Iowa Medicaid
IOWA HHS

INFORMATIONAL LETTER NO. 2535-MC-FFS-D

DATE: November 29, 2023

TO: Iowa Medicaid Physicians, Dentists, Advanced Registered Nurse Practitioners, Therapeutically Certified Optometrists, Podiatrists, Pharmacies, Home Health Agencies, Rural Health Clinics, Clinics, Skilled Nursing Facilities, Intermediate Care Facilities, Nursing Facilities-Mental ILL, Federally Qualified Health Centers (FQHC), Indian Health Service, Maternal Health Centers, Certified Nurse Midwife, Community Mental Health, Family Planning, Residential Care Facilities, ICF/ID State and Community Based ICF/ID Providers, Physician Assistants

APPLIES TO: Managed Care (MC), Fee-for-Service (FFS), Dental (D)

FROM: Iowa Department of Health and Human Services (DHHS), Iowa Medicaid

RE: January 2024 Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: January 1, 2024

1. **Changes to the preferred drug list (PDL) effective January 1, 2024.** Refer to the PDL website[1] to review the complete PDL.

Preferred	Non-Preferred	Non-Recommended
Abilify Asimtufii[2]	Adalimumab fkjp[1]	Jaypirca[1]
Arnuity Ellipta	Adalimumab adaz[1]	Krazati[1]
Austedo XR[1]	Adthyza	Orserdu[1]
Baqsimi	Airsupra	Vanflyta[1]
Briviact	Amjevita[1]	
Darunavir	Altuviiio	
Dulera	Atorvaliq[1]	
Ermeza Oral Solution[3]	Aubagio[1]	
Febuxostat[1]	Baclofen Oral Suspension[1]	

[1] http://www.iowamedicaidpdl.com/

Fingolimod[1]	Betaine Anyhydrous Oral Powder	
Genotropin[1]	Bismuth Subcit-Metronidazole-Tetracycline	
Granix[1]	Brimonidine Ophth Sol 0.1%	
Invega Hafyera[2]	Budesonide Rectal Foam	
Nucala Auto-Injector[1]	Cyltezo[1]	
Nyvepria[1]	Daybue	
Orencia ClickJect[1]	Dichlorphenamide	
Orilissa[1]	Emend Oral Suspension[1]	
Prezcobix	Filspari	
Qelbree[1]	Fulphila[1]	
Quillivant XR[1]	Gefitinib[1]	
Qvar RediHaler	Gilenya[1]	
Relueko[1]	Hadlima[1]	
Simponi[1]	Hulio[1]	
Teriflunomide[1]	Hyrimoz[1]	
Tobramycin & Dexamethasone Ophth Suspension	Idacio[1]	
Trospium Chloride	Inpefa	
Valganciclovir Oral Solution	Iyuzeh	
Vraylar[2]	Joenja	
Zegalogue	Konvomep Oral Suspension[1]	
	Levofloxacin Oral Solution	
	Lisdexamfetamine[1]	
	Liqrev[1]	
	Methsuximide	
	Miebo	
	Mircera[1]	
	Morphine Rectal Suppositories[1]	
	Ngenla[1]	
	Odactra[1]	
	Opvee	

	Oxycodone Oral Concentrate[1]	
	Pradaxa Oral Packet[1]	
	Relyvrio	
	Rezvoglar KwikPen	
	Saxagliptin[1]	
	Saxagliptin-Metformin ER[1]	
	Sodium Polystyrene Sulfonate	
	Sogroya[1]	
	SPS	
	Tezspire[1]	
	Tiotropium Bromide Monohydrate Inhal Cap	
	Topiramate Cap ER Sprinkle	
	Uzedy[4]	
	Valcyte Oral Solution	
	Veozah	
	Vowst	
	Xeljanz Oral Solution[1]	
	Yuflyma[1]	
	Yusimry[1]	
	Zavzpret[1]	
	Zolpidem 7.5mg Cap[1]	
	Zoryve[1]	

[1] Clinical prior authorization (PA) criteria apply
[2] Step 2
[3] PA Required
[4] Step 3

2. **New Drug PA Criteria** – See complete PA criteria under the Prior Authorization Criteria tab[2].

- **Deucravacitinib (Sotyktu)**

  Prior authorization (PA) is required for deucravacitinib (Sotyktu). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met:

  1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; and
  2. Patient has a diagnosis of plaque psoriasis; and
     a. Documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate or cyclosporine is provided; and
     b. Documentation of a trial and inadequate response to the preferred adalimumab agent; and
     c. Will not be combined with any of the following systemic agents: biologic DMARD, Janus kinase inhibitor, phosphodiesterase 4 (PDE4) inhibitor or potent immunosuppressant.

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

- **Tezepelumab-ekko (Tezspire) Prefilled Pen**

  Prior authorization (PA) is required for tezepelumab-ekko (Tezspire) prefilled pen. Requests for tezepelumab-ekko (Tezspire) single dose vial or prefilled syringe will not be considered through the pharmacy benefit. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

  1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; and
  2. Patient has a diagnosis of severe asthma; and
     a. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g., long-acting beta2 agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of three consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and

[2] http://www.iowamedicaidpdl.com/pa_criteria

b. Patient must have one of the following, in addition to the regular maintenance medications defined above:
    i. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months, or
    ii. One or more asthma exacerbations resulting in hospitalization in the previous 12 months; and
c. This medication will be used as an add-on maintenance treatment; and
d. Patient/caregiver will administer medication in patient's home; and
e. Is not prescribed in combination with other biologics indicated for asthma.

If criteria for coverage are met, initial authorization will be given for six months to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy.

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

3. **Changes to Existing PA Criteria** – *Changes are italicized or stricken.* See complete PA criteria under the Prior Authorization Criteria tab[3].

- **Antidepressants**

Prior authorization (PA) is required for non-preferred antidepressants subject to clinical criteria. Payment will be considered *when patient has an FDA approved or compendia indication for the requested drug* when the following criteria are met:

1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; and*
2. Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; and
3. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and
4. Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant*; and*
5. *Documentation of a previous trial and therapy failure at a therapeutic dose with vilazodone; and*
6. *Documentation of a previous trial and therapy failure at a therapeutic dose with vortioxetine; and*

[3] http://www.iowamedicaidpdl.com/pa_criteria

7. *Documentation of a previous trial and therapy failure at a therapeutic dose with an antidepressant plus adjunct; and*
8. *If the request is for dextromethorphan and bupropion extended-release tablet (Auvelity), one of the trials must include a previous trial and inadequate response at a therapeutic dose with an extended-release bupropion agent; and*
9. If the request is for an isomer, prodrug or metabolite of *the requested* medication, one of the trials must be with the preferred parent drug of the same chemical entity that resulted in a partial response with a documented intolerance.

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

- **Janus Kinase Inhibitors**

3. Patient has a diagnosis of:
   d. *Moderately to severely active Crohn's disease (upadacitinib); with*
      i. *A documented trial and inadequate response to two preferred conventional therapies including aminosalicylates (sulfasalazine), azathioprine/6-mercaptopurine and/or methotrexate; and*
      ii. *A documented trial and inadequate response with a preferred TNF inhibitor; OR*

4. Point of Sale Billing Updates:

a. ProDUR Quantity Limits: The following quantity limit edits will be implemented. A comprehensive list of all quantity limit edits appears on the Quantity Limit Chart[4].

Drug Product	Quantity	Days' Supply
Auvelity 45mg/105mg	60	30
Nayzilam 5mg	5 boxes (10 nasal spray units)	30
Sotyktu 6mg	30	30
Tezspire 210mg	1 prefilled pen	28
Valtoco 5mg, 10mg	5 cartons (10 blister packs)	30
Valtoco 15mg, 20mg	10 cartons (20 blister packs)	30

[4] http://www.iowamedicaidpdl.com/billing_quantity_limits

b. **ProDUR Age Edit:**
    - Auvelity will be considered for members 18 years of age and older.
    - Veltassa will be considered for members 12 years of age and older.

c. **15 Day Initial Prescription Supply Limit List:** Effective January 1, 2024, the initial 15 day prescription limit list will be updated. Please refer to the updated list located under the Preferred Drug List link[5].

5. **DUR Update:** The latest issue of the Drug Utilization Review (DUR) Digest is located at the Iowa DUR website[6] under the "Newsletters" link.

We encourage providers to go to the PDL website[7] to view all recent changes to the PDL. If you have questions, please contact the Pharmacy Prior Authorization Helpdesk at 1-877-776-1567, locally in Des Moines at 515-256-4607, or by e-mail at info@iowamedicaidpdl.com.

[5] http://www.iowamedicaidpdl.com/
[6] http://www.iadur.org/
[7] http://www.iowamedicaidpdl.com/