Iowa Department of Human Services

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For Human Services use only:

General Letter No. 398
Employees' Manual, Title 8
Medicaid Appendix

July 25, 2014

PRESCRIBED DRUGS MANUAL TRANSMITTAL NO. 14-2

ISSUED BY: Division of Medical Services

SUBJECT: ***PRESCRIBED DRUGS***, Table of Contents, revised; Chapter III, *Provider-Specific Policies*, Contents (pages 2 and 3), revised; pages 3, 18, 19, 20, 28 through 57, 59, 60, 60a, 60b, 61, 62, 65 through 68, 73, 74, 77, 78, 81, 83 through 88, 88a through 88d, and 96, revised; and the following forms:

470-4116	*Request for Prior Authorization: ADD/ADHD/Narcolepsy Agents*, revised
470-5018	*Request for Prior Authorization: Alpha$_2$ Agonists, Extended Release*, revised
470-4593	*Request for Prior Authorization: Angiotensin Receptor Blocker Before ACE Inhibitor*, revised
470-4093	*Request for Prior Authorization: Anti-Acne Products-Topical*, revised
470-5259	*Request for Prior Authorization: Anti-Diabetic Non-Insulin Agents*, new
470-4095	*Request for Prior Authorization: Antihistamines-Oral*, revised
470-5207	*Request for Prior Authorization: Apixaban (Eliquis®)*, new
470-4550	*Request for Prior Authorization: Extended Release Formulations*, revised
470-5066	*Request for Prior Authorization: Hepatitis C Antiviral Agents Protease Inhibitors*, revised
470-4898	*Request for Prior Authorization: Lidocaine Patch (Lidoderm®)*, revised
470-4705	*Request for Prior Authorization: Modified Formulations*, revised
470-4109	*Request for Prior Authorization: Nonsteroidal Anti-Inflammatory Drugs*, revised
470-4112	*Request for Prior Authorization: Proton Pump Inhibitors*, revised
470-4327	*Request for Prior Authorization: Pulmonary Arterial Hypertension Agents*, revised

470-5016 *Request for Prior Authorization: Sodium Oxybate (Xyrem®)*, revised
470-5188 *Request for Prior Authorization: Testosterone Products*, revised
470-5260 *Request for Prior Authorization: Trametinib (Mekinist™)*, new

Summary

The Prescribed Drug manual is revised to:

- Revise 14 forms for requesting drug prior authorization.
- Add three forms for requesting drug prior authorization.
- Remove two forms for requesting drug prior authorization.
- Renamed one form for requesting drug prior authorization.
- Update the quantity limit chart.

Date Effective

Upon receipt.

Material Superseded

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

Page	Date
Contents (page 1)	September 1, 2011
Chapter III	
Contents (pages 2 and 3)	February 1, 2014
3	August 1, 2013
18-20	February 1, 2014
470-4116	1/14
470-5018	7/11
470-4593	5/13
28	August 1, 2013
470-4093	10/13
29, 30	August 1, 2013
470-4095	5/13
31-40	February 1, 2014
470-4897	1/14
470-4550	1/14
41-44	February 1, 2014
470-5066	5/13
470-4407	10/13
45-48	February 1, 2014
470-4898	1/11
49, 50	February 1, 2014
470-4705	4/14
51-56	February 1, 2014
470-4109	10/11

57, 59, 60	February 1, 2014
470-4112	1/14
470-4327	1/14
60a, 60b	February 1, 2014
61	August 1, 2013
62	February 1, 2014
65-68	August 1, 2013
73	February 1, 2014
74, 77, 78	August 1, 2013
81, 83-86	February 1, 2014
470-5016	4/14
87, 88	February 1, 2014
470-5188	1/14
88a-88d	February 1, 2014
96	August 1, 2013

Additional Information

The updated provider manual containing the revised pages can be found at: http://dhs.iowa.gov/sites/default/files/Drugs.pdf

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.

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Less than effective drug or **DESI drug** means a drug for which:

- The Food and Drug Administration (FDA) has withdrawn approval of the drug application for safety or efficacy reasons as a result of the drug efficacy study implementation (DESI) review; or
- The secretary of the U.S. Department of Health and Human Services has issued a notice of a hearing under section 505(e) of the federal Food, Drug, and Cosmetic Act on a proposed order to withdraw approval of the drug application because the secretary has determined that the drug is less than effective for some or all of the conditions of use prescribed, recommended, or suggested in the drug's labeling.

Medicaid Carve-Out is a billing mechanism available to covered entities that implements the 340B requirement protecting manufacturers from giving a 340B discount and paying a Medicaid rebate on the same drug. If a covered entity implements the carve-out option, the covered entity only purchases through the 340B Program drugs dispensed to non-Medicaid patients. Drugs dispensed to Medicaid patients are purchased outside the 340B Program.

Medically accepted indication means any use for a covered outpatient drug which is approved under the federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Social Security Act.

National drug code (NDC) means the eleven-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging that identifies the product's manufacturer, dose form and strength, and package size.

Nonpreferred drug means a drug on the Preferred Drug List that requires prior authorization, with the primary criteria being failure on the preferred agents rather than clinical guidelines. A nonpreferred drug is designated "N" on the Preferred Drug List.

Nonprescription drugs or **over-the-counter (OTC) drugs** means drugs that may be lawfully sold without a prescription.

Drug	√ = Prior Authorization Required
Senna tablets, 187 mg	
Sodium chloride hypertonic ophthalmic ointment, 5%	
Sodium chloride hypertonic ophthalmic solution, 5%	
Tolnaftate 1% cream	
Tolnaftate 1% powder	
Tolnaftate 1% solution	

Nonprescription multiple vitamins and minerals may also be payable under conditions specified under PRIOR AUTHORIZATION REQUIREMENTS.

Oral solid forms of these items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription, except when dispensed via a unit-dose system.

8. Medical Supplies

Pharmacies that dispense medical equipment and supplies should follow the *MEDICAL EQUIPMENT AND SUPPLY DEALER PROVIDER MANUAL* and purchase a supply of CMS-1500 claim forms from any supplier.

C. PRIOR AUTHORIZATION REQUIREMENTS

Prior approval is required for the following:

- ADD/ADHD/narcolepsy agents
- Alpha$_2$ agonists, extended release
- Alpha$_1$-proteinase inhibitor enzymes
- Amylino mimetic (Symlin®)
- Angiotensin receptor blockers
- Anti-acne
- Anti-diabetic, non-insulin agents
- Antiemetic-5HT3 receptor antagonists/substance P neurokinin products
- Antifungal
- Antihistamines
- Apixaban (Eliquis®)
- Becaplermin (Regranex®)
- Benzodiazepines
- Biologicals for ankylosing spondylitis
- Biologicals for arthritis
- Biologicals for inflammatory bowel disease
- Biologicals for plaque psoriasis

- BRAF inhibitors
- Buprenorphine (Butrans™) transdermal system
- Buprenorphine/Naloxone (Suboxone®)
- Chronic pain syndrome agents
- Colchicine (Colcrys®)
- Concurrent IM/PO antipsychotic use
- Crizotinib (Xalkori®)
- Dabigatran (Pradaxa®)
- Dalfampridine (Ampyra™)
- Dextromethorphan and Quinidine (Nuedexta™)
- Dornase alfa (Pulmozyme®)
- Eplerenone (Inspra®)
- Erythropoiesis stimulating agents
- Extended release formulations
- Febuxostat (Uloric®)
- Fentanyl, short-acting oral products
- Granulocyte colony stimulating factor agents
- Growth hormones
- Hepatitis C Protease Inhibitors-Oral (Incivek™ and Victrelis™)
- Immunomodulators, topical
- Insulin, pre-filled pens
- Isotretinoin (oral)
- Ivacaftor (Kalydeco™)
- Janus Kinase Inhibitors
- Ketorolac tromethamine (Toradol®)
- Lidocaine patch (Lidoderm®)
- Linezolid (Zyvox®)
- Long Acting Narcotics
- Mifepristone (Korlym®)
- Modified formulations
- Multiple Sclerosis-Oral Agents
- Muscle relaxants
- Narcotic agonist-antagonist nasal sprays
- Nebivolol (Bystolic®)
- Nicotine replacement products
- Nonparenteral vasopressin derivatives of posterior pituitary hormone products
- Nonpreferred drugs
- Nonsteroidal anti-inflammatory drugs
- Omalizumab (Xolair®)
- Oral Constipation Agents (Lubiprostone and Linaclotide)
- Palivizumab (Synagis®)
- Proton pump inhibitors
- Pulmonary arterial hypertension agents

- Quantity limit override
- Repository Corticotropin Injection (H.P. Acthar Gel)
- Rivaroxaban (Xarelto®)
- Roflumilast (Daliresp™)
- Sedative/hypnotics-non-benzodiazepine
- Selected brand name drugs
- Serotonin 5-HT1 receptor agonists
- Short-acting narcotics
- Smoking cessation therapy (oral)
- Sodium oxybate (Xyrem®)
- Testosterone Products
- Thrombopoietin receptor agonists
- Topical Retinoids for Acne
- Trametinib (Mekinist™)
- Vilazodone (Viibryd™)
- Vitamins, minerals and multiple vitamins
- Vusion™ ointment

The prescriber requests prior authorizations, not the pharmacy. The process is a **prescriber fax-only system** using the forms provided by the Iowa Medicaid Enterprise. The prescriber must request prior authorization by faxing the designated *Request for Prior Authorization* form to **800-574-2515**.

The specific criteria for approval of a prior authorization request are defined in the subsections that follow. The prior authorization criteria are also available in chart format on the web site www.iowamedicaidpdl.com.

Requests require the information on the applicable *Request for Prior Authorization* form, as noted in each subsection. Prior authorization forms may be obtained:

- From the web site https://www.iowamedicaidpdl.com/pa_forms or
- By calling the drug prior authorization help desk at (515) 256-4607 (local calls) or 877-776-1567. (Requests for prior authorizations will **not** be taken at this number.)

The IME Drug Prior Authorization Unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

Iowa Department of Human Services

Request for Prior Authorization
ADD/ADHD/NARCOLEPSY AGENTS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior Authorization (PA) is required for ADD/ADHD/Narcolepsy Agents for patients 21 years of age or older under the following conditions: 1) Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-IV 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 environments (social, academic, or occupational). 2) Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG). 3) Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist.

Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. * If a non-preferred long-acting medication is requested, a trial of the preferred immediate release and extended release product of the same chemical entity is required. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred

- ☐ Adderall
- ☐ Daytrana
- ☐ Focalin
- ☐ Focalin XR
- ☐ Metadate CD
- ☐ Methylphenidate IR Tablets
- ☐ Methylphenidate ER Tabs (10, 18, 20, 27, 36, 54mg)
- ☐ Provigil
- ☐ Quillivant XR
- ☐ Strattera
- ☐ Vyvanse

Non-Preferred

- ☐ Adderall XR
- ☐ Amphetamine ER
- ☐ Amphetamine Salt Combo
- ☐ Concerta
- ☐ Desoxyn
- ☐ Dexedrine*
- ☐ Dextroamphetamine Tab
- ☐ Dextroamphetamine ER Cap*
- ☐ Dexmethylphenidate
- ☐ Dexmethylphenidate ER
- ☐ Methylin Chew
- ☐ Methylin Solution
- ☐ Methylphenidate ER Capsules
- ☐ Modafinil
- ☐ Nuvigil
- ☐ Procentra
- ☐ Ritalin
- ☐ Ritalin SR
- ☐ Ritalin LA*

Strength_____ **Dosage Instructions** _____**Quantity** _____**Days Supply**_____

Diagnosis:

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

Age of patient at onset of symptoms: _____

Date of most recent mental status exam: _____

Rating scale used to determine diagnosis: _____

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

Environment 1 & description: _____

Environment 2 & description: _____

Request for Prior Authorization
ADD/ADHD/NARCOLEPSY AGENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Narcolepsy (Please provide results from a recent ESS, MSLT, and PSG)**

☐ **Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS)**

Have non-pharmacological treatments been tried? ❑ No ❑ Yes *If Yes, please indicate below:*

☐ Weight Loss

☐ CPAP Date: _____

☐ BiPAP Date: _____

☐ Surgery Date: _____

Specifics:_____

☐ Position therapy

Maximum titration? ❑ Yes ❑ No

Maximum titration? ❑ Yes ❑ No

Diagnosis confirmed by a sleep specialist? ❑ Yes ❑ No

☐ **Other (specify)**_____

Please document prior psychostimulant trial(s) and failures(s) including drug name(s) strength, dose, exact date ranges and failure reasons:_____

_____

Other - Please provide all pertinent medication trial(s) relating to the diagnosis including drug name(s) strength, dose and exact date ranges:

_____

_____

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

_____

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

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

Iowa Department of Human Services

Request for Prior Authorization
ALPHA$_2$ AGONISTS, EXTENDED-RELEASE

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

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

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for extended-release alpha$_2$ agonists. Payment will be considered for patients when the following is met: 1) The patient has a diagnosis of ADHD and is between 6 and 17 years of age. 2) Previous trial with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and 3) Previous trial and therapy failure at a therapeutic dose with one preferred amphetamine and one preferred non-amphetamine stimulant; and 4) Previous trial and therapy failure at a therapeutic dose with atomoxetine (Strattera®). The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ Intuniv ☐ Kapvay ☐ Clonidine ER

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

Diagnosis: _____

Trial of preferred immediate release product of same chemical entity: Drug Name & Dose: _____ Trial Dates: _____ Failure Reason: _____

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

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

Trial of atomoxetine (Strattera®): Dose: _____ Trial Dates: _____
Failure Reason: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

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

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

Iowa Department of Human Services

Request for Prior Authorization
ANGIOTENSIN RECEPTOR BLOCKER BEFORE ACE INHIBITOR

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must fill all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Payment for Angiotensin Receptor Blockers (ARB) and Angiotensin Receptor Blocker Combinations will only be considered for cases in which there is a contraindication or therapy failure with at least one ACE-I or ACE-I Combination. A completed prior authorization form will need to be submitted if a trial with an ACE-I or ACE-I Combination of at least 30 days in length is not found in the point-of-sale system and/or unless evidence is provided that use of an ACE-I or ACE-I Combination would be medically contraindicated. Prior authorization is required for all non-preferred ARBs and ARB Combinations the first day of therapy. Payment for a non-preferred ARB or ARB Combination will be considered following documentation of recent trials and therapy failures with a preferred ACE-I or ACE-I Combination AND a preferred ARB or ARB Combination.

Preferred

- ☐ Diovan
- ☐ Exforge
- ☐ Exforge HCT
- ☐ Irbesartan
- ☐ Irbesartan HCT
- ☐ Losartan
- ☐ Losartan HCT
- ☐ Micardis
- ☐ Micardis HCT
- ☐ Valsartan HCT

Non-Preferred

- ☐ Atacand
- ☐ Atacand HCT
- ☐ Avalide
- ☐ Avapro
- ☐ Azor
- ☐ Benicar
- ☐ Benicar HCT
- ☐ Cozaar
- ☐ Diovan HCT
- ☐ Edarbi
- ☐ Edarbyclor
- ☐ Eprosartan
- ☐ Hyzaar
- ☐ Telmisartan
- ☐ Telmisartan/Amlodipine
- ☐ Teveten
- ☐ Teveten HCt
- ☐ Tribenzor
- ☐ Twynsta
- ☐ Valturna

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:_____

Preferred ACE Inhibitor Trial: Drug Name_____ Strength_____

Dosage Instructions_____ Trial date from: _____ Trial date to:_____

Failure reason with ACE Inhibitor: _____

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

_____

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

Other relevant information:_____

Attach lab results and other documentation as necessary.

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

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

9. Anti-Acne Products

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

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

- The patient has has had previous trial and therapy failure with a preferred over-the-counter benzoyl peroxide product (covered without prior authorization).
- Requests for nonpreferred topical acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical agents of a different chemical entity.
- Requests for nonpreferred combination products will be considered only after documented separate trials and therapy failures with the individual ingredients.
- The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.
- Form 470-4093, *Request for Prior Authorization: Anti-Acne Products - Topical*, is submitted to request prior authorization. Click here to see a sample of the form.

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

10. Anti-Diabetic, Non-Insulin Agents

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

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

Iowa Department of Human Services

Request for Prior Authorization
ANTI-ACNE PRODUCTS-TOPICAL

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for all prescription topical acne products. Payment for the treatment of mild to moderate acne vulgaris will be considered under the following conditions: 1) Previous trial and therapy failure with a preferred over-the-counter benzoyl peroxide product, which is covered by the program. 2) Payment for non-preferred topical acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical agents of a different chemical entity. 3) If the patient presents with a preponderance of comedonal acne, topical retinoid products may be utilized as first line agents with prior authorization (use Topical Retinoids PA form). 4) Requests for non-preferred combination products may only be considered after documented separate trials and therapy failures with the individual ingredients.

Preferred

- ☐ Azelex
- ☐ BenzaClin Pump
- ☐ Benzoyl Peroxide 6% Lotion
- ☐ BPO Gel/Cloths
- ☐ Clindamycin
- ☐ Duac
- ☐ Erythromycin
- ☐ Erythromycin/BPO
- ☐ MetroCream
- ☐ MetroGel
- ☐ MetroLotion

Non-Preferred

- ☐ Aczone
- ☐ Akne-Mycin
- ☐ Benzac AC
- ☐ BenzaClin
- ☐ Benzamycin
- ☐ Benzamycin Pak
- ☐ Brevoxyl
- ☐ Cleocin T
- ☐ Clindagel
- ☐ Clindamycin/BPO
- ☐ Finacea
- ☐ Klaron
- ☐ Metronidazole
- ☐ Noritate
- ☐ Rosanil Cleanser
- ☐ Sodium Sulfa/Sulf
- ☐ Sulfacet-R
- ☐ Triaz Cloths

Other (specify) _____

Strength	Dosage Form	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

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

Trial date from: _____ Trial date to: _____

Medical or contraindication reason to override trial requirements: _____

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

_____

_____

Pertinent Lab data: _____

Other relevant information: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

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

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

Iowa Department of Human Services

Request for Prior Authorization
ANTI-DIABETIC NON-INSULIN AGENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must fill all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions: 1) A diagnosis of Type 2 Diabetes Mellitus, and 2) Patient is 18 years of age or older; and 3) The patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated. Payment for a non-preferred anti-diabetic, non-insulin agent subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor combination and a preferred Incretin Mimetic at maximally tolerated doses, unless evidence is provided that use of these agents would be medically contraindicated. Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented continued improvement in HgbA1C.

Preferred DPP-4 Inhibitors and Combinations

- ☐ Janumet
- ☐ Januvia
- ☐ Kombiglyze XR
- ☐ Onglyza

Non- Preferred DPP-4 Inhibitors and Combinations

- ☐ Janumet XR
- ☐ Jentadueto
- ☐ Kazano
- ☐ Nesina
- ☐ Oseni
- ☐ Tradjenta

Preferred Incretin Mimetics

- ☐ Byetta

Non-Preferred Incretin Mimetics

- ☐ Bydureon
- ☐ Victoza

Non-Preferred SGLT2 Inhibitors

- ☐ Invokana

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

Diagnosis: _____

Metformin Trial: Trial start date: _____ Trial end date: _____ Trial dose: _____

Reason for Failure: _____

Medical or contraindication reason to override trial requirements: _____

_____

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

Iowa Department of Human Services

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

Requests for Non-Preferred Drugs:

DPP-4 Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Incretin Mimetic Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

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

_____

Attach lab results and other documentation as necessary.

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

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

Payment for a non-preferred anti-diabetic, non-insulin agent subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with Metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor combination and a preferred Incretin Mimetic at maximally tolerated doses, unless evidence if provided that use of these agents would be medically contraindicated.

Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented continued improvement in HgbA1C.

Use form 470-5259, *Request for Prior Authorization: Anti-Diabetic, Non-Insulin Agents*, to request prior authorization. Click here to see a sample of the form.

11. Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products

Prior authorization is required for **preferred** antiemetic-5HT3 receptor antagonists/substance P neurokinin medications for quantities exceeding the following dosage limits per month.

- Aprepitant/Emend®:
  - Four 125 mg capsules
  - Eight 80 mg capsules
- Dolasetron/Anzemet®:
  - Five 50 mg tablets
  - Five 100 mg tablets
- Granisetron/Kytril®:
  - Eight 1 mg tablets
  - 30 ml oral solution (1 mg/5 ml)
  - Eight vials (1 mg/ml)
  - Two vials (4 mg/ml)
- Ondansetron ODT/Zofran ODT®:
  - Twelve 4 mg tablets
  - Twelve 8 mg tablets

- Ondansetron/Zofran®:
  - Twelve 4 mg tablets
  - Twelve 8 mg tablets
  - Four 24 mg tablets
  - 50 ml/month oral solution (4 mg/5 ml)
  - Four 20 ml vials (2 mg/ml)
  - Eight 2 ml vials (2 mg/ml)
- Palonosetron/Aloxi®: Four vials (0.25 mg/ml)

Payment for antiemetic-5HT3 receptor antagonists/substance P neurokinin agents beyond these limits will be considered on an individual basis after review of submitted documentation.

NOTE: Aprepitant (Emend®) is payable only when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.

Prior authorization is required for all **nonpreferred** antiemetic-5HT3 receptor antagonists/substance P neurokinin medications beginning the first day of therapy.

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

Use form 470-4410, *Request for Prior Authorization: Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products*, to request prior authorization. Click here to see a sample of the form.

12. Antifungal Therapy

Prior authorization is not required for **preferred** oral antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient.

Payment for any oral antifungal therapy beyond this limit will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This prior authorization requirement does not apply to nystatin.

Prior authorization is required for all **nonpreferred** oral antifungal therapy beginning the first day of therapy. Payment for a nonpreferred oral antifungal agent will be authorized only for cases with documentation of previous trial and therapy failure with a preferred agent.

Iowa Department of Human Services

Request for Prior Authorization
ANTIHISTAMINES-ORAL

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must fill all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for all non-preferred oral antihistamines.
Patients 21 years of age and older must have three unsuccessful trials with oral antihistamines that do not require prior authorization, 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 an unsuccessful trial 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.

Preferred 1st Generation Antihistamines (no PA required)

- ☐ Chlorpheniramine Maleate (OTC)
- ☐ Diphenhydramine (OTC)
- ☐ Other preferred as listed on PDL

Non- Preferred 1st Generation Antihistamines (PA required)

- ☐ Carbinoxamine Maleate
- ☐ Clemastine Fumarate
- ☐ Cyproheptadine
- ☐ Dexchlorpheniramine Maleate

Preferred 2nd Generation OTC Antihistamines (no PA required)

- ☐ Loratadine Tab (OTC)
- ☐ Loratadine Syrup (OTC)
- ☐ Cetirizine Tab (OTC)
- ☐ Cetirizine Syrup (OTC)

Non-Preferred 2nd Generation Antihistamines (PA required)

- ☐ Clarinex/Clarinex D
- ☐ Desloratadine
- ☐ Levocetirizine
- ☐ Xyzal

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:_____

Document antihistamine treatment failure(s) including drug names, strength, exact date ranges and failure reasons:

_____

_____

Medical or contraindication reason to override trial requirements:_____

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

Attach lab results and other documentation as necessary.

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

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

Iowa Department of Human Services

Request for Prior Authorization
APIXABAN (ELIQUIS®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for apixaban (Eliquis®). Payment will be considered under the following conditions: 1) Patient has a diagnosis of non-valvular atrial fibrillation; and 2) Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial); and 3) Presence of at least one additional risk factor for stroke, with a $CHADS_2$ score ≥ 1; and 4) Patient does not have a mechanical prosthetic heart valve; and 5) Patient does not have active pathological bleeding; and 6) Patient does not have severe renal impairment (CrCl < 15mL/min) or is not on dialysis. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

☐ Eliquis®

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Treatment failure with warfarin:

Trial dose: _____ Trial dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies: _____

Does patient have mechanical prosthetic heart valve? ☐ Yes ☐ No

Does patient have active pathological bleeding? ☐ Yes ☐ No

Does patient have severe renal impairment (CrCl < 15mL/min)? ☐ Yes ☐ No

Serum Creatinine: _____ **Date obtained:** _____

Is patient on dialysis? ☐ Yes ☐ No

Patient's Weight: _____ **Date obtained:** _____

Request for Prior Authorization
APIXABAN (ELIQUIS®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Documentation of additional risk factors and $CHADS_2$ score:

Risk factor based $CHADS_2$ Score	
Risk Factors	Score
☐ Congestive heart failure	1
☐ Hypertension (systolic > 160mmHg)	1
☐ Age ≥ 75 years	1
☐ Diabetes mellitus	1
☐ Stroke / TIA / thrombo-embolism	2
Total	

Attach lab results and other documentation as necessary.

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

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

Use form 470-4094, *Request for Prior Authorization: Antifungal Drugs*, to request prior authorization. Click here to see a sample of the form.

13. Antihistamines

Prior authorization is required for all **nonpreferred** antihistamines and preferred second-generation prescription antihistamines.

- Members aged 21 or older must have three unsuccessful trials with oral antihistamines that do not require prior authorization prior to the approval of a nonpreferred oral antihistamine. Two of the trials must be with cetirizine and loratadine.
- Members aged 20 or younger must have unsuccessful trials of cetirizine and loratadine prior to the approval of a nonpreferred oral antihistamine.

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

Use form 470-4095, *Request for Prior Authorization: Antihistamines-Oral*, to request prior authorization. Click here to see a sample of the form.

14. Apixaban (Eliquis®)

Prior authorization is required for apixaban (Eliquis®). Payment will be considered for patients under the following conditions:

- Patient has a diagnosis of non-valvular atrial fibrillation; and
- Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum six month trial); and
- Presence of at least one additional risk factor for stroke, with $CHADS_2$ score ≥1; and
- Patient does not have a mechanical prosthetic heart valve; and
- Patient does not have active bleeding; and
- Patient does not have severe renal impairment (CrCl <15mL/min) or is not on dialysis.

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

Use form 470-5207, *Request for Prior Authorization: Apixaban (Eliquis®)*, to request prior authorization. Click here to see a sample of the form.

15. Becaplermin (Regranex®)

Prior authorization is required for Regranex®. Payment for new prescriptions will be authorized for ten weeks for patients who meet the following criteria:

- Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond.
- Inadequate response to two weeks of wound debridement and topical moist wound dressing.

Authorization will be approved beyond ten weeks for patients whose wound has decreased in size by 30% after ten weeks.

Use form 470-4276, *Request for Prior Authorization: Becaplermin (Regranex®)*, to request prior authorization. Click here to see a sample of the form.

16. Benzodiazepines

Prior authorization is required for nonpreferred benzodiazepines. Payment for nonpreferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. Requests for clobazam (Onfi) will be considered for a diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS) in patients two years of age and older when used as an adjunctive treatment. If a long-acting medication is requested, one of the therapeutic trials must include the immediate-release form of the requested benzodiazepine.

Prior authorization will be approved for up to 12 months for documented:

- Generalized anxiety disorder
- Panic attack with or without agoraphobia
- Seizure
- Nonprogressive motor disorder
- Dystonia

Prior authorization requests will be approved for up to a three-month period for all other diagnoses related to the use of benzodiazepines.

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

Use form 470-4117, *Request for Prior Authorization: Benzodiazepines*, to request prior authorization. Click here to see a sample of the form.

17. Biologicals for Ankylosing Spondylitis

Prior authorization is required for biologicals used for ankylosing spondylitis. Payment will be considered following inadequate responses to two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses unless there are documented adverse responses or contraindications to NSAID use. Trials should be at least three months in duration.

Patients with symptoms of peripheral arthritis must also have failed a 30-day trial with at least one conventional disease-modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate.

Payment for nonpreferred biologicals for ankylosing spondylitis will be considered only for cases in which there is documentation of a previous trials and therapy failures with two preferred biological agents.

Use form 470-4521, *Request for Prior Authorization: Biologicals for Ankylosing Spondylitis*, to request prior authorization. Click here to see a sample of the form.

18. Biologicals for Arthritis

Prior authorization is required for biologicals used for arthritis. Patients initiating therapy with a biological agent must:

- Be screened for hepatitis B and C. Patients with active hepatitis B will not be considered for coverage.
- Not have been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last five years of starting or resuming treatment with a biological agent.
- Not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV with an ejection fraction of 50% or less.
- Be screened for latent TB infection. Patients with latent TB infection will only be considered after one month of TB treatment. Patients with active TB will only be considered upon completion of TB treatment.

Payment will be considered under the following conditions:

- A diagnosis of rheumatoid arthritis (RA). A trial and inadequate response to two preferred disease-modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline). Upon an unsuccessful methotrexate trial in patients with established RA, the combination trial with a second DMARD may be overridden if there is evidence of severe disease documented by radiographic erosions.
- A diagnosis of moderate to severe psoriatic arthritis. A trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).
- A diagnosis of moderate to severe juvenile idiopathic arthritis. A trial and inadequate response to intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

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

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

Use form 470-4522, *Request for Prior Authorization: Biologicals for Arthritis*, to request prior authorization. Click here to see a sample of the form.

19. Biologicals for Inflammatory Bowel Disease

Prior authorization is required for biologicals used for inflammatory bowel disease.

Payment for nonpreferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

- Crohn's disease. Payment will be considered following an inadequate response to two preferred conventional therapies, such as aminosalicylates (mesalamine, sulfasalazine), corticosteroids, azathioprine/6-mercaptopurine, or methotrexate.

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

Use form 470-4523, *Request for Prior Authorization: Biologicals for Inflammatory Bowel Disease*, to request prior authorization. Click here to see a sample of the form.

20. Biologicals for Plaque Psoriasis

Prior authorization is required for biologicals used for plaque psoriasis. Payment will be considered following an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine.

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

Use form 470-4524, *Request for Prior Authorization: Biologicals for Plaque Psoriasis*, to request prior authorization. Click here to see a sample of the form.

21. BRAF Inhibitors

Prior authorization is required for BRAF inhibitors. Payment will be considered for patients when the following criteria are met:

- Patient is 18 years of age or older, and
- Has a diagnosis of unresectable or metastatic melanoma with BRAFV600E mutation as detected by an FDA-approved test, and
- Prescriber is an oncologist.

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

Use form 470-5136, *Request for Prior Authorization: BRAF Inhibitors*, to request prior authorization. Click here to see a sample of the form.

22. Buprenorphine (Butrans™) Transdermal System

Prior authorization is required for Butrans™. Payment will be considered when the following criteria are met:

- Previous trials and therapy failures at a therapeutic dose with two preferred long-acting opioids. The preferred trials must allow for adequate dose titration and show use of a short-acting narcotic for breakthrough pain.
- A trial and therapy failure with fentanyl patch at maximum tolerated dose.

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

Use form 470-5017, *Request for Prior Authorization: Buprenorphine (Butrans™) Transdermal System*, to request prior authorization. Click here to see a sample of the form.

23. Buprenorphine/Naloxone (Suboxone®)

Prior authorization is required for buprenorphine or buprenorphine/naloxone (Suboxone®). Requests for doses above 24mg per day or greater than once daily dosing will not be considered. Initial requests will be considered for up to three months. Requests for maintenance doses above 16mg per day will not be considered on a long-term basis.

Concomitant use with opioids, tramadol, and hypnotics will be prohibited. Benzodiazepines will be allowed up to a cumulative 30 days per 12 month period. Payment will be considered for patients when the following is met:

- Patient has a diagnosis of opioid dependence and is 16 years of age or older; AND
- Prescriber meets qualification criteria to prescribe buprenorphine/naloxone (Suboxone®) for opioid dependence and has an "X" DEA number; AND
- Patient is participating in and compliant with formal substance abuse counseling or psychosocial therapy; AND
- A projected treatment plan is provided, including:
  - Anticipated induction and stabilization dose,
  - Anticipated maintenance dose,
  - Expected frequency of office visits, and
  - Expected frequency of counseling or psychosocial therapy visits

- Requests for renewal must include:
  - An updated treatment plan, including consideration of a medical taper to the lowest effective dose based on a self-assessment scale,
  - Documentation the Iowa Prescription Monitoring Program website has been reviewed for the patient's use of controlled substances since the last prior authorization request,
  - Documentation of a current, negative drug screen,
  - Documentation the patient has been compliant with office visits and counseling or psychosocial therapy visits.

Requests for buprenorphine will only be considered for pregnant patients.

Use form 470-5142, *Request for Prior Authorization: Buprenorphine/ Naloxone (Suboxone®)*, to request prior authorization. Click here to see a sample of the form.

24. Chronic Pain Syndrome Agents

Prior authorization is required for duloxetine (Cymbalta®), pregabalin (Lyrica®), and milnacipran (Savella™). Payment will be considered under the following conditions:

- A diagnosis of **fibromyalgia** (Cymbalta®, Lyrica®, and Savella™) with:
  - A trial and therapy failure at a therapeutic dose with three drugs from three distinct therapeutic classes from the following: tricyclic antidepressant, muscle relaxant, SSRI/SNRI, tramadol, or gabapentin, **and**
  - Documented non-pharmacologic therapies (cognitive behavior therapies, exercise, etc.), **and**
  - Documentation of a previous trial and therapy failure at a therapeutic dose with Savella™ when Cymbalta® and Lyrica® are requested.
- A diagnosis of **postherpetic neuralgia** (Lyrica®) with a trial and therapy failure at a therapeutic dose with at least two drugs from two distinct therapeutic classes from the following: tricyclic antidepressant, topical lidocaine, valproate, carbamazepine, or gabapentin
- A diagnosis of **diabetic peripheral neuropathy** (Cymbalta® and Lyrica®) with a trial and therapy failure at a therapeutic dose with at least two drugs from two distinct therapeutic classes from the following: tricyclic antidepressant, topical lidocaine, tramadol, or gabapentin

- A diagnosis of **partial onset seizures**, as adjunct therapy (Lyrica®)
- A diagnosis of major depressive disorder or generalized anxiety disorder (Cymbalta®)
- A diagnosis of **chronic musculoskeletal pain** (Cymbalta®) with a trial and therapy failure at a therapeutic dose with at least three drugs from three distinct therapeutic classes from the following: NSAIDs, opioids, tramadol, or tricyclic antidepressants.

Requests for concomitant use of these agents for an indicated chronic pain diagnosis may only be considered once each agent has been tried at maximum tolerated dose separately. Duplicate use of drugs from the same therapeutic category will not be considered.

Use form 470-4551, *Request for Prior Authorization: Chronic Pain Syndrome*, to request prior authorization. Click here to see a sample of the form.

25. Colchicine (Colcrys®)

Prior authorization is not required for colchicine (Colcrys®) for the treatment of acute gout for 3 tablets per 60-day period. Prior authorization is required for colchicine (Colcrys®) for the treatment of chronic hyperuricemia/gout prophylaxis or Familial Mediterranean fever. Payment will be considered under the following conditions:

- Chronic hyperuricemia/gout prophylaxis following a trial and therapy failure at a therapeutic dose with allopurinol or probenecid. A quantity limit of 60 tablets per 30 days will be applied, when criteria for coverage are met.
- Familial Mediterranean fever. A maximum quantity limit of 120 tablets per 30 days will be applied for this diagnosis.

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

Use form 470-5059, *Request for Prior Authorization: Colchicine (Colcrys®)*, to request prior authorization. Click here to see a sample of the form.

26. Concurrent IM/PO Antipsychotic Use

Prior authorization is required for concurrent long-acting injectable and oral antipsychotic medications after 12 weeks (84 days) of concomitant treatment. Consideration of concomitant therapy beyond 12 weeks (84 days) will require documentation of medical necessity.

Prior authorization is required for all nonpreferred antipsychotics as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for nonpreferred antipsychotics will be considered only for cases in which there is documentation of previous trials and therapy failures with a preferred agent.

Use form 470-4594, *Request for Prior Authorization: Concurrent IM/PO Antipsychotic Utilization*, to request prior authorization. Click here to see a sample of the form.

27. Crizotinib (Xalkori®)

Prior authorization is required for Xalkori® (Crizotinib). Payment will be considered for patients when the following is met:

- Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test (attach copy of results); and
- Is prescribed by an oncologist.

Use form 470-5118, *Request for Prior Authorization: Crizotinib (Xalkori®)*, to request prior authorization. Click here to see a sample of the form.

28. Dabigatran (Pradaxa®)

Prior authorization is required for dabigatran (Pradaxa®). Payment will be considered for patients under the following conditions:

- Patient has a diagnosis of non-valvular atrial fibrillation; and
- Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum six month trial); and
- Presence of at least one additional risk factor for stroke, with a $CHADS_2$ score ≥1; and
- Patient does not have a mechanical prosthetic heart valve; and
- Patient does not have active pathological bleeding; and
- Patient does not have severe renal impairment (CrCl < 15mL/min) or is not on dialysis.

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

Use form 470-5171, *Request for Prior Authorization: Dabigatran (Pradaxa®)*, to request prior authorization. Click here to see a sample of the form.

29. Dalfampridine (Ampyra™)

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

- For patients that have a gait disorder associated with MS.
- Initial authorizations will be approved for 12 weeks with a baseline timed 25-foot walk (T25FW) assessment.
- Additional prior authorizations will be considered at six-month intervals after assessing the benefit to the patient as measured by a 20% improvement in T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained.
- Prior authorizations will not be considered for patients with a seizure diagnosis or in patients with moderate or severe renal impairment.

Use form 470-5015, *Request for Prior Authorization: Dalfampridine (Ampyra™)*, to request prior authorization. Click here to see a sample of the form.

30. Dextromethorphan and Quinidine (Nuedexta™)

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

- Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to amyotrophic lateral sclerosis (ALS) or multiple sclerosis (MS).
- A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI.
- Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire.
- Subsequent prior authorizations will be considered at six month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire.

Use form 470-5084, *Request for Prior Authorization: Dextromethorphan and Quinidine (Nuedexta™)*, to request prior authorization. Click here to see a sample of the form.

31. Dornase Alfa (Pulmozyme®)

Prior authorization is required for Pulmozyme®. Payment will be authorized only for cases in which there is a diagnosis of cystic fibrosis.

Use form 470-4104, *Request for Prior Authorization: Miscellaneous*, to request prior authorization. Click here to see a sample of the form.

32. Eplerenone (Inspra®)

Prior authorization is required for Inspra®. Payment will be authorized only in cases where there is documented trial and therapy failure on Aldactone® or documented cases of gynecomastia from Aldactone® therapy.

Use form 470-4104, *Request for Prior Authorization: Miscellaneous*, to request prior authorization. Click here to see a sample of the form.

33. Erythropoiesis Stimulating Agents

Prior authorization is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia.

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

Patients who meet all of the following criteria may receive prior authorization for the use of erythropoiesis stimulating agents:

- Hemoglobin less than 10g/dL. If renewal of prior authorization is being requested, a hemoglobin less than 11g/dL (or less than 10g/dL for patients with Chronic Kidney Disease (CKD) not on dialysis) will be required for continued treatment. Hemoglobin laboratory values must be dated within four weeks of the prior authorization request.
- Transferrin saturation greater than or equal to 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron binding capacity), ferritin levels greater than or equal to 100 mg/ml, or on concurrent therapeutic iron therapy.

  Transferrin saturation or ferritin levels must be dated within three months of the prior authorization request.

- For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy.
- No evidence of untreated GI bleeding, hemolysis, or vitamin B-12, iron or folate deficiency.

Use form 470-4098, *Request for Prior Authorization: Erythropoiesis Stimulating Agents*, to request prior authorization. Click here to see a sample of the form.

34. Extended-Release Formulations

Payment for a nonpreferred extended-release formulation will be considered when both of the following criteria are met:

- Previous trial with the preferred immediate-release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance, and
- Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity that is indicated to treat the submitted diagnosis.

Use form 470-4550, *Request for Prior Authorization: Extended Release Formulations*, to request prior authorization. Click here to see a sample of the form.

35. Febuxostat (Uloric®)

Prior authorization is required for febuxostat (Uloric®). Payment for febuxostat (Uloric®) will only be considered for cases in which there is a diagnosis of gout still persistent while currently using 300 mg per day of a preferred allopurinol product unless documentation is provided that such as trial would be medically contraindicated.

Use form 470-4849, *Request for Prior Authorization: Febuxostat (Uloric®)*, to request prior authorization. Click here to see a sample of the form.

36. Fentanyl, Short-Acting Oral Products

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

Iowa Department of Human Services

Request for Prior Authorization
EXTENDED RELEASE FORMULATIONS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Payment for a non-preferred extended release formulation will be considered when the following criteria for coverage are met: 1) Previous trial and therapy failure with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2) Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Prior Authorization is required for the following extended release formulations: Adoxa ,Augmentin XR, Cardura XL, Cipro XR, ConZip ER, Coreg CR, Doryx, Flagyl ER, Fortamet, Gralise, Keppra XR, Lamictal XR, Luvox CR, metronidazole sr, Mirapex ER, Moxatag, Namenda XR, Nexiclon XR, Oleptro,Oxtellar XR, Prozac Weekly, Rayos, Requip XL, Rythmol SR, Ryzolt, Sanctura XR, Seroquel XR, Solodyn ER, tramadol sr, Trokendi XR, Ultram ER.

Drug Name:_____ **Strength:**_____

Dosage Instructions:_____ **Quantity:**_____ **Days Supply:** _____

Diagnosis:_____

Previous therapy with immediate release product of same chemical entity (include strength, exact date ranges, and reason for failure):_____

_____

Previous therapy with a preferred drug of a different chemical entity (include strength, exact date ranges, and reason for failure):_____

_____

Contraindication(s) to using immediate release product and/or a preferred drug of a different chemical entity:

_____

_____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

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

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

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

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

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

37. Granulocyte Colony Stimulating Factor Agents

Prior authorization is required for therapy with granulocyte colony stimulating factor agents.

Payment for **nonpreferred** granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Laboratory values for complete blood and platelet count must be obtained as directed by the manufacturer's instructions.

Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines. Payment shall be authorized for one of the following uses:

- Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
- Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant.
- Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy.
- Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.

Use form 470-4099, *Request for Prior Authorization: Granulocyte Colony Stimulating Factor*, to request prior authorization. Click here to see a sample of the form.

38. Growth Hormones

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

All of the following criteria must be met for approval for prescribing of growth hormones:

- Standard deviation of 2.0 or more below mean height for chronological age.
- No intracranial lesion or tumor diagnosed by MRI.
- Growth rate below five centimeters per year.
- Annual bone age testing is required for the diagnosis of growth hormone deficiency. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required.
- Epiphyses open.
- Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter.

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

Idiopathic short stature (ISS) is an FDA approved indication for growth hormone therapy but treatment is not considered medically necessary. Requests on this basis will be denied.

A request for Zorbtive® [somatropin (rDNA origin) for injection], will be approved for the treatment of short bowel syndrome in patients receiving specialized nutritional support. Zorbtive® therapy should be used in conjunction with optimal management of short bowel syndrome.

Use form 470-4100, *Request for Prior Authorization: Growth Hormones*, to request prior authorization. Click here to see a sample of the form.

Iowa Department of Human Services

Request for Prior Authorization
HEPATITIS C ANTIVIRAL AGENTS
PROTEASE INHIBITORS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for direct-acting oral antiviral agents against the hepatitis C virus. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions: 1) Patient is 18 years of age or older, and 2) Patient's prior treatment history is provided (treatment naïve, prior null responder, partial responder, or relapser); and 3) If patient has a history of failed treatment due to non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and 4) Patient has not previously tried or failed therapy with a hepatitis C protease inhibitor; and 5) Patient is not a pregnant female or a male with a pregnant female partner; and 6) Women of childbearing potential and their male partners must use two forms of effective contraception (non-hormonal contraception for patients taking Incivek) during treatment and for at least 6 months after treatment has concluded; and 7) Documentation that routine monthly pregnancy tests are performed during this time; and 8) Patient has abstained from the use of illicit drugs and alcohol for a minimum of three (3) months as evidenced by a negative urine confirmation test; and 9) Prescriber is an infectious disease specialist, gastroenterologist, hepatologist, or other hepatitis specialist. 10) Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved. 11) Lost or stolen medication replacement requests will not be authorized. 12) The 72-hour emergency supply rule does not apply to oral hepatitis C antiviral agents.

Preferred: ☐ Incivek ☐ Victrelis **Non-Preferred:** ☐ Olysio

Diagnosis:

☐ Chronic Hepatitis C HCV Genotype **(attach results)** ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4

☐ Treatment naïve ☐ Relapser ☐ Partial Responder ☐ Prior null responder

☐ Treatment Initiation ☐ Continuation of therapy, current week: _____

Prior Hepatitis Treatment: ☐ Yes (complete below information) ☐ No

Drug Name & Dose: _____ Dates/Duration of use: _____

Drug Name & Dose: _____ Dates/Duration of use: _____

Has member been previously treated with a HCV protease inhibitor? ☐ Yes ☐ No

Medical necessity for retreatment: _____

Member History:

☐ Does member currently have substance use disorder (illicit drugs or alcohol)? ☐ Yes ☐ No

If no, has member been abstinent for a minimum of 3 months confirmed by urine confirmation test?

☐ Yes **(attach results)** ☐ No

☐ Does member have a history of non-compliance? ☐ Yes ☐ No

Iowa Department of Human Services

Request for Prior Authorization
HEPATITIS C ANTIVIRAL AGENTS
PROTEASE INHIBITORS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

If yes, document steps taken to correct or address non-compliance: _____
_____

If female of childbearing years, confirmed negative serum pregnancy test: ☐ Yes ☐ No Date of test: _____
Will monthly pregnancy tests be performed during treatment and for 6 months after treatment is concluded:

☐ Yes ☐ No

If male, pregnant female partner: ☐ Yes ☐ No

Specify two forms of contraception: _____

Does patient have HIV co-infection: ☐ Yes ☐ No

Is patient receiving dialysis: ☐ Yes ☐ No CrCl: _____ Date Obtained: _____

Does patient have decompensated cirrhosis: ☐ Yes ☐ No

Prescriber information:

☐ infectious disease specialist ☐ gastroenterologist ☐ hepatologist

☐ other hepatitis specialist (please specify):_____ ☐ other (please specify): _____

Patient receiving concurrent peg-interferon alfa and ribavirin? ☐ Yes ☐ No

☐ **Incivek (A maximum 12 weeks of therapy will be allowed based on response)**
Dosing Instructions: _____

HCV-RNA Results at Week 4: _____Date Drawn: _____

☐ **Victrelis (A maximum 24, 32 or 44 weeks will be allowed based on response)**
Dosing Instructions: _____

HCV-RNA Results at Week 8 (including lead in period): _____

HCV-RNA Results at Week 12 (including lead in period): _____

HCV-RNA Results at Week 24 (including lead in period): _____

☐ **Olysio (A maximum 12 weeks of therapy will be allowed based on response)**

If treating genotype 1a, is the NS3 Q80K polymorphism present: ☐ Yes ☐ No

HCV-RNA Results at Week 4: _____Date Drawn: _____

Reason for use of non-preferred drug: _____
_____

Attach lab results and other documentation as necessary.

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

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

39. Hepatitis C Protease Inhibitors-Oral (Incivek™ and Victrelis™)

Prior authorization is required for all oral hepatitis C protease inhibitors. Payment will be considered under the following conditions:

- A diagnosis of hepatitis C genotype 1.
- Patient is 18 years of age or older.
- Adminsitered in combination with peginterferon alfa and ribavirin.
- HCV-RNA results are required at treatment week four for telaprevir (Incivek™). Additional prior authorization will be considered with documentation of response to treatment, measured by HCV-RNA levels. A maximum of 12 weeks of therapy will be allowed for telaprevir (Incivek™).
- HCV-RNA results are required at treatment week 8, 12, and 24 (including lead in period) for boceprevir (Victrelis™). Additional prior authorizations will be considered with documentation of response to treatment, measured by HCV-RNA levels. Prior authorizations will be approved for a maximum of 24, 32, or 44 weeks of therapy with boceprevir (Victrelis™) based on response.

Use form 470-5066, *Request for Prior Authorization: Hepatitis C Antiviral Agents Protease Inhibitors*, to request prior authorization. Click here to see a sample of the form.

40. Immunomodulators – Topical

Prior authorization is required for topical immunomodulators. When there is an adequate trial and therapy failure with two preferred topical corticosteroids, payment will be considered:

- For pimecrolimus (Elidel®) or tacrolimus (Protopic®) 0.03% for non-immunocompromised patients two years of age and older; and
- For tacrolimus (Protopic®) 0.1% for patients 16 years of age and older

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

Use form 470-5040, *Request for Prior Authorization: Immunomodulators – Topical*, to request prior authorization. Click here to see a sample of the form.

If criteria for coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 grams or 100 grams for all other areas.

41. Insulin Pens, Pre-Filled

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

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

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

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

42. Isotretinoin (Oral)

Prior authorization is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne under the following conditions:

- There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Trials and failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata.
- Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (https://www.ipledgeprogram.com/) risk management program.

Payment for nonpreferred oral isotretinoin products will be authorized only for cases in which there is documentation of trials and therapy failure with a preferred agent. Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

Use form 470-4101, *Request for Prior Authorization: Isotretinoin (Oral)*, to request prior authorization. Click here to see a sample of the form.

43. Ivacaftor (Kalydeco™)

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

- Patient is six years of age or older; and
- Has a diagnosis of cystic fibrosis with a G551D mutation in the CFTR gene as detected by an FDA-cleared cystic fibrosis mutation test; and
- Prescriber is a cystic fibrosis specialist or pulmonologist; and
- Patient does not have one of the following infections: *Burkholderia cenecepacia, dolosa, or Mycobacterium abcessus.*

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

44. Janus Kinase Inhibitors

Prior authorization is required for Janus kinase inhibitors. Payment will be considered when the following conditions are met:

- Patient is 18 years of age or older; and
- Has a diagnosis of moderate to severe rheumatoid arthritis; and
- Has a documented trial and inadequate response to two preferred oral disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, leflunomide, or minocycline); and
- Has a documented trial and inadequate response to two preferred biological DMARDs; and
- The patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and
- Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and
- Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to manufacturer labeling; and

- Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and
- Patient is not at an increased risk of gastrointestinal perforation.

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

Use form 470-5175, *Request for Prior Authorization: Janus Kinase Inhibitors*, to request prior authorization. Click here to see a sample of the form.

45. Ketorolac Tromethamine (Toradol®)

Prior authorization is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short-term management of moderately severe, acute pain (up to five days). It is **not** indicated for minor or chronic conditions. This product carries a Black Box Warning.

Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five days. Payment will be approved for the preferred product under the following conditions:

- For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given.
- Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40 mg/day. Maximum IV/IM dose is 120 mg/day. Maximum intranasal dose is 126 mg/day. Maximum duration of therapy is 5 days per month.
- Diagnosis indicating moderately severe, acute pain.

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

Use form 470-4102, *Request for Prior Authorization: Ketorolac Tromethamine (Toradol®)*, to request prior authorization. Click here to see a sample of the form.

Iowa Department of Human Services

Request for Prior Authorization
LIDOCAINE PATCH (LIDODERM®)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for topical lidocaine patches (Lidoderm®). Payment will be considered for a diagnosis of pain associated with post-herpetic neuralgia following a previous treatment failure with a preferred agent at therapeutic dose from two of the following: tricyclic antidepressant, opioid, gabapentin, carbamazepine, or valproic acid. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.

Non-Preferred

☐ Lidoderm ☐ Lidocaine Patch

Dosage Instructions **Quantity** **Days Supply**

_____ _____ _____

Diagnosis: _____

Trial Drug Name/Dose: _____ Trial Dates: _____

Reason for Failure: _____

Trial Drug Name/Dose: _____ Trial Dates: _____

Reason for Failure: _____

Other relevant information: _____

Attach lab results and other documentation as necessary.

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

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

46. Lidocaine Patch (Lidoderm®)

Prior authorization is required for topical lidocaine patches (Lidoderm®). Payment will be considered for a diagnosis of pain associated with post-herpetic neuralgia following a previous treatment failure with a preferred agent at therapeutic dose from two of the following: tricyclic antidepressant, opioid, gabapentin, carbamazepine, or valproic acid.

A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.

Use form 470-4898, *Request for Prior Authorization: Lidocaine Patch (Lidoderm®)*, to request prior authorization. Click here to see a sample of the form.

47. Linezolid (Zyvox®)

Prior authorization is required for linezolid (Zyvox®). Payment for Zyvox® will be authorized when there is documentation that:

- The prescriber is an infectious disease physician or has consulted an infectious disease physician. (Telephone consultation is acceptable.)
- The member has an active infection that meets one of the following diagnostic criteria:
  - Vancomycin-resistant enterococcus (VRE) when no alternative regimens with documented efficacy are available and VRE is not in lower urinary tract.
  - VRE in the lower urinary tract if severe renal insufficiency exists or the patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.
  - Methicillin-resistant staphylococcus aureus (MRSA) when the patient is intolerant to vancomycin.*
  - Methicillin-resistant staphylococcus epidermis (MRSE) when the patient is intolerant to vancomycin.*

* Severe intolerance to vancomycin is defined as:

- Severe rash, immune-complex-mediated, determined to be directly related to vancomycin administration.
- Red-man's syndrome (histamine-mediated), refractory to traditional countermeasures (e.g., prolonged IV infusion, premedicated with diphenhydramine).

Use form 470-4275, *Request for Prior Authorization: Linezolid (Zyvox®)*, to request prior authorization. Click here to see a sample of the form.

48. Long Acting Narcotics

Prior authorization is required for all non-preferred long-acting narcotics. Payment will be considered under the following conditions:

- There is documentation of previous trials and therapy failures with two chemically distinct preferred long-acting narcotics (such as morphine sulfate ER, Opana ER, and methadone) at therapeutic doses, and
- A trial and therapy failure with fentanyl patch at maximum tolerated dose, and
- A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization.
- The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring program website at https://pmp.iowa.gov/IAPMPWebCenter/ prior to requesting the prior authorization.
- Requests for long-acting narcotics will only be considered for FDA approved dosing.

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

Use form 470-4409, *Request for Prior Authorization: Long-Acting Narcotics*, to request prior authorization. Click here to see a sample of the form.

49. Mifepristone (Korlym®)

Prior authorization is required for mifepristone (Korlym®). Payment will be considered for patients when the following is met:

- The patient is 18 years of age or older; and
- Has a diagnosis of endogenous Cushing's Syndrome with hyperglycemia secondary to hypercortisolism in patients with Type 2 Diabetes or glucose intolerance; and
- Patient must have failure surgery or is not a candidate for surgery; and

Iowa Department of Human Services

Request for Prior Authorization
MODIFIED FORMULATIONS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Payment for a non-preferred 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 the use of these preferred agent(s) would be medically contraindicated.

☐ Invega (trial of risperidone) ☐ Trilipix (trial of Tricor) ☐ Xopenex Nebs (trial of albuterol nebs)

☐ Xopenex HFA (trial of albuterol HFA)

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

☐ Abilify Discmelt (trial of Abilify solution) ☐ Aricept ODT (trial of Aricept tablets) ☐ Binosto (trial of alendronate tablets)

☐ Fazaclo (trial of clozapine tablets) ☐ Metozolv ODT (trial of metoclopramide solution)

☐ Remeron SolTab (trial of mirtazapine tablets) ☐ Risperdal M-Tab (trial of risperidone solution)

☐ Zyprexa Zydis (trial of Zyprexa tablets)

Strength: _____Dosage Instructions: _____Quantity: _____**Days Supply: _____**

Diagnosis: _____

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

Failure Reason: _____

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

Failure Reason: _____

Medical Necessity for alternative delivery system: _____

Failure Reason of preferred alternative delivery system: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

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

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

- Prescriber is an endocrinologist.
- Female patients of reproductive age must have a negative pregnancy test confirmed within the last seven days and must use a non-hormonal method of contraception during treatment and for one month after stopping treatment.

Use form 470-5141, *Request for Prior Authorization: Mifepristone (Korlym®)*, to request prior authorization. Click here to see a sample of the form.

50. Modified Formulations

Payment for a nonpreferred isomer, pro-drug, or metabolite will be considered when the following criteria are met:

- Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and
- Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available.

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

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

Use form 470-4705, *Request for Prior Authorization: Modified Formulations*, to request prior authorization. Click here to see a sample of the form.

51. Multiple Sclerosis-Oral Agents

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

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

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

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

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

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

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

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

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

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

52. Muscle Relaxants

Prior authorization is required for nonpreferred muscle relaxants. Payment for **nonpreferred** muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failure with at least three preferred muscle relaxants.

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

If a nonpreferred long-acting medication is requested, one trial must include the preferred immediate-release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.

Use form 470-4105, *Request for Prior Authorization: Muscle Relaxants*, to request prior authorization. Click here to see a sample of the form.

53. Narcotic Agonist-Antagonist Nasal Sprays

Prior authorization is required for narcotic agonist-antagonist nasal sprays. The member's diagnosis must be supplied for consideration.

If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines.

For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration.

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

Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.

Use form 470-4106, *Request for Prior Authorization: Narcotic Agonist/ Antagonist Nasal Sprays*, to request prior authorization. Click here to see a sample of the form.

54. Nebivolol (Bystolic®)

Prior authorization is required for Bystolic®. Payment will be considered in cases where there are documented trials and therapy failures with two preferred cardio-selective beta-blockers of a different chemical entity at a therapeutic dose. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Use form 470-5099, *Request for Prior Authorization: Nebivolol (Bystolic®)*, to request prior authorization. Click here to see a sample of the form.

55. Nicotine Replacement Products

Prior authorization is required for over-the-counter nicotine replacement patches, gum or lozenges, and prescription nicotine nasal spray or inhaler. Requests for authorization must include:

- Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
- Confirmation of enrollment in the Quitline Iowa counseling program is required for approval. Continuation therapy is available only with documentation of ongoing participation in the Quitline Iowa program.
- Approvals will be granted only for patients 18 years of age and older.
- The maximum allowed duration of therapy is 12 weeks total combined therapy within a 12-month period.
- Patients may receive nicotine replacement patches in combination with an oral nicotine replacement product (gum or lozenges).
- A maximum quantity of 14 nicotine replacement patches and 110 pieces of nicotine gum or 144 nicotine lozenges may be dispensed with the initial prescription. Subsequent prescription refills will be allowed for a four-week supply at one unit per day of nicotine replacement patches and 330 pieces of nicotine gum or 288 nicotine lozenges.
- Requests for nonpreferred nicotine replacement products will be considered after documentation of previous trials and intolerance with a preferred oral and preferred topical nicotine replacement product. A maximum quantity of 168 nicotine inhalers or 40ml nicotine nasal spray may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a four-week supply at 336 nicotine inhalers or 80ml of nicotine nasal spray.
- The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation.

Use form 470-4421, *Request for Prior Authorization: Nicotine Replacement Therapy*, to request prior authorization. Click here to see a sample of the form.

56. Nonparenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products

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

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

Payment for oral vasopressin derivatives of posterior pituitary hormone products used in the treatment of primary nocturnal enuresis will be authorized for patients who are six years of age or older for periods of six months.

Approvals will be granted for subsequent six-month periods only after a drug-free interval to assess the need for continued therapy.

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

Use form 470-4107, *Request for Prior Authorization: Nonparenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products*, to request prior authorization. Click here to see a sample of the form.

57. Nonpreferred Drugs

Prior authorization is required for nonpreferred drugs as specified on the Iowa Medicaid Preferred Drug List.

Payment for a nonpreferred medication will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents is medically contraindicated.

Use form 470-4108, *Request for Prior Authorization: Non-Preferred Drug*, to request prior authorization. Click here to see a sample of the form.

58. Nonsteroidal Anti-Inflammatory Drugs

Prior authorization is required for all nonpreferred nonsteroidal anti-inflammatory drugs (NSAIDs) and COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs or COX-2 inhibitors.

- Requests for a nonpreferred NSAID must document previous trials and therapy failures with at least three preferred NSAIDs.
- Requests for a nonpreferred COX-2 inhibitor must document previous trials and therapy failures with three preferred NSAIDs, two of which must be a preferred COX-2 preferentially selective NSAID.
- Requests for a nonpreferred topical NSAID must document previous trials and therapy failures with three preferred NSAIDs. The trials must include two preferred COX-2 preferentially selective NSAIDs and the oral drug of the same chemical entity. In addition, the use of a topical delivery system must be deemed medically necessary.
- Requests for a nonpreferred extended release NSAID must document previous trials and therapy failures with three preferred NSAIDs, one of which must be the preferred.

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

Use form 470-4109, *Request for Prior Authorization: Nonsteroidal Anti-Inflammatory Drugs*, to request prior authorization. Click here to see a sample of the form.

59. Omalizumab (Xolair®)

Prior authorization is required for omalizumab (Xolair®). Payment for Xolair® will be authorized when the following criteria are met:

- Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and
- Patient is 12 years of age or older; and
- Pretreatment IgE level is between 30 IU/ml and 700 IU/ml; and
- Patient's weight is between 30 kg and 150 kg; and
- History of a positive skin or RAST test to a perennial aeroallergen; and
- Prescriber is an allergist, immunologist, or pulmonologist; and

Iowa Department of Human Services

Request for Prior Authorization
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

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

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs (nsaids) and COX-2 inhibitors. Prior authorization is not required for preferred nsaids or COX-2 inhibitors. 1. Requests for a non-preferred nsaid must document previous trials and therapy failures with at least three preferred nsaids. 2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with three preferred nsaids, two of which must be preferred COX-2 preferentially selective nsaids. 3) Requests for a non-preferred topical nsaid must document previous trials and therapy failures with three preferred nsaids. The trials must include two preferred COX-2 preferentially selective nsaids and the oral drug of the same chemical entity. In addition, the use of a topical delivery system must be deemed medically necessary. 4) 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.

Preferred (No PA required)

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

Non-Preferred (PA required for all products)

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

Strength_____ **Dosage Instructions**_____**Quantity**_____ **Days Supply**_____

Diagnosis:_____
Preferred Drug Trial 1: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____

Preferred Drug Trial 2: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____
Preferred Drug Trial 3: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____

Medical Necessity for alternative delivery system: _____

Medical or contraindication reason to override trial requirements: _____

Reason for use of Non-Preferred drug requiring prior approval:_____
Attach lab results and other documentation as necessary.

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

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

- Patient is currently using a high dose inhaled corticosteroid and long-acting beta-agonist, is compliant with therapy and asthma symptoms are not adequately controlled after at least three months of therapy.
- Patient must have access to an EpiPen to treat allergic reactions that may occur after administration of Xolair®.

If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to Xolair® therapy and for patients who do not continue concurrent use with a high dose inhaled corticosteroid and long-acting beta-agonist.

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

Use form 470-4279, *Request for Prior Authorization: Omalizumab (Xolair®)*, to request prior authorization. Click here to see a sample of the form.

60. Oral Constipation Agents (Lubiprostone and Linaclotide)

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

- Patient is 18 years of age or older; and
- Patient must have documentation of adequate trials and therapy failures with at least one medication from each of the following categories:
  - Saline laxative (milk of magnesia); and
  - Osmotic laxative (polyethylene glycol or lactulose); and
  - Stimulant laxative (senna); and
- Patient does not have a known or suspected mechanical gastrointestinal obstruction; and
- Patient has one of the following diagnoses:
  - A diagnosis of chronic idiopathic constipation (Amitiza® or Linzess™).
    - Patient has less then three spontaneous bowel movements (SBMs) per week; and

61. Palivizumab (Synagis®)

Respiratory Syncytial Virus (RSV) season is defined by the centers for disease control and prevention of the United States Department of Health and Human Services and described in the RSV surveillance reports published annually in the Morbidity and Mortality Weekly Report (MMWR) and available at http://www.cdc.gov/surveillance/nrevss/rsv/reports.html.

- Medicaid will use virology data provided by the Iowa Department of Public Health (IDPH) to prospectively estimate the start of the RSV season and follow the virology data to the end of the season.
- Medicaid will provide coverage of prescription drugs that protect against RSV consistent with the American Academy of Pediatrics (AAP) Guidelines for Infants and Children at Risk for Severe Illness due to RSV Infection.
- The start date will begin two weeks before the expected season start date for the state of Iowa. The start date will be adjusted to an earlier date by Medicaid if indicated by the virological data. The expected season start date shall be derived from the median start date of the past five seasons using Iowa virological data.

Prior authorization is required for therapy with palivizumab. Prior authorizations will be approved for a maximum of five doses per patient. No allowances will be made for a sixth dose. Payment for palivizumab will be considered for patients who meet one of the following criteria:

- Chronic lung disease (CLD):

  The patient is less than 24 months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia) requiring medication (bronchodilator, corticosteroid, or diuretic therapy) or oxygen within six months before the anticipated start of RSV season.

- Prematurity:
  - The patient is less than 12 months of age at start of therapy with a gestational age of less than 29 weeks.
  - The patient is less than 6 months of age at start of therapy with a gestational age between 29 weeks through 31 weeks.
  - The patient is less than 3 months of age at start of therapy or born during the RSV season with a gestational age of 32 weeks through 34 weeks and has one of two risk factors. Risk factors include: day care attendance or siblings less than five years of age in household. Doses will be limited to a maximum of 3 doses or until patient reaches 90 days of age, whichever comes first.

- Severe neuromuscular disease or congenital abnormalities:

  Patient is 12 months of age or younger at the start of therapy and has either severe neuromuscular disease or congenital abnormalities of the airway that compromises handling of respiratory secretions.

- Congenital heart disease (CHD):

  The patient is less than 24 months of age at start of therapy and has hemodynamically significant congenital heart disease further defined by any of the following:

  - Receiving medication to control congestive heart failure,
  - Moderate to severe pulmonary hypertension, or
  - Cyanotic congenital heart disease.

- Severe immunodeficiency:

  The patient is less than 24 months of age at start of therapy and has severe immunodeficiencies (e.g., severe combined immunodeficiency or advanced acquired immunodeficiency syndrome).

Use form 470-4110, *Request for Prior Authorization: Palivizumab (Synagis®)*, to request prior authorization. Click here to see a sample of the form.

62. Proton Pump Inhibitors

Prior authorization is not required for the **preferred** proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day.

Requests for PPIs exceeding one unit per day for a diagnosis of gastroesophageal disease will be considered after documentation of a therapeutic trial and therapy failure with concomitant use of once daily PPI dosing and a bedtime dose of a histamine H_2-receptor antagonist. Upon failure of the combination therapy, subsequent requests for PPIs exceeding one unit per day will be considered on a short term basis (up to three months).

After the three-month period, a retrial of the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day.

Requests for twice daily dosing for a diagnosis of Helicobacter pylori will be considered for up to 14 days of treatment with documentation of active infection.

Iowa Department of Human Services

Request for Prior Authorization
PROTON PUMP INHIBITORS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

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

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is not required for the preferred proton pump inhibitors (PPI) for doses within the established quantity limits of one unit per day. Payment for a non-preferred PPI will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred agents.

Preferred
- ☐ Dexilant
- ☐ Omeprazole Caps (RX)
- ☐ Pantoprazole

Non-Preferred (PA required)
- ☐ Aciphex
- ☐ Esomeprazole
- ☐ Lansoprazole
- ☐ Nexium
- ☐ Omeprazole/Sodium Bicarb (RX)
- ☐ Prevacid
- ☐ Prilosec (RX)
- ☐ Protonix
- ☐ Rabeprazole
- ☐ Vimovo

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

- ❑ **Barrett's esophagus *(Please fax a copy of the scope results with the initial request)***
- ❑ **Erosive esophagitis *(Please fax a copy of the scope results with the initial request)***
- ❑ **Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, and multiple endocrine adenomas).**
- ❑ **Recurrent peptic ulcer disease**
- ❑ **Symptomatic gastroesophageal reflux. Requests for PPIs exceeding one unit per day will be considered after documentation of a therapeutic trial and therapy failure with concomitant use of once daily PPI dosing and a bedtime dose of a histamine H2-receptor antagonist. Upon failure of the combination therapy, subsequent requests for PPIs exceeding one unit per day will be considered on a short term basis (up to 3 months). After the three month period, a retrial of the recommended once daily dosing will be required. A trial of the recommended once daily dosing will be required on an annual basis for those patients continuing to need doses beyond one unit per day.**
- ❑ **Active *Helicobacter pylori infection* (attach documentation). Requests for twice daily dosing will be considered for up to 14 days of treatment for an active infection.**
- ❑ **Other:**_____

Trial Medications & Dates:_____

_____

Medical or contraindication reason to override trial requirements: _____
Scope Performed? ❑ No ❑ Yes If yes, date of scope: _____
Reason for use of Non-Preferred drug requiring prior approval: _____
Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

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

Iowa Department of Human Services

Request for Prior Authorization
PULMONARY ARTERIAL HYPERTENSION AGENTS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must fill all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for agents used to treat pulmonary hypertension.

Preferred

- ☐ Epoprostenol
- ☐ Letairis
- ☐ Sildenafil
- ☐ Tracleer
- ☐ Ventavis

Non-Preferred

- ☐ Adcirca
- ☐ Adempas
- ☐ Flolan
- ☐ Opsumit
- ☐ Revatio
- ☐ Tyvaso
- ☐ Veletri

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

Diagnosis:

- ❑ **Pulmonary arterial hypertension**
- ❑ **Other (please specify)**_____

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

_____

Other medical conditions to consider:_____

_____

Attach lab results and other documentation as necessary.

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

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

Payment for a non-preferred PPI will be authorized only for cases in which there is documentation of previous trial and therapy failures with three preferred products.

Use form 470-4112, *Request for Prior Authorization: Proton Pump Inhibitors*, to request prior authorization. Click here to see a sample of the form.

63. Pulmonary Arterial Hypertension Agents

Prior authorization is required for agents used to treat pulmonary hypertension. Payment will be approved for the diagnosis of pulmonary arterial hypertension.

Use form 470-4327, *Request for Prior Authorization: Pulmonary Arterial Hypertension Agents*, to request prior authorization. Click here to see a sample of the form.

64. Quantity Limit Override

a. Initial 15-Day Limit

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

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

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

b. Monthly Limits

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

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

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

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

Drug Product	Quantity	Days' Supply	Comments
Abilify 2 mg (aripiprazole)	15	30	
Abilify 5 mg (aripiprazole)	15	30	
Abilify 10 mg (aripiprazole)	15	30	
Abilify 15 mg (aripiprazole)	15	30	
Abilify 20 mg (aripiprazole)	15	30	
Abilify 30 mg (aripiprazole)	15	30	
Aceon 2 mg (perindopril)	30	30	
Aceon 4 mg (perindopril)	30	30	
Aceon 8 mg (perindopril)	60	30	
Aciphex 20 mg (rabeprazole)	60	30	
Actonel 5 mg (risedronate)	30	30	
Actonel 30 mg (risedronate)	30	30	
Actonel 35 mg (risedronate)	4	30	
Actoplus Met 15-500 mg (metformin/pioglitazone)	60	30	
Actoplus Met 15-850 mg (metformin/pioglitazone)	60	30	
Actos 15 mg (pioglitazone)	30	30	
Actos 30 mg (pioglitazone)	30	30	
Actos 45 mg (pioglitazone)	30	30	
Adalat CC 30 mg (nifedipine ER)	30	30	
Adalat CC 60 mg (nifedipine ER)	30	30	
Adalat CC 90 mg (nifedipine ER)	30	30	
Adderall 5 mg (amphetamine salt combo)	90	30	
Adderall 7.5 mg (amphetamine salt combo)	90	30	
Adderall 10 mg (amphetamine salt combo)	90	30	
Adderall 12.5 mg (amphetamine salt combo)	120	30	
Adderall 15 mg (amphetamine salt combo)	90	30	
Adderall 20 mg (amphetamine salt combo)	120	30	
Adderall 30 mg (amphetamine salt combo)	60	30	
Adderall XR 5 mg (amphetamine ER)	30	30	
Adderall XR 10 mg (amphetamine combo)	30	30	

Drug Product	Quantity	Days' Supply	Comments
Adderall XR 15 mg (amphetamine combo)	30	30	
Adderall XR 20 mg (amphetamine ER)	60	30	
Adderall XR 25 mg (amphetamine ER)	60	30	
Adderall XR 30 mg (amphetamine ER)	60	30	
Advair 100/50 diskus (fluticasone/salmeterol)	60	30	
Advair 250/50 diskus (fluticasone/salmeterol)	60	30	
Advair 500/50 diskus (fluticasone/salmeterol)	60	30	
Advair HFA (fluticasone/salmeterol)	1 inhaler (12 gm)	30	
Aerobid (flunisolide)	21	30	
Aerobid-M (flunisolide)	21	30	
Afinitor 2.5 mg (everolimus)	30	30	
Afinitor 5 mg (everolimus)	30	30	
Afinitor 7.5 mg (everolimus)	30	30	
Afinitor 10 mg (everolimus)	30	30	
Albenza (albendazole)	4	30	
Aldara (imiquimod)	12 pkts	28	Max 48 pkts/16 weeks
Allegra 30 mg (fexofenadine)	60	30	
Allegra 60 mg (fexofenadine)	60	30	
Allegra 180 mg (fexofenadine)	30	30	
Alora (estradiol)	8	28	
Alphagan P (brimonidine tartrate)	15 ml	30	
Alprazolam intensol 1 mg/ml (alprazolam)	180 ml	30	
Altace 1.25 mg (ramipril)	30	30	
Altace 2.5 mg (ramipril)	30	30	
Altace 5 mg (ramipril)	30	30	
Altace 10 mg (ramipril)	60	30	
Amaryl 1 mg (glimepiride)	30	30	
Amaryl 2 mg (glimepiride)	30	30	
Amaryl 4 mg (glimepiride)	60	30	
Ambien 5 mg (zolpidem)	30	30	
Ambien 10 mg (zolpidem)	30	30	
Ambien CR 6.25 mg (zolpidem)	30	30	
Ambien CR 12.5 mg (zolpidem)	30	30	

Drug Product	Quantity	Days' Supply	Comments
Caduet 2.5-20 mg (amlodipine/atorvastatin)	30	30	
Caduet 2.5-40 mg (amlodipine/atorvastatin)	30	30	
Caduet 2.5-100 mg (amlodipine/atorvastatin)	30	30	
Caduet 5-10 mg (amlodipine/atorvastatin)	30	30	
Caduet 5-20 mg (amlodipine/atorvastatin)	30	30	
Caduet 5-40 mg (amlodipine/atorvastatin)	30	30	
Caduet 5-80 mg (amlodipine/atorvastatin)	30	30	
Caduet 10-10 mg (amlodipine/atorvastatin)	30	30	
Caduet 10-20 mg (amlodipine/atorvastatin)	30	30	
Caduet 10-40 mg (amlodipine/atorvastatin)	30	30	
Caduet 10-80 mg (amlodipine/atorvastatin)	30	30	
Catapres 0.1 mg (clonidine)	120	30	
Catapres 0.2 mg (clonidine)	90	30	
Catapres 0.3 mg (clonidine)	60	30	
Celebrex 100 mg (celecoxib)	60	30	
Celebrex 200 mg (celecoxib)	30	30	
Celebrex 400 mg (celecoxib)	30	30	
Celexa 10 mg (citalopram)	45	30	
Celexa 20 mg (citalopram)	45	30	
Claritin OTC 10 mg (loratadine)	30	30	
Clindesse 2% vaginal cream (clindamycin phosphate)	40 gm	30	
Cocet (acetaminophen/codeine)	180	30	
Codeine Sulfate 15 mg	180	30	
Codeine Sulfate 30 mg	180	30	
Codeine Sulfate 60 mg	180	30	
Combunox (oxycodone/ibuprofen)	28	30	
Complera (emtricitabine/rilpivirine/ tenofovir disoproxil fumarate)	30	30	
Concerta SA 18 mg (methylphenidate ER)	60	30	

Drug Product	Quantity	Days' Supply	Comments
Concerta SA 27 mg (methylphenidate ER)	60	30	
Concerta SA 36 mg (methylphenidate ER)	60	30	
Concerta SA 54 mg (methylphenidate ER)	60	30	
Cosopt (dorzolamide hydrochloride/ timolol maleate)	10 ml	30	
Cozaar 25 mg (losartan)	60	30	
Cozaar 50 mg (losartan)	60	30	
Cozaar 100 mg (losartan)	30	30	
Crestor 5 mg (rosuvastatin)	30	30	
Crestor 10 mg (rosuvastatin)	30	30	
Crestor 20 mg (rosuvastatin)	30	30	
Crestor 40 mg (rosuvastatin)	30	30	
Cymbalta 20 mg (duloxetine)	60	30	
Cymbalta 30 mg (duloxetine)	60	30	
Cymbalta 60 mg (duloxetine)	60	30	
Dalmane 15 mg (flurazepam)	30	30	
Dalmane 30 mg (flurazepam)	30	30	
Darvocet-N 50 (propoxyphene-n/ acetaminophen)	180	30	
Darvocet-N 100 (propoxyphene-n/acetaminophen)	180	30	
Daytrana 10 mg/9-hour patch (methylphenidate)	30	30	
Daytrana 15 mg/9-hour patch (methylphenidate)	30	30	
Daytrana 20 mg/9-hour patch (methylphenidate)	30	30	
Daytrana 30 mg/9-hour patch (methylphenidate)	30	30	
Dermotic (fluocinolone)	20 ml	30	
Detrol LA 2 mg (tolterodine)	30	30	
Detrol LA 4 mg (tolterodine)	30	30	
Dexedrine 5 mg SR (dextroamphetamine SR)	60	30	
Dexedrine 10 mg SR (dextroamphetamine SR)	60	30	
Dexedrine 15 mg SR (dextroamphetamine SR)	120	30	
Dexilant 30 mg (dexlansoprazole)	30	30	
Dexilant 60 mg (dexlansoprazole)	30	30	

Drug Product	Quantity	Days' Supply	Comments
Diastat (diazepem)	6	30	
Diazepam syringes	15 syringes	30	
Diazepam intensol 5 mg/ml (diazepam)	240 ml	30	
Diazepam oral solution 1 mg/ml (diazepam)	1200 ml	30	
Differin 0.1% cream (adapalene)	45	30	
Differin 0.1% gel (adapalene)	45	30	
Diovan 40 mg (valsartan)	30	30	
Diovan 80 mg (valsartan)	30	30	
Diovan 160 mg (valsartan)	30	30	
Diovan 320 mg (valsartan)	30	30	
Diovan HCT 80-12.5 mg (valsartan/HCTZ)	30	30	
Diovan HCT 160-12.5 mg (valsartan/HCTZ)	30	30	
Diovan HCT 160-25 mg (valsartan/HCTZ)	30	30	
Diovan HCT 320-12.5 mg (valsartan/HCTZ)	30	30	
Diovan HCT 320-25 mg (valsartan/HCTZ)	30	30	
Ditropan XL 5 mg (oxybutynin ER)	30	30	
Ditropan XL 10 mg (oxybutynin ER)	60	30	
Ditropan XL 15 mg (oxybutynin ER)	60	30	
Doral 7.5 mg (quazepam)	30	30	
Doral 15 mg (quazepam)	30	30	
Duoneb 3 ml vial (albuterol/ipratropium)	620 ml	30	
Edurant 25 mg (rilpivirine)	30	30	
Effexor XR 37.5 mg (venlafaxine)	30	30	
Effexor XR 75 mg (venlafaxine)	30	30	
Effexor XR 150 mg (venlafaxine)	90	30	
EMLA (lidocaine-prilocaine)	30 grams	30	
Emsam 6 mg/24-hour patch (selegiline)	30	30	
Emsam 9 mg/24-hour patch (selegiline)	30	30	
Emsam 12 mg/24-hour patch (selegiline)	30	30	
Enablex 7.5 mg (darifenacin)	30	30	
Enablex 15 mg (darifenacin)	30	30	

Drug Product	Quantity	Days' Supply	Comments
Epinephrine, racemic solution 2.25% (racepinephrine)	30	15	
Epipen (epinephrine)	2 units	30	
Epipen, Jr (epinephrine)	2 units	30	
Estraderm (estradiol)	8 patches	30	
Exelon 1.5 mg (rivastigmine)	60	30	
Exelon 2 mg/ml oral solution (rivastigmine)	180 ml	30	
Exelon 3 mg (rivastigmine)	60	30	
Exelon 4.5 mg (rivastigmine)	60	30	
Exelon 6 mg (rivastigmine)	60	30	
Fanapt 1 mg (iloperidone)	60	30	
Fanapt 2 mg (iloperidone)	60	30	
Fanapt 4 mg (iloperidone)	60	30	
Fanapt 6 mg (iloperidone)	60	30	
Fanapt 8 mg (iloperidone)	60	30	
Fanapt 10 mg (iloperidone)	60	30	
Fanapt 12 mg (iloperidone)	60	30	
Fioricet (butalbital-acetaminophen-caffeine)	60	30	
Fioricet/Codeine (butalbital-acetaminophen-caffeine-codeine)	60	30	
Fiorinal (butalbital-aspirin-caffeine)	60	30	
Fiorinal/Codeine (butalbital-aspirin-caffeine-codeine)	60	30	
Flomax 0.4 mg (tamsulosin)	60	30	
Flonase (fluticasone propionate)	2 inhalers (32 grams)	30	
Flovent HFA 44 mcg (fluticasone propionate)	1 inhaler (10.6 gm)	30	
Flovent HFA 110 mcg (fluticasone propionate)	1 inhaler (12 gm)	30	
Flovent HFA 220 mcg (fluticasone propionate)	2 inhalers (24 gm)	30	
Focalin XR 5 mg (dexmethylphenidate)	60	30	
Focalin XR 10 mg (dexmethylphenidate)	60	30	
Focalin XR 15 mg (dexmethylphenidate)	90	30	
Focalin XR 20 mg (dexmethylphenidate)	60	30	

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

Drug Product	Quantity	Days' Supply	Comments
Pravachol 40 mg (pravastatin)	30	30	
Pravachol 80 mg (pravastatin)	30	30	
Premarin 0.625 mg (conjugated estrogens)	30	30	
Premarin vaginal cream (conjugated estrogens)	1 tube (42.5 gm)	30	
Prevacid 15 mg (lansoprazole)	30	30	Prior authorization required for more than 60 days of PPI therapy
Prevacid 30 mg (lansoprazole)	30	30	Prior authorization required for more than 60 days of PPI therapy
Prevacid SoluTabs 15 mg (lansoprazole)	30	30	
Prevacid SoluTabs 30 mg (lansoprazole)	30	30	
Prilosec 10 mg (omeprazole)	30	30	
Prilosec 20 mg (omeprazole)	30	30	
Prilosec 40 mg (omeprazole)	30	30	
Pristiq 50 mg (desvenlafaxine)	30	30	
Pristiq 100 mg (desvenlafaxine)	30	30	
Proair HFA 8.5 gm (albuterol)	3 inhalers (25.5 gm)	30	
Procardia XL 30 mg (nifedipine ER)	30	30	
Procardia XL 60 mg (nifedipine ER)	30	30	
Procardia XL 90 mg (nifedipine ER)	30	30	
Procentra 5 mg/5 ml (dextroamphetamine)	1800 ml	30	
Prosom 1 mg (estazolam)	30	30	
Prosom 2 mg (estazolam)	30	30	
Protonix 20 mg (pantoprazole)	30	30	Prior authorization required for more than 60 days of PPI therapy
Protonix 40 mg (pantoprazole)	30	30	Prior authorization required for more than 60 days of PPI therapy
Provigil 100 mg (modafinil)	30	30	
Provigil 200 mg (modafinil)	60	30	
Prozac 20 mg/5 ml solution (fluoxetine)	600 ml	30	
Prozac 10 mg tablet (fluoxetine)	45	30	
Prozac 10 mg capsule (fluoxetine)	30	30	
Prozac 20 mg (fluoxetine)	120	30	
Prozac 40 mg (fluoxetine)	60	30	

Drug Product	Quantity	Days' Supply	Comments
Singulair 4 mg granules (montelukast)	30	30	
Singulair 4 mg chew tablets (montelukast)	30	30	
Singulair 5 mg chew tablets (montelukast)	30	30	
Singulair 10 mg tablets (montelukast)	30	30	
Soma 350 mg (carisoprodol)	120	30	
Sonata 5 mg (zaleplon)	30	30	
Sonata 10 mg (zaleplon)	60	30	
Spiriva cap handihaler pkg size 30 (tiotropium bromide)	30	30	
Strattera 10 mg (atomoxetine)	60	30	
Strattera 18 mg (atomoxetine)	60	30	
Strattera 25 mg (atomoxetine)	60	30	
Strattera 40 mg (atomoxetine)	60	30	
Strattera 60 mg (atomoxetine)	30	30	
Strattera 80 mg (atomoxetine)	30	30	
Strattera 100 mg (atomoxetine)	30	30	
Stribild (elvitegravir/cobicistat/ emtricitabine/tenofovir/disoproxil fumarate)	30	30	
Stromectol (ivermectin)	15	30	
Sudafed 30 mg (pseudoephedrine)	72	30	Allowed for a cumulative 90 days per 12 month period
Sudafed 60 mg (pseudoephedrine)	72	30	Allowed for a cumulative 90 days per 12 month period
Sudafed 30 mg/5 ml (pseudoephedrine)	240 ml	30	Allowed for a cumulative 90 days per 12 month period
Sutent 12.5 mg (sunitinib)	90	30	
Sutent 25 mg (sunitinib)	30	30	
Sutent 50 mg (sunitinib)	30	30	
Talacen (pentazocine/ acetaminophen)	180	30	
Tenex 1 mg (guanfacine)	90	30	
Tenex 2 mg (guanfacine)	90	30	
Terazol 3 (terconazole vaginal cream 0.8%)	20 gm	30	
Terazol 7 (terconazole vaginal cream 0.4%)	45 gm	30	

Drug Product	Quantity	Days' Supply	Comments
Tilade inhaler (nedocromil sodium)	3 inhalers (48.6 gm)	30	
Timoptic ophthalmic solution 0.25% (timolol)	15 ml	30	
Timoptic ophthalmic solution 0.5% (timolol)	15 ml	30	
Timoptic-XE 0.25% (timolol gel forming)	15 ml	30	
Timoptic-XE 0.5% (timolol gel forming)	15 ml	30	
Topamax 25 mg (topiramate)	60	30	
Topamax 50 mg (topiramate)	60	30	
Topamax 100 mg (topiramate)	60	30	
Toprol XL 25 mg (metoprolo ER)	45	30	
Toprol XL 50 mg (metoprolol ER)	45	30	
Toprol XL 100 mg (metoprolo ER)	45	30	
Toprol XL 200 mg (metoprolol ER)	60	30	
Toviaz 4 mg (fesoterodine)	30	30	
Toviaz 8 mg (fesoterodine)	30	30	
Transderm Scop 1.5mg (scopolamine)	8	30	
Travatan Z (travoprost)	5 ml	30	
Tricor 48 mg (fenofibrate)	30	30	
Tricor 145 mg (fenofibrate)	30	30	
Triglide 160 mg (fenofibrate)	30	30	
Twinject (epinephrine)	4 units	30	
Tylenol w/ codeine elixir (acetaminophen/codeine)	2700 ml	30	
Tylenol with codeine No. 2 (acetaminophen/codeine)	390	30	
Tylenol wth codeine No. 3 (acetaminophen/codeine)	390	30	
Tylenol wth codeine No. 4 (acetaminophen/codeine)	390	30	
Uloric 40 mg (febuxostat)	30	30	
Ultracet (tramadol/apap)	240	30	
Ultram 50 mg (tramadol)	240	30	
Ultram ER 100 mg (tramadol ER)	30	30	
Ultram ER 200 mg (tramadol ER)	30	30	
Ultram ER 300 mg (tramadol ER)	30	30	
Uroxatral (alfuzosin)	30	30	

Drug Product	Quantity	Days' Supply	Comments
Zyprexa 10 mg (olanzapine)	30	30	
Zyprexa 15 mg (olanzapine)	60	30	
Zyprexa 20 mg (olanzapine)	60	30	
Zyprexa Zydis 5 mg (olanzapine)	30	30	
Zyprexa Zydis 10 mg (olanzapine)	30	30	
Zyprexa Zydis 15 mg (olanzapine)	60	30	
Zyprexa Zydis 20 mg (olanzapine)	60	30	
Zyrtec 1 mg/ml liquid OTC (cetirizine)	300	30	
Zyrtec 5 mg tablet OTC (cetirizine)	30	30	
Zyrtec 10 mg tablet OTC (cetirizine)	30	30	

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

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

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

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

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

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

66. Rivaroxaban (Xarelto®)

Prior authorization is required for rivaroxavan (Xarelto®). Payment will be considered for patients under the following conditions:

- Patient is 18 years of age or older; and
- Patient does not have a mechanical prosthetic heart valve; and
- Patient does not have active bleeding; and
- Patient is not pregnant; and
- Patient does not have severe renal impairment (CrCl < 15mL/min).

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

67. Roflumilast (Daliresp™)

Prior authorization is required for roflumilast (Daliresp™). Payment will be considered for patients 18 years of age or older when the following is met:

- A diagnosis of severe COPD with chronic bronchitis as documented by spirometry results, and
- A smoking history of ≥ 20 pack-years, and
- Currently on a long-acting bronchodilator in combination with an inhaled corticosteroid with documentation of inadequate control of symptoms, and
- A history of at least one exacerbation in the past year requiring treatment with oral glucocorticosteroids.

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

Use form 470-5085, *Request for Prior Authorization: Roflumilast (Daliresp™)*, to request prior authorization. Click here to see a sample of the form.

68. Sedative/Hypnotics-Non-Benzodiazepine

Preferred agents are available without prior authorization (PA). Although intermittent therapy is recommended, quantity limits will allow for 30 tablets per 30 days supply without PA for preferred medications.

Prior authorization is required for all nonpreferred nonbenzodiazepine sedative/hypnotics. Payment for nonpreferred nonbenzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of a previous trial and therapy failure with the preferred agents. Payment for nonpreferred nonbenzodiazepine sedative/hypnotics will be considered when there is:

- A diagnosis of insomnia.
- Medications with a side effect of insomnia (i.e., stimulants) are decreased in dose, changed to a short-acting product, or discontinued.
- Enforcement of good sleep hygiene is documented.

- All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses.
- A documented trial and therapy failure with zaleplon.

Use form 470-4328, *Request for Prior Authorization: Sedative/Hypnotics-Non-Benzodiazepine*, to request prior authorization. Click here to see a sample of the form.

69. Selected Brand-Name Drugs

Prior authorization is required for selected brand-name drugs, as determined by the Department, for which there is available an "A" rated bioequivalent generic product, as determined by the federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List.

The list of selected brand-name drugs includes the drugs on the Federal Upper Limit (FUL) list at http://www.mslc.com/Iowa/AACList.aspx.

For prior authorization to be considered, the prescriber must submit a completed Selected Brand Name Drugs PA form and Iowa Medicaid MedWatch form with:

- Documentation of trials and therapy failures with two different generic manufacturers of the same chemical entity. If an allergy to an inactive component is suspected, the second trial must be with a generic product that does not contain the allergen, if available.
- Documentation of the failure must include the specific adverse reaction as defined by the FDA. (See Section B of the MedWatch form). Intolerances, such as nausea and vomiting, to the generic drugs will not be considered as a basis for approval.

Trials may be overridden when evidence is provided that use of the generic product would be medically contraindicated.

Use forms 470-5039 and 470-4119, *Request for Prior Authorization: Selected Brand Name Drugs*, to request prior authorization. Click here to see a sample of form 470-5039. Click here to see a sample of form 470-4119.

70. Serotonin 5-HT1 Receptor Agonists

Prior authorization is required for serotonin 5-HT1 receptor agonists for quantities exceeding 12 unit doses of tablets, syringes, or sprays per 30 days. Payment for serotonin 5-HT1 receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation.

Prior authorization is required for all **nonpreferred** serotonin 5-HT1 receptor agonists beginning the first day of therapy. Payment for nonpreferred serotonin 5-HT1 receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents.

Requests for nonpreferred combination products may be considered only after documented separate trials and therapy failures with the individual ingredients.

For consideration, the following information must be supplied:

- The diagnosis requiring therapy.
- Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

Use form 470-4113, *Request for Prior Authorization: Serotonin 5-HT1 Receptor Agonists*, to request prior authorization. Click here to see a sample of the form.

71. Short-Acting Narcotics

Prior authorization is required for all nonpreferred short-acting narcotics.

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

Use form 470-4899, *Request for Prior Authorization: Short Acting Narcotics*, to request prior authorization. Click here to see a sample of the form.

72. Smoking Cessation Therapy-Oral

Prior authorization is required for varenicline (Chantix™) or bupropion SR that is FDA approved for smoking cessation. Requests for authorization must include:

- Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
- Confirmation of enrollment and ongoing participation in the Quitline Iowa counseling program is required for approval and continued coverage.

Approvals will be granted only for patients 18 years of age or older.

- The duration of therapy is initially limited to 12 weeks within a 12-month period.
- For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment will be considered with a prior authorization request. The maximum duration of approvable therapy is 24 weeks within a 12-month period.
- Requests for varenicline to be used in combination with bupropion SR that is FDA-indicated for smoking cessation or nicotine replacement therapy will not be approved.
- The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation.

Use form 470-4517, *Request for Prior Authorization: Smoking Cessation Therapy-Oral*, to request prior authorization. Click here to see a sample of the form.

73. Sodium Oxybate (Xyrem®)

Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered for patients 16 years of age or older under the following conditions:

- A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS0 and previous trial and therapy failure at a therapeutic dose with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline.
- Patient is enrolled in the Xyrem® Success Program.

Iowa Department of Human Services

Request for Prior Authorization
SODIUM OXYBATE (XYREM®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must fill all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for sodium oxybate (Xyrem®). Payment will be considered for patients 16 years of age or older under the following conditions: 1) A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trial and therapy failure at a therapeutic dose with one of the following tricyclic antidepressants: clomipramine, imipramine, or protriptyline. 2) Patient is enrolled in the Xyrem® Success Program. 3) A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant. 4) Patient has been instructed to not drink alcohol when using Xyrem®. 5) Patients with and without history of substance abuse have been counseled regarding potential for abuse and dependence and will be closely monitored for signs of abuse and dependence. 6) Requests for patients with concurrent use of a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered. 7) The presciber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at https://pmp.iowa.gov/IAPMPWebCenter/ prior to requesting prior authorizations. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ Xyrem® **Strength** _____ **Dosage Instructions** _____ **Quantity** _____ **Days Supply** _____

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

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

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

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

Medical or contraindication reason to override trial requirements: _____

Patient is enrolled in the Xyrem® Success Program: ☐ Yes ☐ No

Patient has a history of substance abuse: ☐ Yes ☐ No

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

Patient has a semialdehyde dehydrongenase deficiency: ☐ Yes ☐ No

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

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

Attach lab results and other documentation as necessary.

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

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

- A diagnosis of excessive daytime sleepiness associated with narcolepsy verified by a recent sleep study (including a PSG, MSLT, and ESS) and previous trials and therapy failures at a therapeutic dose with a preferred amphetamine and non-amphetamine stimulant.
- Patient has been instructed to not drink alcohol when using Xyrem®.
- Patients with and without a history of substance abuse have been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence.
- The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring website at https://pmp.iowa.gov/IAPMPWebCenter/ prior to requesting prior authorization.

Requests for patients with concurrent use with a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered.

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

Use form 470-5016, *Request for Prior Authorization: Sodium Oxybate (Xyrem®)*, to request prior authorization. Click here to see a sample of the form.

74. Testosterone Products

Prior authorization is required for testosterone products.

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 symptoms of sexual dysfunction, erectile dysfunction, and infertility will not be considered.

Payment for a diagnosis of hypogonadism (testosterone deficiency) will be considered under the following conditions:

- Patient is male and 18 years of age or older (or 12 years of age for testosterone cypionate); and
- Patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (attach lab results); and

- Patient has at least one of the signs and symptoms specific to androgen deficiency:
  - Incomplete or delayed sexual development
  - Breast discomfort, gynecomastia
  - Loss of body hair, reduction in shaving frequency
  - Very small (< 5mL) or shrinking testes
  - Hot flushes, sweats
  - Height loss, low trauma fracture, low bone mineral density; and
- Patient does not have:
  - Breast or prostate cancer
  - Palpable prostate nodules or prostate-specific antigen (PSA) > 4ng/mL
  - Hematocrit > 50 percent
  - Untreated severe obstructive sleep apnea
  - Sever lower urinary tract symptoms
  - Uncontrolled or poorly controlled heart failure

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

- An updated testosterone level (attach lab result); and
- Documentation of how the patient's specific symptoms have responded to therapy; and
- Documentation the patient has not experienced a hematocrit > 54 percent or an increase in PSA > 1.4ng/mL in the past 12 months.

Requests for FDA approved and compendia indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis.

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

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

Iowa Department of Human Services

Request for Prior Authorization
TESTOSTERONE PRODUCTS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for testosterone products. 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 symptoms of sexual dysfunction, erectile dysfunction and infertility will not be considered. Payment for a diagnosis of hypogonadism (testosterone deficiency) will be considered under the following conditions:

1) **Patient is male and 18 years of age or older (or 12 years of age and older for testosterone cypionate); and**
2) **Patient has two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (attach results); and**
3) **Patient has at least one of the signs and symptoms specific to androgen deficiency; and**
    - **Incomplete or delayed sexual development**
    - **Breast discomfort, gynecomastia**
    - **Loss of body hair, reduction in shaving frequency**
    - **Very small (<5mL) or shrinking testes**
    - **Hot flushes, sweats**
    - **Height loss, low trauma fracture, low bone mineral density**
4) **Patient does not have:**
    - **Breast or prostate cancer**
    - **Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL**
    - **Hematocrit > 50%**
    - **Untreated severe obstructive sleep apnea**
    - **Severe lower urinary tract symptoms**
    - **Uncontrolled or poorly controlled heart failure**

If criteria for coverage are met, initial authorizations will be given for 3 months. Requests for continuation of therapy will require the following:

- **An updated testosterone level (attach result); and**
- **Documentation of how the patient's specific symptoms have responded to therapy; and**
- **Documentation the patient has not experienced a hematocrit > 54% or an increase in PSA > 1.4ng/mL in the past 12 months.**

Requests for FDA approved and compendia indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis.

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

Preferred

- ☐ Androderm
- ☐ Android
- ☐ Depo-Testosterone
- ☐ Testim
- ☐ Testosterone Cypionate
- ☐ Testosterone Enanthate
- ☐ Testred

Non-Preferred

- ☐ Androgel
- ☐ Axiron
- ☐ Fortesta
- ☐ Methitest
- ☐ Striant

Diagnosis:_____

Strength_____ **Dosage Instructions**_____ **Quantity**_____ **Days Supply**_____

Complete for diagnosis of hypogonadism (testosterone deficiency):

List & attach results of two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used:

Level 1:_____ Date:_____ Level 2:_____ Date:_____

Patient has at least one of the signs and symptoms specific to androgen deficiency:

- ☐ Incomplete or delayed sexual development
- ☐ Loss of body hair, reduction in shaving frequency
- ☐ Height loss, low trauma fracture, low bone mineral density
- ☐ Breast discomfort, gynecomastia
- ☐ Very small (<5mL) or shrinking testes
- ☐ Hot flushes, sweats

Does patient have any of the following:

Breast or prostate cancer:	☐ Yes	☐ No
Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL:	☐ Yes	☐ No
Hematocrit > 50%:	☐ Yes	☐ No
Untreated severe obstructive sleep apnea:	☐ Yes	☐ No
Severe lower urinary tract symptoms:	☐ Yes	☐ No
Uncontrolled or poorly controlled heart failure:	☐ Yes	☐ No

Renewal Requests:

List & attach updated testosterone level: Level:_____ Date:_____

Describe the patient's specific symptom response to therapy:_____

_____

Has patient experienced the following in the past 12 months:

Hematocrit > 54%:	☐ Yes	☐ No	Most recent lab date:_____
Increase in PSA > 1.4ng/mL:	☐ Yes	☐ No	Most recent lab date:_____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

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

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

75. Thrombopoietin Receptor Agonists

Payment for a preferred thrombopoietin receptor agonist will be considered only for cases in which there is a diagnosis of chronic immune thrombocytopenic purpura (ITP) including documentation of an insufficient response to a corticosteroid or an immunoglobulin, or the member has undergone splenectomy.

Payment for eltrombopag (Promacta®) for the treatment of chronic hepatitis C associated thrombocytopenia will only be considered to allow for initiation and/or maintenance of interferon-based therapy with ribavirin when the patient has a baseline platelet count less than 75 x 109/L. Requests will not be considered under the following conditions:

- Patients taking direct acting antiviral agents for the treatment of chronic hepatitis C genotype 1 infection in addition to interferon-based therapy with ribavirin.
- Patients with decompensated liver disease with a Child-Pugh score > 6 (Class B & C).
- Patients with a history of ascites.
- Patients with hepatic encephalopathy.

Payment for a nonpreferred thrombopoietin receptor agonist will be considered following documentation of a recent trial and therapy failure with a preferred thrombopoietin receptor agonist unless such a trial would be medically contraindicated.

Use form 470-4850, *Request for Prior Authorization: Thrombopoietin Receptor Agonists*, to request prior authorization. Click here to see a sample of the form.

76. Topical Retinoids

Prior authorization is required for all prescription topical retinoid products.

Payment for prescription topical retinoid products will be considered under the following conditions:

- Patients with a diagnosis of skin cancer, lamellar ichthyosis, or Darier's disease will receive automatic approval for lifetime use of topical retinoid products.

- Payment will be authorized when the patient has had previous trial and therapy failure with:
  - A preferred over-the-counter benzoyl peroxide product, and
  - Two preferred topical or oral antibiotics for the treatment of mild to moderate acne (noninflammatory and inflammatory) or drug-induced acne.

  EXCEPTION: Trials and therapy failure are not required for patients presenting with a preponderance of comedonal acne.
- Payment for nonpreferred topical retinoid products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.
- Requests for nonpreferred combination products will be considered only after documentation of separate trials and therapy failures with the individual ingredients.
- Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for tazorac for a psoriasis diagnosis.

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

Use form 470-4114, *Request for Prior Authorization: Topical Retinoids for Acne*, to request prior authorization. Click here to see a sample of the form.

77. Trametinib (Mekinist™)

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

- Patient is 18 years of age or older, and
- Patient has a documented diagnosis of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutation as detected by an FDA-approved test, and
- Patient has not received prior therapy with a BRAF-inhibitor, and
- Prescriber is an oncologist.

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

Iowa Department of Human Services

Request for Prior Authorization
TRAMETINIB (MEKINIST™)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for trametinib (Mekinist™). Payment will be considered for patients when the following is met: 1) Patient is 18 years of age or older; and 2) Patient has a documented diagnosis of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutation as detected by an FDA-approved test; and 3) Patient has not received prior therapy with a BRAF-inhibitor; and 4) Prescriber is an oncologist. If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.

☐ Mekinist™

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

Diagnosis (Attach copy of test results): _____

Has patient received prior therapy with a BRAF-inhibitor? ☐ No ☐ Yes (Please provide drug name and trial dates): _____

Is Prescriber an Oncologist? ☐ Yes ☐ No

Renewals: Has disease progressed? ☐ Yes ☐ No Date of last office visit: _____

Attach lab results and other documentation as necessary.

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

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

Use form 470-5260, *Request for Prior Authorization: Trametinib (Mekinist™)*, to request prior authorization. Click here to see a sample of the form.

78. Vilazodone (Viibryd™)

Prior authorization is required for Viibryd™. Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered for patients when the following criteria are met:

- The patient has a diagnosis of Major Depressive Disorder (MDD) and is 18 years of age and older; and
- Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SSRI; and
- Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and
- Documentation of a previous trial and therapy failure at a therapeutic dose with an additional generic antidepressant from any class.

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

Use form 470-5098, *Request for Prior Authorization: Vilazodone (Viibryd™)*, to request prior authorization. Click here to see a sample of the form.

79. Vitamins, Minerals and Multiple Vitamins

Payment for vitamins, minerals, and multiple vitamins for treatment of specific conditions will be approved when:

- A specific vitamin or mineral deficiency disease is diagnosed; or
- A member aged 20 or under has a diagnosed disease that inhibits the nutrition absorption process as a secondary effect of the disease.

Prior approval is not required for prescribed multi-vitamins with or without iron or vitamin D supplements for patients under 12 months of age or a prescription product primarily classified as a blood modifier if that product does not contain more than three vitamins and minerals, or for products principally marketed as prenatal vitamin-mineral supplements.

Prior authorization is **not** required for a vitamin and mineral product principally marketed for use as a dietary supplement during pregnancy and lactation.

Use form 470-4115, *Request for Prior Authorization: Vitamins & Minerals*, to request prior authorization. Click here to see a sample of the form.

80. Vusion™ Ointment

Prior authorization is required for Vusion™ ointment. Payment will be considered only for cases in which there is documentation of previous trials and therapy failures with (1) over-the-counter miconazole 2% cream (payable with a prescription) **and** (2) nystatin cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated.

Use form 470-4655, *Request for Prior Authorization: Vusion™ Ointment*, to request prior authorization. Click here to see a sample of the form.

b. Correction of Insurance Information

The Department makes every attempt to keep current data regarding other insurance Medicaid members may have. However, if the primary insurance is no longer valid or has changed, the Department's records need to be corrected. The pharmacy can facilitate this in one of three ways:

- Instruct the client to notify the Department; or
- Complete form 470-2826, *Insurance Questionnaire*, available on the IME web site (http://dhs.iowa.gov/ime/), under Providers/Forms, and FAX the form to Revenue Collections at (515) 725-1352; or
- Notify the Department by e-mailing Revcoll@dhs.state.ia.us or by calling (515) 256-4619 (local) or 1-866-810-1206. The minimum information necessary for insurance carriers to verify the other insurance coverage is the following:
  - Member last name
  - Member first name
  - State identification number or social security number
  - Date of birth
  - Policy number
  - Full insurance company name

  For example, if the company is Blue Cross/Blue Shield, include which state the policy is from, as most every state has a BC/BS carrier. (In Iowa, it's Wellmark.)

2. Claiming Payment for Retroactively Eligible Member

For Iowa Medicaid prescription drug claims involving claims for a member whose Medicaid eligibility was determined retroactively, call the IME Point of Sale (POS) Unit at (515) 256-4608 (local calls) or 877-463-7671. Have the following information available:

- The pharmacy's national provider identifier.
- The member's Iowa Medicaid number, name, and date of birth.
- The drug's name, strength, quantity, and dates requested for reimbursement.
- The date the pharmacy was made aware the member had Medicaid coverage for the state of Iowa.