbered steps and appropriate trials must be made of the drugs assigned to each step before payment will be made for drugs assigned to a subsequent step. These therapeutic classes, as well as the specific step edit requirements, are identified on the Iowa Medicaid Preferred Drug List posted on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab. Providers should submit a Prior Authorization (PA) request for override consideration. Therapeutic Classes Included: Antipsychotics-Atypicals

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Updated 10/01/2024

Tasimelteon (Hetlioz) *Use Tasimelteon (Hetlioz) PA form*	Prior authorization (PA) is required for tasimelteon (Hetlioz). Requests will be considered when patient has an FDA approved or compendia indication for the requested drug. Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a documented diagnosis of: a. Non-24-Hour Sleep-Wake Disorder (Non-24); and i. Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic-non-benzodiazepine agent; and ii. Patient has a documented trial and therapy failure with ramelteon (Rozerem®); or b. Sleep disturbances in Smith-Magenis Syndrome (SMS); and i. Documentation of confirmed deletion of 17p11.2 (cytogenic analysis or microarray) or RAI1 gene mutation is provided (attach results); and ii. Patient has a documented trial and therapy failure with at least one other medication used for sleep disturbances; and 3. Is prescribed by, or in consultation with a physician who specializes in the treatment of sleep disorders; and 4. Will not be used concomitantly with other sleep medications. If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered under the following conditions: 1. Patient's use of tasimelteon (Hetlioz) has been continuous without gaps in treatment; and 2. Documentation patient has experienced a positive clinical response to therapy with tasimelteon (Hetlioz®), such as entrainment, significant increases in nighttime sleep, significant decreases in daytime sleep, and/or nighttime sleep quality.
Testosterone Products	Prior authorization (PA) 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 non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for erectile dysfunction, infertility, and age-related hypogonadism will not be considered. Payment will be considered under the following conditions: 1. Patient is male and 18 years of age or older (or 12 years of age or 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 (please attach lab results); and 3. Patient has primary hypogonadism or hypogonadotropic hypogonadism (further defined below): a. Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:

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The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Use Testosterone Products PA form	• Cryptorchidism • Bilateral torsion • Orchitis • Vanishing testes syndrome • Orchiectomy • Klinefelter's syndrome • Chemotherapy • Toxic damage from alcohol or heavy metals b. Hypogonadotropic hypogonadism • Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency • Pituitary-hypothalamic injury from tumors, trauma, or radiation 4. Patient does not have: a. Breast or prostate cancer b. Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL c. Hematocrit > 50% d. Untreated severe obstructive sleep apnea e. Severe lower urinary tract symptoms f. Uncontrolled or poorly controlled heart failure If criteria for coverage are met, initial authorization will be given for 3 months. Requests for continuation of therapy will require the following: 1. An updated testosterone level (Please attach lab result); and 2. 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 beoverridden when documented evidence is provided that use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Tezepelumab-ekko (Tezspire) Prefilled Pen *Use Tezepelumab-ekko (Tezspire) Prefilled Pen PA form*	Prior authorization (PA) is required for tezepelumab-ekko (Tezspire) prefilled pen. Requests for tezepelumab-ekko (Tezspire) single dose vial or prefilled syringe will not be considered through the pharmacy benefit. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of severe asthma; and a. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g., long-acting beta2 agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and b. Patient must have one of the following, in addition to the regular maintenance medications defined above: i. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months, or ii. One or more asthma exacerbations resulting in hospitalization in the previous 12 months; and c. This medication will be used as an add-on maintenance treatment; and d. Patient/caregiver will administer medication in patient's home; and e. Is not prescribed in combination with other biologics indicated for asthma. If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Topical Acne and Rosacea Products *Use Topical Acne and Rosacea Products PA form*	Prior authorization (PA) is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered when member has an FDA approved or compendia indication for the requested drug, except for any drug or indication excluded from coverage, as defined in Section 1927 (2)(d) of the Social Security Act, Iowa's CMS approved State Plan, and the Iowa Administrative Code (IAC) when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Documentation of diagnosis; and 3. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and 4. Payment for non-preferred topical antibiotic or topical retinoid 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 from the requested topical class (topical antibiotic or topical retinoid); and 5. Payment for non-preferred topical acne products outside of the antibiotic or retinoid class (e.g., Winlevi) will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred topical retinoid and at least two other topical acne agents. If criteria for coverage are met, initial requests will be approved for six months; and 6. Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical agent; and 7. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and 8. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis; and 9. Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) 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.
Topical Antifungals for Onychomycosis *Use Topical Antifungals for Onychomycosis PA form*	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 (attach results) without dermatophytomas or lunula (matrix) involvement; and 2. Patient is 18 years of age or older; and 3. Patient has documentation of a complete trial and therapy failure or intolerance to oral terbinafine; and 4. Patient has documentation of a complete trial and therapy failure or intolerance to ciclopirox 8% topical solution; and 5. 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 use of these agents would be medically contraindicated.
Topical Corticosteroids *Use Topical Corticosteroids PA form*	Prior authorization (PA) 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.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Tralokinumab-Idrm (Adbry) *Use Tralokinumab (Adbry) PA form*	Prior authorization (PA) is required for tralokinumab-Idrm (Adbry). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of moderate to severe atopic dermatitis; and 3. Is prescribed by or in consultation with a dermatologist; and 4. Patient has failed to respond to good skin care and regular use of emollients; and 5. Patient has documentation of an adequate trial and therapy failure with at least one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and 6. Patient has documentation of a previous trial and therapy failure with a preferred topical immunomodulator for a minimum of 4 weeks; and 7. Patient has documentation of a previous trial and therapy failure with cyclosprorine or azathioprine; and 8. Patient will continue with skin care regimen and regular use of emollients. If criteria for coverage are met, initial authorization will be given for 16 weeks to assess the response to treatment. Request for continuation of therapy will require documentation of a positive response to therapy and documentation patient will continue with skin care regimen and regular use of emollients. The required trials may be overridden when documented evidence if provided that the use of these agents would be medically contraindicated.
Triheptanoin (Dojolvi) *Use Triheptanoin (Dojolvi) PA form*	Prior authorization (PA) is required for triheptanoin (Dojolvi). Payment will be considered under the following conditions: 1. Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and 2. Patient has a diagnosis of long-chain fatty acid oxidation disorder (LC-FAOD), with supporting documentation of gene mutation(s) associated with LC-FAOD (LC-FOADs include: CPT1, CACT, CPT11, VLCAD, TFP, LCHAD); and 3. Patient will not be using another medium chain triglyceride (MCT) product; and 4. Documentation of a patient's daily caloric intake (DCI) is provided; and 5. Patient's target daily dose is provided as a percentage of the patient's total daily prescribed DCI, not to exceed 35%; and 6. Is prescribed by or in consultation with an endocrinologist, geneticist, or metabolic disease specialist. If the criteria for coverage are met, initial requests will be approved for four months. Additional authorizations will be considered upon documentation of a positive clinical response to therapy.

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made, unless otherwise noted in criteria. Certain drugs are allowed a 7 day supply while prior authorization is being requested. PDL IMPLEMENTATION DATE 01-15-05

The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Vericiguat (Verquvo) *Use Vericiguat (Verquvo) PA form*	Prior authorization (PA) is required for vericiguat (Verquvo). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of symptomatic chronic heart failure (NYHF class II-IV) with a left ventricular ejection fraction (LVEF) ≤ 45%; and 3. Patient meets one of the following: a. Recent hospitalization for heart failure (within the last 6 months); or b. Recent need for outpatient intravenous diuretics (within the last 3 months); and 4. Female patients of reproductive potential have been advised to use effective contraception during treatment and for at least one month after the last dose; and 5. Will not be used concomitantly with other soluble guanylate cyclase (sGC) stimulators (e.g. riociguat) or phosphodiesterase type 5 (PDE-5) inhibitors (e.g. sildenafil, tadalafil, vardenafil); and 6. Documentation of prior or current therapy, at a maximally tolerated dose, with one drug from each category below: a. Renin-angiotensin system inhibitor (angiotensin converting enzyme [ACEI], angiotensin receptor blocker [ARB], or angiotensin receptor-neprilysin inhibitor [ARNI]); and b. Evidence-based beta-blocker (carvedilol, metoprolol succinate, or bisoprolol); and c. Mineralocorticoid receptor antagonist (MRA); and d. Sodium-glucose cotransporter 2 inhibitor (SGLT2i) indicated for the treatment of heart failure (empagliflozin or dapagliflozin); and 7. Initial requests for vericiguat (Verquvo) 2.5 mg and 5 mg tablets will be limited to one 14-day supply for each strength. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

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Updated 10/01/2024

Vesicular Monoamine Transporter (VMAT) 2 Inhibitors *Use Vesicular Monoamine Transporter (VMAT) 2 Inhibitors PA form*	Prior authorization (PA) is required for VMAT 2 inhibitors. Payment for non-preferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered when the patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Will not be used concurrently with other vesicular monoamine (VMAT) 2 inhibitors; and 3. Prescribed by or in consultation with a neurologist, psychiatrist, psychiatric nurse practitioner, or psychiatric physician assistant; and Tardive Dyskinesia (Ingrezza or Austedo) 1. Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following: a. Involuntary athetoid or choreiform movements b. Documentation or claims history of current or prior chronic use (≥ 3 months or 1 month in patients ≥ 60 years old) of a dopamine receptor blocking agent (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.) c. Symptoms lasting longer than 4-8 weeks; and 2. Prescriber has evaluated the patient's current medications for consideration of a dose reduction, withdrawal, or change of the dopamine receptor blocking agent causing the TD; and 3. Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS), If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met: 1. Patient continues to meet the criteria for initial approval; and 2. Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS); or Chorea associated with Huntington's disease (Austedo, Ingrezza or tetrabenazine) 1. Patient has a diagnosis of Huntington's disease with chorea symptoms; and 2. Patient is not suicidal, or does not have untreated or inadequately treated depression; and 3. 4. For tetrabenazine, patients requiring doses above 50mg per day have been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor metabolizer or extensive metabolizer; and If criteria for coverage are met, initial requests will be given for 3 months. Continuation of therapy will be considered when the following criteria are met: 1. Patient continues to meet the criteria for initial approval; and 2. Documentation of improvement in chorea symptoms is provided.

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The 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. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. Duplicate use of drugs from the same therapeutic category or therapeutic duplication will not be considered**.** All required trials must be of appropriate dose and duration for the indication and must be documented by the prescriber, on the request for prior authorization form, including dates, dose, and nature of failure. The use of pharmaceutical samples (from the prescriber or manufacturer assistance program) will not be considered when evaluating the medical condition or prior prescription history for drugs that require prior authorization.

Updated 10/01/2024

Viloxazine (Qelbree) *Use Viloxazine (Qelbree) PA form*	Prior authorization is required for viloxazine (Qelbree). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug under the following conditions: 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 2. Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV); and 3. 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) and 4. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine or a preferred stimulant; and 5. Dose does not exceed 400 mg per day for pediatric patients (< 18 years of age) and 600 mg per day for adult patients; and 6. Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
Vitamins, Minerals and Multiple Vitamins *Use Vitamin/Mineral PA form*	Payment for vitamins, minerals and multiple vitamins for treatment of specific conditions will be approved when there is a diagnosis of specific vitamin or mineral deficiency disease or for patients under 21 years of age if there is a diagnosed disease which 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/minerals or for products principally marketed as prenatal vitamin-mineral supplements.)
Voxelotor (Oxbryta) *Use Voxelotor (Oxbryta) PA form*	Prior authorization (PA) is required for Oxbryta (voxelotor). Payment will be considered for patients when the following criteria are met: 1. Patient meets the FDA approved age; and 2. Patient has a diagnosis of sickle cell disease (SCD); and 3. Requested dose is within the FDA approved dosing; and 4. Patient has experienced at least two sickle cell-related vaso-occlusive crises within the past 12 months (documentation required); and 5. Patient has documentation of an adequate trial and therapy failure with hydroxyurea; and 6. Baseline hemoglobin (Hb) range is ≥5.5 to ≤10.5 g/dL; and 7. Is prescribed by or in consultation with a hematologist; and 8. Patient is not receiving concomitant blood transfusion therapy. If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met: 1. Documentation of an increase in hemoglobin by ≥1 g/dL from baseline; and 2. Documentation of a decrease in the number of sickle cell-related vaso-occlusive crises. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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