IOWA | Health and Human Services

INFORMATIONAL LETTER NO. 2586-MC-FFS-D

DATE: May 8, 2024

TO: Iowa Medicaid Physicians, Dentists, Advanced Registered Nurse Practitioners, Therapeutically Certified Optometrists, Podiatrists, Pharmacies, Home Health Agencies (HHA), Rural Health Clinics, Clinics, Skilled Nursing Facilities, Intermediate Care Facilities (ICF), 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, 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 (HHS), Iowa Medicaid

RE: June 2024 Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: June 1, 2024

1. **Changes to the preferred drug list (PDL) effective June 1, 2024.** Refer to the Medicaid Pharmacy webpage[1] on the Iowa Department of Health and Human Services (HHS) website to review the complete PDL.

Preferred	Non-Preferred	Non-Recommended
Dupixent[1]	Abrilada[1]	Akeega[1]
Emgality[1]	Adalimumab aacf[1]	Augtyro[1]
Everolimus Tablets[1]	Adalimumab adbm[1]	Fruzaqla[1]
Lubiprostone[1]	Afinitor[1]	Iwilfin[1]
Opvee	Agamree	Ojjaara[1]

[1] https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/medicaid-pharmacy

Skytrofa[2]	Amphetamine-Dextroamphetamine 3-Bead Cap ER[1]	Truqap[1]
	Bimzelx[1]	
	Cabtreo[1]	
	Cyanocobalamin Spray	
	Cuvrior	
	Dapagliflozin[1]	
	Dapagliflozin-Metformin[1]	
	Dextroamphetamine Sulfate Tabs[1]	
	Entyvio SQ Pen Injector[1]	
	Fabhalta	
	Fluticasone Propionate BA	
	Furoscix	
	Insulin Glargine 300 units/mL	
	Insulin Glargine Yfgn	
	Jylamvo	
	Likmez[1]	
	Motpoly XR[1]	
	Nitrofurantoin Oral Suspension 50mg/5mL	
	Olpruva	
	Omvoh Auto-Injector[1]	
	Pazopanib[1]	
	Pitavastatin	
	Prednisolone Tablets	
	Risperidone Injection[3]	
	Rykindo[3]	
	Skyclarys	
	Sohonos	

	Spironolactone Oral Suspension
	Suflave
	Tramadol 25mg Tablets[1]
	Valsartan Oral Solution[1]
	Velsipity[1]
	Vevye
	Wainua
	Xdemvy
	Xphozah
	Zilbrysq
	Zituvio[1]
	Zurzuvae

[1] Clinical prior authorization (PA) criteria apply
[2] Clinical PA criteria apply, step through one preferred short acting growth hormone product required
[3] Step 3

2. **Pharmacy Benefit Policy Changes** – **Effective June 1, 2024,** coverage for the following drugs will be removed under the pharmacy benefit, however, coverage will continue to be available through the medical benefit. The drugs include Eligard, Lupron Depot, Lupron Depot-PED and Trelstar.
3. **Changes to Existing Prior Authorization (PA) Criteria** – The below criteria only include the sections with changes which are *italicized* or removed entirely. See the complete prior authorization (PA) criteria chart on the Medicaid Pharmacy webpage[2] on the HHS website.

- **Odevixibat (Bylvay)**

  Prior authorization (PA) is required for odevixibat (Bylvay). Payment will be considered under the following conditions:

  3. *Patient has a diagnosis of Alagille Syndrome (ALGS) confirmed by genetic testing demonstrating a JAG1 or NOTCH2 mutation or deletion; and*
     a. *Patient has cholestasis with moderate to severe pruritis; and*
     b. *Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents:*
        i. *Ursodeoxycholic acid (ursodiol)*
        ii. *Cholestyramine*

[2] https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/medicaid-pharmacy

iii. *Rifampin; and*

5. Is prescribed by or in consultation with a hepatologist, gastroenterologist *or a prescriber who specializes in PFIC or ALGS*.

- **Oral Constipation Agents**

Prior authorization (PA) is required for oral constipation agents subject to clinical criteria. Payment for non-preferred oral constipation agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred oral constipation agent. Payment will be considered *when patient has a Food and Drug Administration (FDA) approved or compendia indication for the requested drug when the following criteria are met*:

1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations*; and
2. Patient must have documentation of adequate trials and therapy failures with the following:
    a. *Members 18 years of age or older:*
        i. Stimulant laxative (senna) plus saline laxative (milk of magnesia); and
        ii. Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose); *or*
    b. *Members 17 years of age or younger:*
        i. *Polyethylene glycol; and*
        ii. *One other preferred generic laxative, such as lactulose or senna; and*
4. Patient has one (1) of the following diagnoses:
    d. *A diagnosis of functional constipation (Linzess)*
        i. *Patient has less than three (3) SBMs per week; and one (1) or more of the following criteria at least once per week for at least two (2) months:*
            1. *History of stool withholding or excessive voluntary stool retention;*
            2. *History of painful or hard bowel movements;*
            3. *History of large diameter stools that may obstruct the toilet;*
            4. *Presence of a large fecal mass in the rectum;*
            5. *At least one (1) episode of fecal incontinence per week.*

If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation of therapy may be provided if prescriber documents adequate response to treatment *and patient continues to meet the age for indication*.

- **Oral Immunotherapy**

Prior authorization (PA) is required for sublingual allergen immunotherapy. Payment will be considered *when patient has an FDA approved or compendia indication for the requested drug* under the following conditions:

1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings & precautions, drug interactions, and use in specific populations; and*

2. Medication is prescribed by *or in consultation with* an allergist *or immunologist*; and
3. *Patient has documentation of an adequate trial and therapy failure with an intranasal corticosteroid and oral or nasal antihistamine used concurrently; and*
4. Patient has a documented intolerance to immunotherapy injections; and
5. The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration).
6. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved.

Short Ragweed Pollen (Ragwitek®) In addition to the above criteria being met:

1. *Patient is diagnosed with short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis; and*
2. Patient has a positive skin test or *in vitro* testing (pollen-specific IgE antibodies) to short ragweed pollen.
3. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen season and continued throughout the season.

Grass Pollen (Grastek® and Oralair®) In addition to the above criteria being met:

1. *Request is for* Oralair®; and
    a. *Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and*
    b. Patient has a positive skin test or *in vitro* testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, and Kentucky blue/June grass.
    c. If criteria for coverage are met, authorization will be considered at least four (4) months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season; or
2. *Request is for* Grastek; and
    a. *Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and*
    b. Patient has a positive skin test or *in vitro* testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop).
    c. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of grass pollen season *as follows:*
        - *Seasonally, through the end of the grass pollen season or*
        - *For sustained effectiveness, up to three consecutive years (including the intervals between grass pollen seasons) for one grass pollen season after cessation of treatment. Authorizations would be given in 12-month intervals up to three consecutive years with one grass pollen season.*

House Dust Mite (Odactra®) In addition to the above criteria being met:

1. *Patient is diagnosed with house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, and*
2. *Patient has a positive skin test to licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites; and*
3. *If criteria for coverage are met, authorization will be considered for 12 months.*

- **Vesicular Monoamine Transporter (VMAT) 2 Inhibitors**

  Prior authorization (PA) is required for VMAT 2 inhibitors. Payment for non-preferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered *when the patient has an FDA approved or compendia indication for the requested drug* under the following conditions:

1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings & precautions, drug interactions, and use in specific populations; and*
2. *Will not be used concurrently with other vesicular monoamine transporter (VMAT) 2 inhibitors; and*
3. Prescribed by or in consultation with a neurologist, psychiatrist*, psychiatric nurse practitioner, or psychiatric physician assistant*; *and*

<u>Tardive Dyskinesia</u> (Ingrezza or Austedo)

1. Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following:
   a. Involuntary athetoid or choreiform movements
   b. Documentation or claims history of current or prior chronic use (≥ three (3) months or one (1) month in patients ≥ 60 years old) of a dopamine receptor blocking agent (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.)
   c. Symptoms lasting longer than four (4) to eight (8) weeks; and
2. Prescriber has evaluated the patient's current medications for consideration of a dose reduction, withdrawal, or change of the dopamine receptor blocking agent causing the TD; and
3. Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS).

If criteria for coverage are met, initial requests will be given for three (3) months. Continuation of therapy will be considered when the following criteria are met:

1. Patient continues to meet the criteria for initial approval; and
2. Documentation of improvement in TD symptoms as evidenced by a reduction of AIMS score from baseline (attach current AIMS)*; or*

<u>Chorea associated with Huntington's disease</u> (Austedo*, Ingrezza* or tetrabenazine)

1. Patient has a diagnosis of Huntington's disease with chorea symptoms; and

2. Patient is not suicidal, or does not have untreated or inadequately treated depression; and
3. For tetrabenazine, patients requiring doses above 50mg per day have been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor metabolizer or extensive metabolizer.

If criteria for coverage are met, initial requests will be given for three (3) months. Continuation of therapy will be considered when the following criteria are met:

1. Patient continues to meet the criteria for initial approval; and
2. Documentation of improvement in chorea symptoms is provided.

4. Point of Sale Billing Updates:

15 Day Initial Prescription Supply Limit List: Effective June 1, 2024, the following medications will be added to the initial 15-day prescription limit list: Akeega, Augtyro, Fruzaqla and Iwilfin.

We encourage providers to go to the Medicaid Pharmacy webpage[3] on the HHS website to view all recent changes to the PDL. If you have questions, please contact the Pharmacy Prior Authorization (PA) Helpdesk at 1-877-776-1567, locally in Des Moines at 515-256-4607, or by e-mail at info@iowamedicaidpdl.com.

[3] https://hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/medicaid-pharmacy