Department of HUMAN SERVICES

For Human Services use only:

General Letter No. 8-AP-487
Employees' Manual, Title 8
Medicaid Appendix

August 9, 2019

PRESCRIBED DRUGS MANUAL TRANSMITTAL NO. 19-1

ISSUED BY: Division of Medical Services

SUBJECT: ***Prescribed Drugs Manual***, *Provider-Specific Policies*, Contents (pages 1, 2, and 3), revised; pages 2, 6, 7, 15, 16, 18 through 30, 46, and 49 through 63, revised; page 64, new; and the following forms:

470-5259	*Request for Prior Authorization: Anti-Diabetic Non-Insulin Agents*, revised
470-4094	*Request for Prior Authorization: Antifungal Drugs-Oral / Injectable*, revised
470-4521	*Request for Prior Authorization: Biologicals for Ankylosing Spondylitis*, revised
470-4522	*Request for Prior Authorization: Biologicals for Arthritis*, revised
470-4523	*Request for Prior Authorization: Biologicals for Inflammatory Bowel Disease*, revised
470-4524	*Request for Prior Authorization: Biologicals for Plaque Psoriasis*, revised
470-5142	*Request for Prior Authorization: Buprenorphine/Naloxone*, revised
470-5554	*Request for Prior Authorization: CGRP Inhibitors*, revised
470-4116	*Request for Prior Authorization: CNS Stimulants and Atomoxetine*, revised
470-5015	*Request for Prior Authorization: Dalfampridine (Ampyra)*, revised
470-5578	*Request for Prior Authorization: Elagolix (Orilissa)*, new
470-5410	*Request for Prior Authorization: Eluxadoline (Viberzi)*, revised
470-4098	*Request for Prior Authorization: Erythropoiesis Stimulating Agents*, revised
470-4550	*Request for Prior Authorization: Extended Release Formulations*, revised
470-4099	*Request for Prior Authorization: Granulocyte Colony Stimulating Factor*, revised

470-4850 *Request for Prior Authorization: Hematopoietics/Chronic ITP*, renamed and revised
470-5270 *Request for Prior Authorization: Hepatitis C Treatments*, revised
470-5531 *Request for Prior Authorization: High Dose Opioids*, revised
470-5040 *Request for Prior Authorization: Immunomodulators-Topical*, revised
470-4111 *Request for Prior Authorization: Insulin*, *Pre-Filled Pens,* revised
470-5117 *Request for Prior Authorization: Ivacaftor (Kalydeco)*, revised
470-5175 *Request for Prior Authorization: Janus Kinase (JAK) Inhibitors*, revised
470-4409 *Request for Prior Authorization: Long-Acting Opioids*, revised
470-5366 *Request for Prior Authorization: Lumacaftor/Ivacaftor (Orkambi)*, revised
470-5434 *Request for Prior Authorization: Lupron Depot - Pediatric*, revised
470-4655 *Request for Prior Authorization: Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment*, renamed and revised
470-5060 *Request for Prior Authorization: Multiple Sclerosis Agents-Oral*, revised
470-5577 *Request for Prior Authorization: Nocturnal Polyuria Treatments*, new
470-4109 *Request for Prior Authorization: Nonsteroidal Anti-Inflammatory Drugs*, revised
470-5423 *Request for Prior Authorization: Novel Oral Anticoagulants*, revised
470-5174 *Request for Prior Authorization: Oral Constipation Agents*, revised
470-5399 *Request for Prior Authorization: PCSK9 Inhibitors*, revised
470-5425 *Request for Prior Authorization: Potassium Binders*, revised
470-4327 *Request for Prior Authorization: Pulmonary Arterial Hypertension Agents*, revised
470-4328 *Request for Prior Authorization: Sedative/Hypnotics Non-Benzodiazepine*, revised
470-4899 *Request for Prior Authorization: Short Acting Opioids*, revised
470-5016 *Request for Prior Authorization: Sodium Oxybate (Xyrem)*, revised
470-5188 *Request for Prior Authorization: Testosterone Products*, revised
470-5426 *Request for Prior Authorization: Topical Acne and Rosacea Products*, revised
470-5398 *Request for Prior Authorization: Valsartan/Sacubitril (Entresto)*, revised
470-5534 *Request for Prior Authorization: Vesicular Monoamine Transporter (VMAT) 2 Inhibitors*, revised

Summary

The Prescribed Drug manual is revised to:

- Revise 39 forms for requesting drug prior authorization.
- Add two forms for requesting drug prior authorization.
- Rename the following forms for requesting drug prior authorization:
  - 470-4850, *Request for Prior Authorization: Thrombopoietin Receptor Agonists*, to *Request for Prior Authorization: Hematopoietics/Chronic ITP*
  - 470-4655, *Request for Prior Authorization: Vusion Ointment*, to *Request for Prior Authorization: Miconazole-Zinc Oxide-White Petrolatum (Vusion) Ointment*
- Remove the following forms for requesting drug prior authorization:
  - 470-5476, *Request for Prior Authorization: Eteplirsen (Exondys 51)*
  - 470-5424, *Request for Prior Authorization: Mepolizumab (Nucala)*
  - 470-4421, *Request for Prior Authorization: Nicotine Replacement Therapy*
  - 470-4517, *Request for Prior Authorization: Smoking Cessation Therapy-Oral*
- Update new drug entity process.
- Update prior authorization submission address.
- Update reimbursement language for Generic and Nonprescription Drugs, Brand-Name Drugs, 340B, Federal Supply Schedule, and Nominal Price.
- Update age edit chart.
- Remove coverage of medical supplies through Pharmacy Point of Sale

Effective Date

Upon receipt.

Material Superseded

This material replaces the following pages from the ***Prescribed Drugs Manual***:

Page	Date
Chapter III	
Contents (pages 1-3)	August 1, 2018
2, 6, 7, 15, 16, 18	August 1, 2018
470-5259	6/18
470-4094	10/18
470-4521	4/18
470-4522	10/18
470-4523	4/18
470-4524	10/18
470-5142	6/18
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470-5040	4/18
19, 20	August 1, 2018
470-4111	6/18
470-5117	4/18
470-5175	10/18
470-4409	8/16
470-5366	6/17
470-5434	1/17
470-5424	10/16
470-5060	4/17
470-4421	7/16
470-4109	6/16
470-5423	6/17
470-5174	10/18
470-5399	6/16
470-5425	10/16
470-4327	6/18
470-4328	7/15
470-4899	1/17
470-4517	7/16
470-5016	6/16
470-5188	1/18
470-4850	6/15
470-5426	6/18
470-5398	4/18
470-5534	10/18
470-4655	1/09
21-30, 46, 49-63	August 1, 2018

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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Average actual acquisition cost (average AAC) means the average prices that retail pharmacies paid to acquire drug products.

Compendium of drug information means one of the following:

- The American Hospital Formulary Service Drug Information (AHFS);
- The United States Pharmacopeia Drug Information (USP-DI) (or its successor publications); or
- DRUGDEX Information System.

DESI drugs means drug products identified by the federal Food and Drug Administration, in the Drug Efficacy Study Implementation Program, as lacking substantial evidence of effectiveness.

Drug rebates means payments provided by pharmaceutical manufacturers to state Medicaid programs under the terms of the manufacturers' agreements with the Department of Health and Human Services or with the individual state.

Drug utilization review (DUR) means a quality review of covered outpatient drugs that assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Drug Utilization Review Commission means a quality assurance body of nine members that seeks to improve the quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid members in Iowa. The website for the Commission is www.iadur.org.

Equivalent products means those products that meet therapeutic equivalence standards as published in the federal Food and Drug Administration document, *Approved Prescription Drug Products with Therapeutic Equivalence Evaluations*.

Excipient means an inactive substance used in drug compounding.

Federal upper limit (FUL) means the maximum allowable reimbursement set by the Centers for Medicare and Medicaid Services for a multiple-source drug. The list is available at the federal pharmacy reimbursement website: https://www.medicaid.gov/medicaid/prescription-drugs/federal-upper-limits/index.html

2. Entities Involved in Developing Medicaid Drug Policies

a. Drug Utilization Review Commission

The Iowa Medicaid Drug Utilization Review (DUR) Commission, established pursuant to Iowa Code section 249A.24, is a quality assurance body of ten members that seeks to improve the quality of pharmacy services and ensure rational, cost-effective medication therapy for Medicaid members in Iowa.

This Commission meets four times a year in a public forum. The Commission discusses potential medications or therapeutic classes where prior authorization may be beneficial, and discusses existing criteria to determine if the criteria continue to be therapeutically valid.

b. Pharmaceutical and Therapeutics Committee

The Pharmaceutical and Therapeutics (P&T) Committee was established pursuant to Iowa Code section 249A.20A. The P&T Committee has nine members appointed by the Governor for a two-year term. The Committee meets three times a year in a public forum.

The P&T Committee is charged with developing and providing ongoing review of the Preferred Drug List (PDL). The PDL is a list of drugs that have been identified as being therapeutically equivalent within a drug class and that provide cost benefit to the Medicaid program.

The PDL was created in an effort to select medications for use by the members of Iowa Medicaid that are both clinically sound and cost-effective. The Department of Human Services is attempting to contain Medicaid drug expenditures while ensuring that members' access to effective drug solutions are preserved.

The P&T Committee's focus is maximizing the initial utilization of the most cost-effective clinical choices available. All drug manufacturers have been given the opportunity to state the therapeutic benefit of their drugs and to reduce the net cost to the state through a supplemental rebate program.

The Committee has reviewed each product within a therapeutic class for:

- Pharmacology,
- Indications,
- Comparative clinical trials,
- Adverse effects and safety,
- Evaluated relative cost of each product, and
- Compared products within the same class to identify the most clinically effective, cost efficient product in each class.

By first considering the therapeutics and then the cost, the P&T Committee ultimately decides which drugs to recommend to the Iowa Medicaid program as "preferred."

The P&T Committee holds public meetings, with public notice of its agenda and opportunity for public comment. The website for the Committee is www.iowamedicaidpdl.com.

3. Pharmacies Eligible to Participate

Under the Iowa Medicaid program, drugs must be furnished by a licensed pharmacy enrolled as a Medicaid provider. (The Board of Pharmacy Examiners issues these licenses.)

a. Licensure

Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

b. Survey Participation

As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the Department to assist in monitoring and revising reimbursement rates pursuant to 441 IAC 79.1(8) or for the efficient operation of the pharmacy benefit.

4. Preferred or Recommended Drugs

Drug products designated on the Preferred Drug List as "P" (preferred) or "R" (recommended) do not require prior authorization unless the drug has a number in the comments column to indicate a prior authorization is required, as defined on the first page of the Preferred Drug List. See www.iowamedicaidpdl.com for the current designations.

A **preferred drug with conditions** has "preferred" agents but must meet certain medical criteria and guidelines that coincide with current prior authorization guidelines.

5. Nonpreferred Drugs

Drug products designated "N" (nonpreferred) on the Preferred Drug List require prior authorization, with the primary criteria being failure on the preferred agents rather than clinical guidelines. See www.iowamedicaidpdl.com for the current designations.

Drug products within a therapeutic class that are not selected as preferred will be denied for payment unless the prescriber obtains prior authorization. Payment for drugs requiring a prior authorization will be made only when:

- The drugs are prescribed for treatment of one or more conditions set forth for each, and
- The Iowa Medicaid prior authorization criteria have been met, and
- Approval is obtained through the prior authorization process.

EXCEPTION: In the event of an emergency when the prescriber cannot submit a prior authorization request, the pharmacist may dispense a 72-hour supply of the drug, except when noted in policy, and reimbursement will be made.

6. Newly Released Drugs

a. New Drug Entities

New drug entities (including new generic drugs) and new drug product dosage forms of existing drug entities will be identified weekly and immediately be coded as "Nonpreferred – Prior authorization required" until presented at the next scheduled P&T Committee meeting. If the drug category requires step therapy, the step therapy requirements must also be met, treating the new drug as a nonpreferred step 3 drug.

These prior authorization and step therapy restrictions will continue through the review process, including while committee recommendations are being made, and lasting until DHS makes a final determination.

The 72 hour emergency supply may not be available for medications intended for a short duration therapy.

b. Exceptions to the Nonpreferred Default Policy for New PDL Drugs

There are two major potential exceptions to the nonpreferred default policy for new PDL drugs:

- If the FDA classifies a new medication as a priority drug, the state may indicate that such a drug is preferred until the P&T Committee reviews the drug at its next scheduled meeting.
- The state may decide to designate a new drug as "draft preferred" and provide immediate access and increased therapeutic choice to physicians until the P&T Committee reviews the drug at its next scheduled meeting if:
  - A new drug is therapeutically equivalent or superior to existing preferred or nonpreferred choices, and
  - Is as safe or safer than existing preferred or nonpreferred choices, and
  - The net cost, adjusted for all rebates, is less expensive than all existing preferred choices.

Select nonprescription medications are covered although the manufacturers have not entered into a rebate agreement with CMS. Payment will be made in the same manner as for prescription drugs.

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

8. Medical Supplies

Pharmacies that dispense medical equipment and supplies should follow the *MEDICAL EQUIPMENT AND SUPPLY DEALER PROVIDER MANUAL*.

C. PRIOR AUTHORIZATION REQUIREMENTS

1. Prior Authorization (PA) Criteria

Refer to the most current PA criteria chart located at http://www.iowamedicaidpdl.com/pa_criteria.

2. Prior Authorization (PA) Forms

PA forms are required for the following and can be found at the links below:

- Age edit override – Codeine or Tramadol
- Alpha$_2$ agonists, extended release
- Alpha$_1$ proteinase inhibitor enzymes
- Amylino mimetic (Symlin)
- Anti-diabetic, non-insulin agents
- Antidepressants
- Antiemetic-5HT3 receptor antagonists/substance P neurokinin products
- Antifungal
- Antihistamines
- Apremilast (Otezla)
- Becaplermin (Regranex)
- Benzodiazepines
- Binge eating disorder agents
- Biologicals for ankylosing spondylitis
- Biologicals for arthritis
- Biologicals for Hidradenitis Suppurativa
- Biologicals for inflammatory bowel disease
- Biologicals for plaque psoriasis
- Buprenorphine/Naloxone (Suboxone)
- Calcifediol (Rayaldee)
- CGRP inhibitors

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 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 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. 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, a preferred Incretin Mimetic, and a preferred SGLT2 Inhibitor at maximally tolerated doses. The required trials may be overridden when documented 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
- ☐ Janumet XR
- ☐ Januvia
- ☐ Jentadueto
- ☐ Tradjenta

Non- Preferred DPP-4 Inhibitors and Combinations
- ☐ Alogliptin
- ☐ Alogliptin-Metformin
- ☐ Alogliptin-Pioglitazone
- ☐ Glyxambi
- ☐ Jentadueto XR
- ☐ Kazano
- ☐ Kombiglyze XR
- ☐ Nesina
- ☐ Onglyza
- ☐ Oseni

Preferred Incretin Mimetics
- ☐ Byetta
- ☐ Bydureon
- ☐ Ozempic
- ☐ Victoza

Non-Preferred Incretin Mimetics
- ☐ Adlyxin
- ☐ Bydureon BCise
- ☐ Trulicity

Preferred SGLT2 Inhibitors and Combinations
- ☐ Jardiance
- ☐ Synjardy
- ☐ Synjardy XR

Non-Preferred SGLT2 Inhibitors and Combinations
- ☐ Farxiga
- ☐ Invokamet
- ☐ Invokamet XR
- ☐ Invokana
- ☐ Qtern
- ☐ Segluromet
- ☐ Steglatro
- ☐ Steglujan
- ☐ Xigduo XR

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

Diagnosis: _____

Request for Prior Authorization
ANTI-DIABETIC NON-INSULIN AGENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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: _____

Requests for Non-Preferred Drugs:

Preferred DPP-4 Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Preferred Incretin Mimetic Trial: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Preferred SGLT2 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.*

Iowa Department of Human Services

Request for Prior Authorization
ANTIFUNGAL DRUGS-ORAL / INJECTABLE

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 not required for preferred antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. Prior authorization is required for all non-preferred antifungal therapy as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for a non-preferred antifungal will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Payment for any 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.

Preferred (PA required after 90 days)
- ☐ Clotrimazole Troche
- ☐ Fluconazole
- ☐ Griseofulvin Suspension
- ☐ Terbinafine
- ☐ Voriconazole
- ☐ Other: _____

Non-Preferred (PA required from Day 1)
- ☐ Cresemba
- ☐ Diflucan
- ☐ Grifulvin V
- ☐ Gris-Peg
- ☐ Griseofulvin Tablets
- ☐ Itraconazole
- ☐ Ketoconazole Tablets
- ☐ Lamisil
- ☐ Noxafil
- ☐ Onmel
- ☐ Oravig
- ☐ Sporanox
- ☐ Tolsura
- ☐ Vfend
- ☐ Other: _____

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:_____

Does the patient have an immunocompromised condition? ☐ Yes ☐ No
If yes, diagnosis:_____

Does the patient have a systemic fungal infection? ☐ Yes ☐ No

If yes, date of diagnosis:_____ Type of infection:_____

Previous trial(s) with preferred drug(s): Drug Name_____ Strength_____

Trial Date from_____ Trial Date to:_____

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
BIOLOGICALS FOR ANKYLOSING SPONDYLITIS

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 biologicals used for ankylosing spondylitis. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for ankylosing spondylitis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions: 1) Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least three months in duration. Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate; and 2) Patient has been screened for latent TB infection, patient with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and 3) Patient has been screened for hepatitis B and C, patient with active hepatitis B will not be considered for coverage.
In addition to the above:
Requests for TNF Inhibitors: 1) Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and 2) Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less.
Requests for Interleukins: Medication will not be given concurrently with live vaccines.
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred
☐ Cosentyx (after Humira trial) ☐ Humira
☐ Enbrel

Non-Preferred
☐ Cimzia ☐ Simponi

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

Screening for Hepatitis B: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Hepatitis C: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Latent TB infection: Date:_____ Results: _____

Request for Prior Authorization
BIOLOGICALS FOR ANKYLOSING SPONDYLITIS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

NSAID Trial #1 Name/Dose: _____Trial start date: _____Trial end date: _____

Reason for Failure: _____

NSAID Trial #2 Name/Dose: _____ Trial start date: _____Trial end date: _____

Reason for Failure: _____

DMARD Trial (for peripheral arthritis diagnosis) Name/Dose:_____

Trial start date: _____Trial end date: _____ Reason for Failure:_____

Requests for TNF Inhibitors:

Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last 5 years of starting or resuming treatment with a biologic agent? ☐ Yes ☐ No

Does patient have a diagnosis of NYHA class lll or lV CHF diagnosis with ejection fraction of 50% or less? ☐ Yes ☐ No

Requests for Interleukins:

Will medication be given concurrently with live vaccines? ☐ Yes ☐ No

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

_____

Other medical conditions to consider: _____

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
BIOLOGICALS FOR ARTHRITIS

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 biologicals used for arthritis. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions: 1) Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and 2) Patient has been screened for hepatitis B and C. Patients with evidence of active hepatitis B infection (hepatitis surface antigen positive > 6 months) must have documentation they are receiving or have received effective antiviral treatment.
In addition to the above:
Requests for TNF Inhibitors: 1) Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and 2) Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less.
Requests for Interleukins: Medication will not be given concurrently with live vaccines.
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred
- ☐ Cosentyx (after Humira trial)
- ☐ Enbrel
- ☐ Humira

Non-Preferred
- ☐ Actemra
- ☐ Cimzia (prefilled syringe)
- ☐ Ilaris
- ☐ Kevzara
- ☐ Kineret
- ☐ Orencia
- ☐ Simponi
- ☐ Stelarai
- ☐ Taltz

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Screening for Hepatitis B: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Hepatitis C: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Latent TB infection: Date:_____ Results: _____

Requests for TNF Inhibitors:

Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last 5 years of starting or resuming treatment with a biologic agent? ☐ Yes ☐ No

Does patient have a diagnosis of NYHA class lll or lV CHF diagnosis with ejection fraction of 50% or less? ☐ Yes ☐ No

Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Requests for Interleukins:

Will medication be given concurrently with live vaccines? ☐ Yes ☐ No

☐ **Rheumatoid arthritis (RA)** (Humira, Enbrel, Actemra, Cimzia, Kineret, Orencia, Simponi, Kevzara)-
Payment will be considered upon 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 (hydroxychoroquine, sulfasalazine, or leflunomide). 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.

Methotrexate trial: Dose: _____ Trial dates: _____

Failure reason: _____

Plus preferred oral DMARD trial: Drug Name & Dose: _____ Trial dates: _____
Failure reason: _____

Radiographic evidence indicating erosions: ☐ Yes ☐ No

☐ **Psoriatic arthritis, moderate to severe** (Cimzia, Cosentyx, Enbrel, Humira, Simponi, Stelara, Taltz)-
Payment will be considered upon a trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Methotrexate or preferred oral DMARD trial: Drug Name &Dose: _____
Trial dates: _____ Failure reason: _____
Methotrexate contraindication if applicable: _____

☐ **Juvenile idiopathic arthritis, moderate to severe** (Enbrel, Humira, Actemra, Orencia, Ilaris)-

Payment will be considered upon 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).

Intraarticular Glucocorticoid Injections: Drug Name & Dose: _____ Trial dates: _____

Failure reason: _____

Plus methotrexate or preferred oral DMARD trial: Drug Name & Dose: _____
Trial dates: _____ Failure reason: _____
Methotrexate contraindication if applicable: _____

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.*

Iowa Department of Human Services

Request for Prior Authorization
BIOLOGICALS FOR INFLAMMATORY BOWEL DISEASE

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 biologicals used for inflammatory bowel disease. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions: 1) Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and 2) Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment.
In addition to the above:
Requests for TNF Inhibitors: 1) Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and 2) Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less.
Requests for Interleukins: Medication will not be given concurrently with live vaccines.
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred
- ☐ Humira
- ☐ Humira Starter Kit

Non-Preferred
- ☐ Cimzia (prefilled syringe)
- ☐ Simponi
- ☐ Stelara

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

Screening for Hepatitis B: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Hepatitis C: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Latent TB infection: Date:_____ Results: _____

Requests for TNF Inhibitors:

Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last 5 years of starting or resuming treatment with a biologic agent? ☐ Yes ☐ No

Does patient have a diagnosis of NYHA class III or IV CHF diagnosis with ejection fraction of 50% or less? ☐ Yes ☐ No

Requests for Interleukins:

Request for Prior Authorization
BIOLOGICALS FOR INFLAMMATORY BOWEL DISEASE

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Will medication be given concurrently with live vaccines? ☐ Yes ☐ No

☐ **Crohn's Disease – Payment will be considered following an inadequate response to two preferred conventional therapies including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, and/or methotrexate.**

Trial Drug Name/Dose: _____ Trial dates:_____

Reason for failure: _____

Trial Drug Name/Dose: _____Trial dates:_____

Reason for failure: _____

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

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

Trial Drug Name/Dose: _____Trial dates:_____

Reason for failure:_____

Trial Drug Name/Dose: _____Trial dates:_____

Reason for failure: _____

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

Possible drug interactions/conflicting drug therapies/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.*

Iowa Department of Human Services

Request for Prior Authorization
BIOLOGICALS FOR PLAQUE PSORIASIS

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 biologicals used for plaque psoriasis. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions: 1) Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and 2) Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and 3) Patient has documentation of an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine.
In addition to the above:
Requests for TNF Inhibitors: 1) Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and 2) Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less.
Requests for Interleukins: Medication will not be given concurrently with live vaccines.
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

☐ Cosentyx (after Humira trial) ☐ Humira
☐ Enbrel

Non-Preferred

☐ Siliq ☐ Taltz
☐ Stelara ☐ Tremfya

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

Screening for Hepatitis B: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Hepatitis C: Date:_____ Active Disease: ☐ Yes ☐ No

Screening for Latent TB infection: Date:_____ Results: _____

Treatment failure with a preferred oral therapy: Trial Drug Name: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Request for Prior Authorization
BIOLOGICALS FOR PLAQUE PSORIASIS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Non-Pharmacological Treatments Tried: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Requests for TNF Inhibitors:

Has patient received treatment for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within last 5 years of starting or resuming treatment with a biologic agent? ☐ Yes ☐ No

Does patient have a diagnosis of NYHA class lll or lV CHF diagnosis with ejection fraction of 50% or less? ☐ Yes ☐ No

Requests for Interleukins:

Will medication be given concurrently with live vaccines? ☐ Yes ☐ No

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

_____

Other medical conditions to consider: _____

_____

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
Buprenorphine/Naloxone

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 transmucosal buprenorphine or buprenorphine/naloxone. Requests will be considered for FDA approved dosing, including induction and maintenance dose. Requests for doses above 24 mg per day will not be considered. Initial requests will be considered for up to 3 months. Requests for maintenance doses above 16 mg per day will not be considered on a long-term basis. After the initial 3 month PA, renewal requests for doses ≤ 16mg per day may be considered for 12 month renewals as long as the member meets all other PA criteria. 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, unless evidence is provided that use of these agents would be medically contraindicated. Requests for surgically implanted buprenorphine or buprenorphine depot injections products will not be considered through the pharmacy benefit and should be directed to the member's medical benefit. Payment will be considered when the following is met:

1) Patient has a diagnosis of opioid dependence and meets the FDA approved age; AND
2) Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has an "X" DEA number (provide X DEA number); AND
3) Documentation the Iowa Prescription Monitoring Program website has been reviewed for the patient's use of controlled substances; AND
4) Documentation is provided that transmucosal buprenorphine will not be used concomitantly with the buprenorphine implant or depot injection.
5) Requests for single ingredient buprenorphine will only be considered for pregnant patients.

Requests for renewal must include:

1) Documentation the Iowa PMP website has been reviewed for the patient's use of controlled substances since the last PA request; AND
2) Patient does not have documentation of concomitant use of an opioid or tramadol with the requested buprenorphine product as seen in paid pharmacy claims; AND
3) Patient is not using transmucosal buprenorphine with buprenorphine implant or depot injection.

Preferred

☐ Buprenorphine/Naloxone SL Tabs

Non-Preferred

☐ Bunavail
☐ Buprenorphine (Please verify patient is pregnant) ☐ No ☐ Yes
☐ Suboxone SL Film
☐ Zubsolv

Iowa Department of Human Services

Request for Prior Authorization
Buprenorphine/Naloxone

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Initial Requests:

Prescriber meets qualifications to prescribe and treat opioid dependence and possess "X" DEA number:
☐ No ☐ Yes X DEA number: _____

Is patient using transmucosal buprenorphine with buprenorphine implant or depot injection? ☐ No ☐ Yes

- Documentation the Iowa Prescription Monitoring Program (PMP) website has been reviewed for the patient's use of controlled substances. ☐ No ☐ Yes Date reviewed: _____

Renewal Requests:

- Documentation the Iowa Prescription Monitoring Program (PMP) website has been reviewed for the patient's use of controlled substances since the last prior authorization request. ☐ No ☐ Yes
  Date reviewed: _____
- Does patient have concomitant use of an opioid or tramadol with the requested buprenorphine product?
  ☐ No ☐ Yes
- Is patient using transmucosal buprenorphine with buprenorphine implant or depot injection? ☐ No ☐ Yes

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
CGRP 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 CGRP Inhibitors. Payment will be considered for patients when the following is met:

1. **Patient has a diagnosis of migraine as defined by one of the following:**
   a. **Chronic Migraine**
      i. **≥ 15 headache days per month for a minimum of 3 months; and**
      ii. **≥ 8 migraine headache days per month for a minimum of 3 months; or**
   b. **Episodic Migraine**
      i. **4 to 14 migraine days per month for a minimum of 3 months; and**
2. **Patient meets the FDA approved age; and**
3. **Patient has been evaluated for and does not have medication overuse headache; and**
4. **Patient has documentation of three trials and therapy failures, of at least three months per agent, at a maximally tolerated dose with a minimum of two different migraine prophylaxis drug classes (i.e., anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]; and**
5. **The requested dose does not exceed the maximum FDA labeled dose; and**
6. **Lost, stolen, or destroyed medication replacement requests will not be authorized.**

Initial requests will be approved for three months. Additional prior authorizations will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days).

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

Non-Preferred

☐ Aimovig ☐ Ajovy ☐ Emgality

Strength	Dosage Instructions	Quantity	Days Supply

Request for Prior Authorization
CGRP Inhibitors

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Chronic Migraine (must document each criteria below):**
Patient has ≥ 15 headache days per month for a minimum of 3 months
Number of headache days per month:

Month 1: _____ Month 2: _____ Month 3: _____

Patient has ≥ 8 migraine headache days per month for a minimum of 3 months
Number of migraine headache days per month:

Month 1: _____ Month 2: _____ Month 3: _____

☐ **Episodic Migraine:**
Patient has 4 to 14 migraine headache days per month for a minimum of 3 months

Number of migraine headache days per month: _____ Duration (months): _____

Has patient been evaluated and medication overuse headache ruled out? ☐ Yes ☐ No

Treatment failures:

Trial 1: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Trial 2: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Trial 3: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

☐ **Renewal Requests:** Document clinical response to therapy:_____

_____

_____

Number of headache/migraine days per month since start of therapy:_____

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
CNS STIMULANTS AND ATOMOXETINE

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 CNS stimulants and atomoxetine for patients 21 years of age or older. Requests will be considered for an FDA approved age for the submitted diagnosis. Prior to requesting PA for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website. Payment for CNS stimulants and atomoxetine will be considered under the following conditions: 1) Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, Snap-IV). Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms improvement in symptoms from baseline will be required for renewals or patients newly eligible that are established on medication to treat ADHD. Adults (≥ 21 years of age) are limited to the use of long-acting agents only. If a supplemental dose with a short-acting agent is needed for an adult in the mid to late afternoon, requests will be considered under the following circumstances: the dose of the long-acting agent has been optimized, documentation is provided a short-acting agent of the same chemical entity is medically necessary (e.g. employed during the day with school in the evening), and will be limited to one unit dose per day. Children (< 21 years of age) are limited to the use of long-acting agents with one unit of a short acting agent per day. 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 with the preferred extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Requests for Vyvanse for Binge Eating Disorder must be submitted on the Binge Eating Disorder Agents PA form.

Preferred

- ☐ Amphetamine Salt Combo
- ☐ Amphetamine ER Caps
- ☐ Aptensio XR
- ☐ Armodafinil
- ☐ Atomoxetine
- ☐ Concerta
- ☐ Daytrana
- ☐ Dexmethylphenidate Tabs
- ☐ Focalin XR
- ☐ Methylin Solution
- ☐ Methylphenidate IR Tabs
- ☐ Methylphenidate ER 20mg Tabs
- ☐ Modafinil
- ☐ Quillichew ER
- ☐ Quillivant XR
- ☐ Vyvanse

Non-Preferred

- ☐ Adderall
- ☐ Adderall XR*
- ☐ Adzenys ER Susp
- ☐ Adzenys XR ODT
- ☐ Amphetamine Sulfate Tabs
- ☐ Cotempla*
- ☐ Desoxyn
- ☐ Dexedrine*
- ☐ Dexmethylphenidate ER caps*
- ☐ Dextroamphetamine ER Caps*
- ☐ Dyanavel XR
- ☐ Evekeo
- ☐ Focalin
- ☐ Methylphenidate CD
- ☐ Methylphenidate Chew
- ☐ Methylphenidate ER Tabs
- ☐ Methylphenidate ER Caps
- ☐ Methylphenidate LA Caps
- ☐ Mydayis*
- ☐ Nuvigil
- ☐ Procentral
- ☐ Provigil
- ☐ Ritalin
- ☐ Ritalin LA
- ☐ Straterra

Strength_____ Dosage Instructions _____Quantity _____Days Supply_____

Request for Prior Authorization
CNS STIMULANTS AND ATOMOXETINE

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Diagnosis:

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

Age of patient at onset of symptoms: _____

Date of most recent clinical visit confirming improvement in symptoms from baseline: _____

Rating scale used to determine diagnosis: _____

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

Current Environment 1 & description: _____

Current Environment 2 & description: _____

Requests for short-acting agents for adults:

Has dose of long-acting agent been optimized? ❑ Yes ❑ No

Provide medical necessity for the addition of a short-acting agent: _____

_____

☐ **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 ☐ Position therapy

☐ CPAP Date: _____ Maximum titration? ☐ Yes ☐ No

☐ BiPAP Date: _____ Maximum titration? ☐ Yes ☐ No

☐ Surgery Date: _____

Specifics:_____

Diagnosis confirmed by a sleep specialist? ❑ Yes ❑ No

☐ **Other (specify)_____**

Prescriber review of patient's controlled substances use on the Iowa PMP website:

☐ No ☐ Yes Date Reviewed:_____

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
DALFAMPRIDINE (AMPYRA)

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 dalfampridine (Ampyra™). Payment will be considered under the following conditions: 1) Patients must be diagnosed with a gait disorder associated with multiple sclerosis (MS). 2) Initial authorizations will be approved for 12 weeks with a baseline Timed 25-foot Walk (T25FW) assessment. 3) Additional prior authorizations will be considered at 6 month intervals after assessing the benefit to the patient as measured by a 20% improvement in the T25FW from baseline. Renewal will not be approved if the 20% improvement is not maintained. Prior authorizations will not be considered for patients with a seizure diagnosis or in patients with moderate or severe renal impairment.

Preferred **Non-Preferred**

☐ Ampyra ☐ Dalfampridine ER

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

_____ _____ _____ _____

Diagnosis: _____

Result of the baseline Timed 25-foot Walk (T25FW) assessment: _____

Date of the baseline T25FW assessment : _____

Result of subsequent T25FW assessment: _____

Date of subsequent T25FW assessment:_____

% improvement from baseline assessment:_____

Patient has a seizure diagnosis: ☐ Yes ☐ No

Patient has moderate or severe renal impairment: ☐ Yes ☐ No

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.

Department of HUMAN SERVICES

Request for Prior Authorization
Elagolix (Orilissa)

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 gonadotropin-releasing hormone (GnRH) antagonists. Payment will be considered for patients when the following is met:

1) Patient has a diagnosis of moderate to severe pain associated with endometriosis; and
2) Pregnancy has been ruled out; and
3) Patient does not have osteoporosis; and
4) Patient does not have severe hepatic impairment; and
5) Patient is not taking a strong organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine and gemfibrozil); and
6) Patient has documentation of a previous trial and therapy failure with at least one preferred oral NSAID and at least one preferred 3-month course of a continuous hormonal contraceptive taken concurrently; and
7) Patient has documentation of a previous trial and therapy failure with a preferred GnRH agonist.
8) Requests will be considered for a maximum of 24 months for the 150mg dose and 6 months for the 200mg dose.

Initial requests will be considered for 3 months. Additional requests will be considered upon documentation of improvement of symptoms.

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

Non-Preferred

☐ Orilissa

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Request for Prior Authorization
Elagolix (Orilissa)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Initial Requests:**

Has pregnancy been ruled out? ☐ Yes ☐ No Date of pregnancy test:_____

Does patient have osteoporosis? ☐ Yes ☐ No

Does patient have severe hepatic impairment? ☐ Yes ☐ No

Is patient taking a strong organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine and gemfibrozil)? ☐ Yes ☐ No

Treatment Failures:

Preferred Oral NSAID Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication:_____

_____

Preferred Continuous Hormonal Contraceptive Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication:_____

_____

Preferred GnRH Agonist Trial:

Name/dose:_____ Trial dates:_____

Failure reason/medical contraindication:_____

_____

☐ **Renewal Requests:**

Provide documentation of improvement in symptoms:_____

_____

_____

Attach lab results and other documentation as necessary.

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

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Iowa Department of Human Services

Request for Prior Authorization
ELUXADOLINE (VIBERZI™)

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 eluxadoline (Viberzi™). Only FDA approved dosing will be considered. Payment will be considered under the following conditions:

1) **Patient is 18 years of age or older; and**
2) **Patient has a diagnosis of irritable bowel syndrome with diarrhea (IBS-D); and**
3) **Patient does not have any of the following contraindications to therapy:**
   - **Patient is without a gallbladder**
   - **Known or suspected biliary duct obstruction, or sphincter of Oddi disease/dysfunction**
   - **Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than 3 alcoholic beverages per day**
   - **A history of pancreatitis or structural diseases of the pancreas (including known or suspected pancreatic duct obstruction)**
   - **Severe hepatic impairment (Child-Pugh Class C)**
   - **Severe constipation or sequelae from constipation**
   - **Known or suspected mechanical gastrointestinal obstruction; and**
4) **Patient has documentation of a previous trial and therapy failure at a therapeutic dose with both of the following:**
   - **A preferred antispasmodic agent (dicyclomine or hyoscyamine) and**
   - **A preferred antidiarrheal agent (loperamide).**

If the criteria for coverage are met, initial authorization will be given for 3 months to assess the response to treatment. Requests for continuation therapy will require the following:

1) **Patient has not developed any contraindications to therapy (defined above); and**
2) **Patient has experienced a positive clinical response to therapy as demonstrated by at least one of the following:**
   a) **Improvement in abdominal cramping or pain, and/or**
   b) **Improvement in stool frequency and consistency.**

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

Preferred

☐ Viberzi

Strength	Dosage Instructions	Quantity	Days Supply

Request for Prior Authorization-*Continued*
ELUXADOLINE (VIBERZI™)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Diagnosis: _____

Treatment failures:

Antispasmodic Trial (dicyclomine or hyoscyamine):

Drug name & dose: _____ Trial dates: _____

Reason for failure: _____

Antidiarrheal Trial (loperamide): Dose: _____ Trial dates: _____

Reason for failure: _____

Indicate if patient has any of the following contraindications to therapy:

Patient is without a gallbladder:	☐ No	☐ Yes
Known or suspected biliary duct obstruction, or sphincter of Oddi disease/dysfunction:	☐ No	☐ Yes
Alcoholism, alcohol abuse, alcohol addiction, or consumption of more than 3 alcoholic beverages per day:	☐ No	☐ Yes
A history of pancreatitis or structural diseases of the pancreas (including known or suspected pancreatic duct obstruction):	☐ No	☐ Yes
Severe hepatic impairment (Child-Pugh Class C):	☐ No	☐ Yes
Severe constipation or sequelae from constipation:	☐ No	☐ Yes
Known or suspected mechanical gastrointestinal obstruction:	☐ No	☐ Yes

Renewal Requests

Has patient developed any contraindications to therapy (defined above)?

☐ No ☐ Yes (document contraindications to therapy): _____

Has patient experienced a positive clinical response to therapy as demonstrated by at least one of the following?

☐ Improvement in abdominal cramping or pain

☐ Improvement in stool frequency and consistency

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

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

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Iowa Department of Human Services

Request for Prior Authorization
ERYTHROPOIESIS STIMULATING 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
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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 erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia. Payment for non-preferred erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s).

Preferred
☐ Procrit

Non-Preferred
☐ Aranesp ☐ Mircera
☐ Epogen

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Hemoglobin:_____ **%** **Lab Test Date:**_____ **(Lab Test must be within 4 weeks of the PA request date)**

Transferrin Saturation:_____**Ferritin:** _____ **Lab Test Date:**_____**(Lab Test must be within 3 months of the PA request date)**

Is the patient currently on dialysis? ☐ Yes ☐ No
Is the patient on concurrent therapeutic iron therapy? ☐ Yes ☐ No
If yes, what is the current drug name, strength & dose? _____

Does the patient have active gastrointestinal bleeding? ☐ Yes ☐ No If yes, what is the current treatment?
_____

Does the patient have hemolysis? ☐ Yes ☐ No
Does the patient have a vitamin B-12, iron, or folate deficiency? ☐ Yes ☐ No

Previous Erythropoiesis Stimulating Agent therapy (include drug name(s), strength and exact date ranges) :
_____

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

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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 , Amoxicillin ER, Astagraf XL, Augmentin XR, Cardura XL, Carvedilol ER, Cipro XR, Coreg CR, Doryx, Envarsus XR, Fortamet, Glumetza, Gocovri, Gralise, Kapspargo, Keppra XR, Lamictal XR, Luvox CR, Memantine ER, Mirapex ER, Moxatag, Namenda XR, Oleptro, Osmolex ER, Oxtellar XR, pramipexole ER, Prozac Weekly, Qudexy XR, Rayos, Requip XL, Rythmol SR, Solodyn ER, topiramate er, Trokendi XR, Ximino.

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

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Iowa Department of Human Services

Request for Prior Authorization
GRANULOCYTE COLONY STIMULATING FACTOR

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 therapy with granulocyte colony stimulating factor agents. Payment for non-preferred granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). 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.

Preferred
- ☐ Granix
- ☐ Neupogen Vials (members < 18 years of age)

Non-Preferred
- ☐ Fulphila
- ☐ Leukine
- ☐ Neulasta
- ☐ Neupogen Syrignes
- ☐ Nivestym
- ☐ Zarxio

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis (or indication for the product):
- ☐ Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
- ☐ Treatment of neutropenia in patients with malignancies undergoing myelopblative chemotherapy followed by a bone marrow transplant.
- ☐ Moibilization of progenitor cells into the peripheral blood stream for leukapheresis collections to be used after myeloblative chemotherapy.
- ☐ Treatment of congenital, cyclic, or idopathyic neutropenia in symptomatic patients.
- ☐ On current chemotherapy drug(s) that would cause severe neutropenia (specify)_____
- ☐ Other condition specify) _____

Absolute Neutrophil Count (ANC): _____

Dates of routine CBC: _____

Platelet Counts: _____

Pertinent Lab data: _____

Previous therapy (include drug name, strength and exact date ranges): _____

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

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

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

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Iowa Department of Human Services

Request for Prior Authorization
HEMATOPOIETICS/CHRONIC ITP

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
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Provider NPI	Prescriber name	Phone
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Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for hematopoietics/chronic ITP agents. Request must adhere to all FDA approved labeling. Payment for a non-preferred hematopoietic/chronic ITP agent will be considered following documentation of a recent trial and therapy failure with a preferred hematopoietic/chronic ITP agent, when applicable, unless such a trial would be medically contraindicated. Payment will be considered under the following conditions:

Preferred

☐ Promacta

Non-Preferred

☐ Doptelet ☐ Mulpleta ☐ Nplate ☐ Promacta Powder ☐ Tavalisse

Strength	Dosage Instructions	Quantity	Days Supply

☐ **Thrombocytopenia with Chronic Immune Thrombocytopenia (ITP) (Promacta, Nplate, Tavalisse)**

Documentation of an insufficient response to a corticosteroid, immunoglobulin, or splenectomy.

Trial Drug Name: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Has the patient undergone splenectomy? ☐ No ☐ Yes

☐ **Severe Aplastic Anemia (Promacta)**

1. Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy; and 2. Patient has a platelet count ≤ 30 x 10^9/L. 3. If criteria for coverage are met, initial authorization will be given for 16 weeks. Documentation of hematologic response after 16 weeks of therapy will be required for further consideration.

Trial Drug Name: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Platelet count: _____ Lab Date: _____

Renewal Requests:
Has patient had a hematologic response after 16 weeks of Promacta therapy? ☐ Yes (attach labs) ☐ No

Iowa Department of Human Services

Request for Prior Authorization
HEMATOPOIETICS/CHRONIC ITP

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Thrombocytopenia with chronic liver disease in patients scheduled to undergo a procedure (Doptelet, Mulpleta)**

Documentation of the following: 1. Pre-treatment platelet count ; and 2. Scheduled dosing prior to procedure; and 3. Therapy completion prior to scheduled procedure; and 4. Platelet count will be obtained before procedure.

Platelet count: _____ Lab Date: _____

Date of scheduled procedure: _____

Date for start of drug treatment: _____

After the last dose, a platelet count will be obtained prior to undergoing the procedure: ☐ Yes ☐ No

☐ **Other Diagnosis:**_____

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

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Iowa Department of Human Services

Request for Prior Authorization
HEPATITIS C TREATMENTS

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		Patient phone
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 hepatitis C treatments. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions: 1) Patient has a diagnosis of chronic hepatitis C; and 2) Patient's age and/or weight is within the FDA labeled age and/or weight; and 3) Patient has had testing for hepatitis C virus (HCV) genotype; and 4) Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and 5) Patient has been tested for hepatitis B (HBV) prior to initiating treatment of HCV and individuals with active HBV infection are treated (either at same time as HCV therapy or before HCV therapy is started); and 6) Patient has advanced liver disease corresponding to a Metavir score of 2 or greater fibrosis as confirmed by one of the following: a) liver biopsy confirming a Metavir score ≥2; or b) transient elastography (FibroScan) score ≥ 7.5kPa; or c) FibroSURE (FibroTest) score ≥0.48; or d) APRI score >0.7; or e) radiological imaging consistent with cirrhosis (i.e., evidence of portal hypertension); or f) physical findings or clinical evidence consistent with cirrhosis; or g) patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), proteinuria, nephrotic syndrome, or membranoproliferative glomerulonephritis; and 7) Patient's prior treatment history is provided (treatment naïve or treatment experienced); and 8) If patient has a history of non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and 9) 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 10) For regimens containing sofosbuvir (Sovaldi/ledipasvir/sofosbuvir/sofosbuvir/velpatasvir/Vosevi), patient does not have severe renal impairment (creatinine clearance <30ml/min) or end stage renal disease requiring hemodialysis; and 11) HCV treatment is prescribed by or in consultation with a digestive disease, liver disease, or infectious disease provider practice; and 12) For patients on a regimen containing ribavirin, documentation of the following on the PA form: a) Patient is not a pregnant female or a male with a pregnant female partner; and b) Women of childbearing potential and their male partners must use two forms of effective contraception during treatment and for at least 6 months after treatment has concluded; and c) Monthly pregnancy tests will be performed during treatment; and 13) Prescriber has reviewed the patient's current medication list and acknowledged that there are no significant drug interactions with the HCV medication; and 14) Documentation is provided for patients who are ineligible to receive ribavirin. 15) Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved. 16) Patient does not have limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions. 17) If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on established length of therapy for the particular treatment (defined below). 18) Lost or stolen medication replacement requests will not be authorized. 19) The 72-hour emergency supply rule does not apply to hepatitis C treatments. 20) Only one treatment attempt will be allowed per calendar year, regardless of compliance.

Preferred:
- ☐ Mavyret
- ☐ Sofosbuvir/Velpatasvir

Non-Preferred:
- ☐ Daklinza
- ☐ Epclusa
- ☐ Harvoni
- ☐ Ledipasvir/Sofosbuvir
- ☐ Sovaldi
- ☐ Vosevi
- ☐ Zepatier

Instructions for completing the Hepatitis C Treatments PA form:

Section 1 of the PA form lists the various regimens and clinical situations for which hepatitis C treatments will be considered medically necessary according to Iowa Medicaid PA criteria. Section 2 includes additional supporting documentation that is required on the PA form.

- Check ONE box in Section 1 – Treatment Regimen.

- Review and complete each numbered item in Section 2 – Supporting Documentation.
- Attach lab results, chart notes, and other documentation, sign, and fax the completed form to (800) 574-2515.

SECTION 1 – TREATMENT REGIMEN

Check ONE box below to indicate the requested treatment regimen based on the patient's genotype, treatment history, and extent of liver disease.

Genotype 1 (Note: the subtype is listed if there are differences in the recommended treatments)
Treatment naïve, no cirrhosis ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks
Treatment naïve, compensated cirrhosis (Child-Pugh A ONLY) ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks
Treatment experienced (PEG-IFN/RBV ONLY), no cirrhosis ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks
Treatment experienced (PEG-IFN/RBV ONLY), compensated cirrhosis (Child-Pugh A ONLY) ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks
Treatment experienced (PEG-IFN/RBV + NS3/4A protease inhibitor, no prior NS5A, no prior sofosbuvir), no cirrhosis ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks
Treatment experienced (PEG-IFN/RBV+NS3/4A protease inhibitor, no prior NS5A, no prior sofosbuvir), compensated cirrhosis (Child-Pugh A ONLY) ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks
Treatment experienced (sofosbuvir + ribavirin +/- PEG-IFN OR simeprevir, no NS5A), no cirrhosis ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks ❑ 1b: sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks
Treatment experienced (sofosbuvir + ribavirin +/- PEG-IFN OR simeprevir, no NS5A), compensated cirrhosis (Child-Pugh A ONLY) ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks ❑ 1b: sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks
Treatment experienced, any NS5A inhibitor but NO NS3/4A protease inhibitor (prior therapy ONLY with daclatasvir+sofosbuvir, ledipasvir+sofosbuvir or sofosbuvir +velpatasvir), no or compensated cirrhosis (Child-Pugh A ONLY) ❑ Mavyret 100/40 mg, three (3) tablets daily for 16 weeks ❑ Vosevi 400/100/100 mg daily for 12 weeks
Treatment experienced (prior treatment with any NS5A inhibitor (ledipasvir (Harvoni), velpatasvir (Epclusa/Vosevi), elbasvir (Zepatier), dasabuvir (Viekira), pibrentasvir (Mavyret) and daclatasvir (Daklinza), including those given with a NS3/4A protease inhibitor), no cirrhosis or compensated cirrhosis (Child-Pugh A ONLY) ❑ Vosevi 400/100/100 mg daily for 12 weeks
Re-infection of allograft liver after transplant, no cirrhosis ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
Re-infection of allograft liver after transplant, compensated cirrhosis (Child-Pugh A ONLY) ❑ ledipasvir/sofosbuvir 90/400 mg plus weight based ribavirin daily for 12 weeks
Re-infection of allograft liver after transplant, decompensated cirrhosis (Child-Pugh B or C ONLY) ❑ ledipasvir/sofosbuvir 90/400 mg plus low dose ribavirin# daily for 12 weeks
Decompensated cirrhosis, no prior sofosbuvir or NS5A ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks (low dose ribavirin# if Child-Pugh Class C) ❑ sofosbuvir/velpatasvir 400/100 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

Decompensated cirrhosis, prior treatment with sofosbuvir or NS5A

- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 24 weeks (low dose ribavirin if Child-Pugh Class C)

Recurrent HCV infection post–liver transplantation, no cirrhosis

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks

Recurrent HCV infection post–liver transplantation, compensated cirrhosis (Child-Pugh A ONLY)

- ❑ ledipasvir/sofosbuvir 90/400 mg plus weight based ribavirin daily for 12 weeks

Recurrent HCV infection post–liver transplantation, decompensated cirrhosis (Child-Pugh B and C ONLY)

- ❑ ledipasvir/sofosbuvir 90/400 mg plus low dose ribavirin[#] daily for 12 weeks

Genotype 2

Treatment naïve, no cirrhosis

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment naïve, compensated cirrhosis (Child-Pugh A ONLY)

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced (PEG-IFN + ribavirin), no cirrhosis

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced (PEG-IFN + ribavirin), with compensated cirrhosis (Child-Pugh A only)

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced (sofosbuvir + ribavirin) (no cirrhosis)

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks (label indication) or 12 (guideline recommendation) weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced (sofosbuvir + ribavirin) with compensated cirrhosis (Child-Pugh A only)

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced, (sofosbuvir + any NS5A inhibitor) with or without compensated cirrhosis (Child-Pugh A only)

- ❑ Vosevi 400/100/100 mg daily for 12 weeks

Decompensated cirrhosis, no prior sofosbuvir or NS5A failure

- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

Decompensated cirrhosis, prior sofosbuvir or NS5A failure

- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight based ribavirin daily for 24 weeks (low dose ribavirin if Child-Pugh C)

Recurrent HCV infection post–liver transplantation, no cirrhosis

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks

Recurrent HCV infection post–liver transplantation, compensated cirrhosis (Child-Pugh A ONLY)

- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks

Recurrent HCV infection post–liver transplantation, decompensated cirrhosis

- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks

Genotype 3

Treatment naive, no cirrhosis

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment naive, with compensated cirrhosis (Child-Pugh A only), Y93H negative

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks (Child-Pugh A only)
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment naive, with compensated cirrhosis (Child-Pugh A only), Y93H positive
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks

Treatment experienced (PEG-IFN + ribavirin), no cirrhosis, Y93H negative
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 16 weeks

Treatment experienced (PEG-IFN + ribavirin), no cirrhosis, Y93H positive
- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 16 weeks

Treatment experienced (PEG-IFN + ribavirin), compensated cirrhosis (Child-Pugh A ONLY)
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 16 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks

Treatment experienced (any direct acting antiviral including NS5A), no or compensated cirrhosis (Child-Pugh A ONLY)
- ❑ Vosevi 400/100/100 mg daily for 12 weeks (add weight based ribavirin if both prior NS5A and cirrhosis)

Decompensated cirrhosis, no prior sofosbuvir or NS5A failure
- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 24 weeks (will only be approved for patients with documented ineligibility for ribavirin¶)

Decompensated cirrhosis, prior sofosbuvir or NS5A failure
- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 24 weeks (low dose ribavirin# if Child-Pugh C)

Recurrent HCV infection post–liver transplantation, no cirrhosis
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks

Recurrent HCV infection post–liver transplantation, compensated cirrhosis (Child-Pugh A ONLY)
- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks

Recurrent HCV infection post–liver transplantation, decompensated cirrhosis (Child-Pugh B and C ONLY)
- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks

Genotype 4

Treatment naïve, no cirrhosis
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment naïve, compensated cirrhosis (Child-Pugh A only)
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced (PEG-IFN/RBV ONLY), no cirrhosis
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced (PEG-IFN/RBV ONLY), compensated cirrhosis (Child-Pugh A only)
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced (any direct acting antiviral including NS5A), with or without compensated cirrhosis (Child-Pugh A ONLY)
- ❑ Vosevi 400/100/100 mg daily for 12 weeks

Decompensated cirrhosis, no prior sofosbuvir or NS5A
- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks (low dose ribavirin# if Child-Pugh C)
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 24 weeks (will only be approved for patients with documented ineligibility for ribavirin¶)

Decompensated cirrhosis, prior treatment with sofosbuvir or NS5A
- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 24 weeks (low dose ribavirin# if Child-Pugh C)

Recurrent HCV infection post–liver transplantation, no cirrhosis
- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks

Recurrent HCV infection post–liver transplantation, compensated cirrhosis (Child-Pugh A ONLY)
- ❑ ledipasvir/sofosbuvir 90/400 mg plus weight-based ribavirin daily for 12 weeks

Recurrent HCV infection post–liver transplantation, decompensated cirrhosis

- ❑ ledipasvir/sofosbuvir 90/400 mg plus low dose ribavirin# daily for 12 weeks

Genotype 5 or 6

Treatment naïve, no cirrhosis

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment naïve, compensated cirrhosis (Child-Pugh A only)

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced (PEG-IFN/RBV), no cirrhosis

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced (PEG-IFN/RBV), compensated cirrhosis (Child-Pugh A ONLY)

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 12 weeks

Treatment experienced (any Direct Acting HCV Antiviral (DAA) including NS5A inhibitors, with no or compensated cirrhosis (Child-Pugh A ONLY)

- ❑ Vosevi 400/100/100 mg daily for 12 weeks

Decompensated cirrhosis, no prior sofosbuvir or NS5A

- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 12 weeks (low dose ribavirin# if Child-Pugh C)
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 24 weeks (will only be approved for patients with documented ineligibility to ribavirin¶)

Decompensated cirrhosis, prior treatment with sofosbuvir or NS5A

- ❑ sofosbuvir/velpatasvir 400/100 mg plus weight-based ribavirin daily for 24 weeks (low dose ribavirin# if Child-Pugh C)

Recurrent HCV infection post–liver transplantation, no cirrhosis

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks

Recurrent HCV infection post–liver transplantation, compensated cirrhosis (Child-Pugh A ONLY)

- ❑ ledipasvir/sofosbuvir 90/400 mg plus weight-based ribavirin daily for 12 weeks

Recurrent HCV infection post–liver transplantation, decompensated cirrhosis

- ❑ ledipasvir/sofosbuvir 90/400 mg plus low dose ribavirin# daily for 12 weeks

Other Treatment Regimen

Genotype, treatment history, and extent of liver disease: _____

Drug name, dose and duration: _____

Clinical rationale for selecting regimens other than those outlined above: _____

_____

_____

Abbreviations: PEG-IFN=peg-interferon; RBV=ribavirin; PI=protease inhibitor; DAA=direct acting antiviral

 # low dose ribavirin = 600 mg/day and increase as tolerated

^Dose of Daklinza (daclatasvir) MUST BE ADJUSTED with certain co-administered drugs (reduced to 30 mg daily with concurrent CYP3A4 inhibitors and increased to 90 mg daily with concurrent moderate CYP3A4 inducers)

SECTION 2 – SUPPORTING DOCUMENTATION

Review and complete each numbered item below to provide the supporting documentation for the PA request.

Diagnosis:

1. Pretreatment viral load (**attach results**): _____ Date Obtained:_____
2. Documentation of advanced liver disease (**attach results**): Date Obtained:_____

- ❑ Liver biopsy confirming a Metavir score ≥ F2
- ❑ Transient elastography (FibroScan) score ≥ 7.5kPa
- ❑ FibroSURE (FibroTest) score ≥ 0.48
- ❑ APRI score > 0.7
- ❑ Radiological imaging consistent with cirrhosis (i.e. evidence of portal hypertension)
- ❑ Physical findings or clinical evidence consistent with cirrhosis
- ❑ Patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), proteinuria, nephrotic syndrome, or membranoproliferative glomerulonephritis.

Patient History:

3. Does the patient have a history of non-compliance? ☐Yes ☐No
   If yes, submit chart notes documenting the steps taken to correct or address the non-compliance (**attach chart notes**)
4. Documentation in provider notes (**must be submitted**) showing that member has had no abuse of alcohol and drugs for the previous 3 months. **MUST submit** urine drug screen for members with history of abuse of drugs other than alcohol. Counseling MUST be provided and documented regarding non-abuse of alcohol and drugs as well as education on how to prevent HCV transmission
5. Is the patient receiving dialysis? ☐Yes ☐No
6. Is the patient's creatinine clearance ≥30 ml/min? ☐Yes ☐No
7. Has patient been screened for Hepatitis B? □ No □ Yes Date:_____ Active Disease: □ No □ Yes If yes, has patient been treated or currently being treated? □ No □ Yes
8. Patient weight: _____ Date obtained: _____
9. Does patient have a limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions? ☐Yes ☐No

Prescriber Information:

10. Provider Practice: ☐Digestive Disease ☐Liver Disease ☐Infectious Disease ☐Other: _____

    If other, note consultation with Specialist:

    Consultation Date:_____ Physician Name, Phone & Specialty: _____

Regimens Containing Ribavirin:

11. If the patient is female and of childbearing potential, or the patient is male with a female partner of childbearing potential, the prescriber must acknowledge the following:

- ❑ The patient is not pregnant (or a male patient with a pregnant female partner) and is not planning to become pregnant during treatment or within 6 months of stopping treatment.
- ❑ Both partners will use two forms of effective contraception during treatment and for at least 6 months after stopping treatment.
- ❑ Monthly pregnancy tests will be performed throughout treatment.

12. Complete blood count with differential (**attach results**)
13. If the patient is ineligible for ribavirin¶, select the appropriate reason from the list below:

- ❑ History of severe or unstable cardiac disease
- ❑ Pregnant women and men with pregnant partners
- ❑ Diagnosis of hemoglobinopathy (e.g., thalassemia major, sickle cell anemia)
- ❑ Hypersensitivity to ribavirin
- ❑ Baseline platelets <70,000 cells/μL
- ❑ Baseline absolute neutrophil count <1,500 cells/μL
- ❑ Baseline hemoglobin <12 g/dL in women or <13 g/dL in men
- ❑ Other: _____

Iowa Department of Human Services
Request for Prior Authorization
HEPATITIS C TREATMENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Note: Laboratory values will be reviewed and requests will not be considered if labs are outside of a specific range. Patients with CrCl <50 ml/min (moderate or severe renal dysfunction, ESRD, HD) should have dosage reduced.

Potentially Significant Drug Interactions:

14. Coadministration of Hepatitis C treatments with the following medications is not recommended. By checking one of the following boxes, the prescriber attests that they have reviewed the patient's medications for potentially significant drug interactions with the Hepatitis C treatment. If the medication list contains one or more of the following medications, the medication(s) will be changed to another agent.

- ❑ **ledipasvir/sofosbuvir:** The patient's current medication list does NOT include: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St. John's Wort, ritonavir, tipranavir, Stribild, rosuvastatin, H_2-receptor antagonists above the following daily doses: famotidine 80 mg, ranitidine/nizatidine 600 mg or cimetidine 1600 mg; or proton-pump inhibitors above the following daily doses: esomeprazole 20 mg, lansoprazole or 30 mg, dexlansoprazole 60mg, omeprazole 20 mg, pantoprazole 40 mg, rabeprazole 20 mg
- ❑ **Sovaldi:** The patient's current medication list does NOT include: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St. John's Wort, or tipranavir/ritonavir
- ❑ **sofosbuvir/velpatasvir:** The patient's current medication list does NOT include: all meds listed under Sovaldi plus efavirenz, proton pump inhibitors other than omeprazole 20 mg, topotecan or rosuvastatin at doses > 10 mg/day
- ❑ **Daklinza:** The patient's current medication list does NOT include significant drug interactions or dose is adjusted appropriately. Consult the full prescribing information for potential drug interactions including MANY that require dosage adjustment.
- ❑ **Zepatier:** The patient's current medication list does NOT include significant drug interactions. Consult the full prescribing information for potential drug interactions.
- ❑ **Mavyret:** The patient's current medication list does NOT include atazanavir or rifampin, Consult the full prescribing information for other potential "not recommended" drug interactions.
- ❑ **Vosevi:** Medication list does NOT include rifampin. Consult the full prescribing information for other potential "not recommended" drug interactions.

Attach lab results and other documentation

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
High Dose Opioids

(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 use of high-dose opioids ≥ 150 morphine milligram equivalents (MME) per day. (See CDC Guideline for Prescribing Opioids for Chronic Pain at https://www.cdc.gov/drugoverdose/prescribing/guideline.html.) Patients undergoing active cancer treatment or end-of-life care will not be subject to the criteria below. Payment will be considered when the following is met:

1. Requests for non-preferred opioids meet criteria for coverage (see criteria for Long-Acting Opioids and/or Short-Acting Opioids); and
2. Patient has a diagnosis of severe, chronic pain with a supporting ICD-10 code. Requests for a diagnosis of fibromyalgia or migraine will not be considered; and
3. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy (CBT); and
4. Patient has tried and failed at least two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants); and
5. There is documentation demonstrating an appropriate upward titration or an appropriate conversion from other opioid medications; and
6. Pain was inadequately controlled at the maximum allowed dose without prior authorization for the requested opioid(s); and
7. Pain was inadequately controlled by two other chemically distinct preferred long-acting opioids at the maximum allowed dose without prior authorization; and
8. Chart notes from a recent office visit for pain management is included documenting the following: a) Treatment plan, including all therapies to be used concurrently (pharmacologic and nonpharmacologic); and b) Treatment goals; and
9. Patient has been informed of the risks of high-dose opioid therapy; and
10. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that use of high-dose opioid therapy is appropriate for this patient; and
11. The patient's risk for opioid addiction, abuse and misuse has been reviewed and prescriber has determined the patient is a candidate for high-dose opioid therapy; and
12. A signed chronic opioid therapy management plan between the prescriber and patient dated within 12 months of this request is included; and
13. The requested dosing interval is no more frequent than the maximum FDA-approved dosing interval; and
14. Patient has been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose; and
15. Patient has been educated on opioid overdose prevention; and
16. Patient's household members have been educated on the signs of opioid overdose and how to administer naloxone; and
17. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with initial and subsequent requests; and
18. A documented dose reduction is attempted at least annually.

If criteria for coverage are met, initial requests will be given for three months. Requests for continuation of high-dose opioid therapy will be considered every six months with the following:

1. High-dose opioid therapy continues to meet treatment goals, including sustained improvement in pain and function; and
2. Patient has not experienced an overdose or other serious adverse event; and

Request for Prior Authorization
High Dose Opioids
(PLEASE PRINT – ACCURACY IS IMPORTANT)

3. Patient is not exhibiting warning signs of opioid use disorder; and
4. The benefits of opioids continue to outweigh the risks; and
5. A documented dose reduction has been attempted at least annually, and the prescriber has determined the dose cannot be reduced at this time; and
6. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that continued use of high-dose opioid therapy is appropriate for this patient; and
7. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with subsequent requests; and
8. Patient has been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose; and
9. Patient has been reeducated on opioid overdose prevention; and
10. Patient's household members have been reeducated on the signs of opioid overdose and how to administer naloxone.

Drug name:_____ Strength:_____

Dosage instructions:_____ Quantity:_____ Days supply:_____

Drug name:_____ Strength:_____

Dosage instructions:_____ Quantity:_____ Days supply:_____

Diagnosis:_____ **ICD-10 code:**_____
* Proceed to Prescriber Signature for active cancer treatment or end of life care diagnoses.

Initial Requests:

Document non-pharmacologic therapies (such as physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy (CBT), etc.)

Non-pharmacological treatment trial #1:_____

Trial dates:_____ Failure reason:_____

Non-pharmacological treatment trial #2:_____

Trial dates:_____ Failure reason:_____

Document two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants, and anticonvulsants)

Nonopioid pharmacologic trial #1: Name/dose:_____

Trial dates:_____ Failure reason:_____

Nonopioid pharmacologic trial #2: Name/dose:_____

Trial dates:_____ Failure reason:_____

Document upward titration or conversion from other opioid medications:_____

_____

_____

Was pain inadequately controlled at the maximum dose allowed without prior authorization for the requested opioid(s)?
☐ No ☐ Yes Document dose and trial dates:_____

Was pain inadequately controlled by two other chemically distinct preferred long-acting opioids at the maximum dose allowed without prior authorization? ☐ No ☐ Yes Document below.

Preferred long-acting narcotic trial #1: Name/dose:_____

Trial dates:_____ Failure reason:_____

Preferred long-acting narcotic trial #2: Name/dose:_____

Trial dates:_____ Failure reason:_____

Request for Prior Authorization
High Dose Opioids

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Attach notes from a recent office visit for pain management documenting both of the following:

☐ Treatment plan, including all therapies to be used concurrently (pharmacologic and nonpharmacologic)
☐ Treatment goals

Has patient been informed of the risks of high-dose opioid therapy? ☐ No ☐ Yes

Prescriber review of patient's controlled substance use on the Iowa PMP website: ☐ No ☐ Yes
Date reviewed:_____

Is long-acting opioid use appropriate for patient based on PMP review and patient's risk for opioid addiction, abuse and misuse? ☐ No ☐ Yes

Attach a signed chronic opioid therapy management plan between the prescriber and patient dated **within 12 months of this request**.

Has patient been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose? ☐ No ☐ Yes Date RX written:_____

Has patient been educated on opioid overdose prevention? ☐ No ☐ Yes Date:_____

Has patient's household members been educated on the signs of opioid overdose and how to administer naloxone?
☐ No ☐ Yes Date:_____

Is patient using opioids and benzodiazepines concurrently? ☐ No ☐ Yes (provide taper plan to discontinue the benzodiazepine)

Date of patient's most recent documented dose reduction:_____

Renewals:

Does high-dose opioid therapy continue to meet treatment goals, including sustained improvement in pain and function?
☐ No ☐ Yes (describe):_____

Has patient experienced an overdose or other serious adverse event? ☐ No ☐ Yes

Is patient exhibiting warning signs of opioid use disorder? ☐ No ☐ Yes

Do the benefits of opioids continue to outweigh the risks? ☐ No ☐ Yes

Date of patient's most recent documented dose reduction:_____

Updated prescriber review of patient's controlled substances use on the Iowa PMP website: ☐ No ☐ Yes
Date reviewed:_____

Is patient using opioids and benzodiazepines concurrently? ☐ No ☐ Yes (provide taper plan to discontinue the benzodiazepine)

Has patient been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose? ☐ No ☐ Yes Date RX written:_____

Has patient been reeducated on opioid overdose prevention? ☐ No ☐ Yes Date:_____

Has patient's household members been reeducated on the signs of opioid overdose and how to administer naloxone?
☐ No ☐ Yes Date:_____

Attach a signed chronic opioid therapy management plan between the prescriber and patient dated **within 12 months of this request.**

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
IMMUNOMODULATORS-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 topical immunomodulators. Payment for non-preferred topical immunomodulator products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment for pimecrolimus (Elidel®) or tacrolimus (Protopic®) 0.03% will be considered for non-immunocompromised patients two years of age and older and tacrolimus (Protopic®) 0.1% for patients 16 years of age and older when there is an adequate trial and therapy failure with one preferred topical corticosteroid, except on face or groin. If criteria for coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 grams or 100 grams for all other areas. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred
☐ Elidel ☐ Protopic

Non-Preferred
☐ Pimecrolimus ☐ Tacrolimus Ointment

Strength	Usage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Preferred Drug Trial 1: Drug Name& Dose_____ Trial Dates:_____
Failure Reason_____

Does the patient have an immunocompromised condition? ☐ Yes ☐ No
If yes, diagnosis:_____

Affected area to be treated: _____

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

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Iowa Department of Human Services

Request for Prior Authorization
INSULIN, PRE-FILLED PENS

(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 (PA) is required for pre-filled insulin pens as designated on the Preferred Drug List (PDL). For pre-filled insulin pens requiring PA where the requested insulin is available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria: 1) The patient's visual or motor skills are impaired to such that they cannot accurately draw up their own insulin (not applicable for pediatric patients), and 2) There is no caregiver available to provide assistance, and 3) Patient does not reside in a long-term care facility, and 4) For requests for non-preferred pre-filled pens, patient has documentation of a previous trial and therapy failure with a preferred pre-filled insulin pen within the same class (i.e. rapid, regular or basal). For pre-filled insulin pens requiring PA where the requested insulin is not available in a vial, payment will be considered for a diagnosis of diabetes mellitus and FDA approved age in addition to the following criteria: 1) Preferred pre-filled insulin pens- Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e. rapid, regular, or basal) or clinical rationale as to why the patient cannot use a preferred insulin agent, and 2) Non-preferred pre-filled insulin pens- Patient has documentation of a previous trial and therapy failure with a preferred insulin agent within the same class (i.e. rapid, regular or basal). 3) Requests for Toujeo will require clinical rationale as to why the patient cannot use Lantus and patient must be using a minimum of 100 units of Lantus per day.

Preferred (no PA required)

☐ Fiasp FlexTouch ☐ Lantus SoloSTAR ☐ Levemir FlexTouch

☐ NovoLog FlexPen/PenFill ☐ Novolog Mix FlexPen ☐ Tresiba FlexTouch

PA Required:

Non-Preferred (available in vial)

☐ Admelog SoloSTAR
☐ Apidra SoloSTAR
☐ Humalog KwikPen
☐ Humalog Mix 50/50 Pen
☐ Humulin Mix 75/25 Pen
☐ Humulin N KwikPen
☐ Humulin R KwikPen
☐ Humulin 70/30 KwikPen

Non-Preferred (not available in vial)

☐ Basaglar KwikPen
☐ Toujeo SoloStar

Strength _____ **Number of Units** _____ **How Often** _____ **Number of Cartridges/Pens/PenFills (circle requested item)** _____

Diagnosis: _____

☐ **Requests for insulin agents available in a vial:**

What visual or physical conditions limit the patient's ability to prepare their own syringes (adult patients only)?

_____

Does the patient lack capable assistance residing with them? ☐ Yes ☐ No

Does the patient reside in a long-term care facility? ☐ Yes ☐ No

Iowa Department of Human Services

Request for Prior Authorization
INSULIN, PRE-FILLED PENS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

Requests for a non-preferred pre-filled insulin pen, document preferred pre-filled insulin pen trial within the same class:

Drug Name and Dosage Instructions:_____ Trial start date: _____Trial end date:____
Failure Reasons: _____
_____

☐ **Requests for insulin agents not available in a vial:**

Document Preferred Insulin Trial in same class as requested agent:

Drug Name and Dosage Instructions:_____ Trial start date: _____Trial end date:____
Failure Reasons: _____
_____

Toujeo:

Patient's current daily Lantus dose: _____

Clinical rationale as to why patient cannot use Lantus: _____
_____

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
IVACAFTOR (KALYDECO™)

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 Kalydeco™ (ivacaftor). Payment will be considered for patients when the following criteria are met: 1) Patient meets the FDA approved age; and 2) Patient has a diagnosis of cystic fibrosis; and 3) Patient has one of the CFTR gene mutations as indicated in the FDA approved label as detected by an FDA-cleared CF mutation test; and 4) Prescriber is a CF specialist or pulmonologist; and 5) Baseline liver function tests (AST/ALT) are provided. If the criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 6 months at a time if the following criteria are met: 1) Adherence to ivacaftor therapy is confirmed; and 2) Liver function tests (AST/ALT) are assessed every 3 months during the first year of treatment and annually thereafter.

☐ **Kalydeco™**

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis (Attach copy of FDA-cleared CF mutation test results): _____

Attach copy of baseline liver function test (AST/ALT).

Prescriber Specialty: ❑ CF Specialist ❑ Pulmonologist ❑ Other (specify): _____

Renewal Requests:

Patient is adherent to ivacaftor therapy: ☐ Yes ☐ No

Liver function tests (AST/ALT) are assessed every 3 months during first year of treatment and annually thereafter: ☐ Yes ☐ No Most recent lab date: _____

Ivacaftor Therapy Start Date: _____

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
JANUS KINASE (JAK) 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 Janus kinase (JAK) inhibitors. Payment will be considered for a FDA approved or compendia indicated diagnosis when the following conditions are met:

1. **Patient meets the FDA approved age; and**
2. **Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and**
3. **Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and**
4. **Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and**
5. **Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and**
6. **Patient is not at an increased risk of gastrointestinal perforation.**
7. **Patient does not have an active, serious infection, including localized infections; and**
8. **Medication will not be given concurrently with live vaccines; and**
9. **Follows FDA approved dosing based on indication; and**
10. **Patient has a diagnosis of:**
    - **a. Moderate to severe rheumatoid arthritis with**
      - **i. 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, or leflunomide); and**
      - **ii. A documented trial and inadequate response to two preferred biological DMARDS; or**
    - **b. Psoriatic arthritis with**
      - **i. A documented trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and**
      - **ii. Documented trial and therapy failure with two preferred biological agents used for psoriatic arthritis.**
    - **c. Moderately to severely active ulcerative colitis with**
      - **i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and**
      - **ii. A documented trial and inadequate response with a preferred biological DMARD; and**
      - **iii. If requested dose for tofacitinib is 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests as this dose will need to document an adequate therapeutic benefit.**

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

Non-Preferred

☐ Olumiant ☐ Xeljanz ☐ Xeljanz XR

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

Diagnosis:_____

Request for Prior Authorization
JANUS KINASE (JAK) INHIBITORS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Will the JAK inhibitor be used in combination with other JAK inhibitors, biologic DMARDs or potent immunosuppressants?
☐ Yes ☐ No

Screening for Latent TB infection: Date:_____ Results:_____

Will patient be monitored for active tuberculosis during treatment? ☐ Yes ☐ No

Does patient have a history of malignancy, except successfully treated non-melanoma skin cancer (NMSC)? ☐ Yes ☐ No

Does patient have an increased risk of gastrointestinal perforation? ☐ Yes ☐ No

Recommended laboratory monitoring will be conducted according to manufacturer labeling (lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids)?
☐ Yes ☐ No Date of most recent labs:_____

Does patient have an active, serious infection, including localized infections? ☐ Yes ☐ No

Will requested medication be given concurrently with live vaccines? ☐ Yes ☐ No

☐ **Moderate to Severe Rheumatoid Arthritis (RA) (Olumiant, Xeljanz or Xeljanz XR)**

Methotrexate trial: Dose:_____ Trial dates:_____
Failure reason:_____

Plus preferred oral DMARD trial: Drug Name & Dose:_____ Trial dates:_____
Failure reason:_____

Preferred Biological DMARD Trial #1: Name/Dose:_____ Trial Dates:_____
Failure reason:_____

Preferred Biological DMARD Trial #2: Name/Dose:_____ Trial Dates:_____
Failure reason:_____

☐ **Psoriatic Arthritis (Xeljanz or Xeljanz XR)**

Methotrexate trial (leflunomide or sulfasalazine if methotrexate is contraindicated):
Dose:_____ Trial dates:_____
Failure reason:_____

Preferred Biological DMARD Trial #1: Name/Dose:_____ Trial Dates:_____
Failure reason:_____

Preferred Biological DMARD Trial #2: Name/Dose:_____ Trial Dates:_____
Failure reason:_____

☐ **Ulcerative Colitis (Xeljanz)**

Document two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine

Trial #1 : Dose:_____ Trial dates:_____
Failure reason:_____

Trial #2: Name/Dose:_____ Trial Dates:_____
Failure reason:_____

Preferred Biological DMARD Trial #1: Name/Dose:_____ Trial Dates:_____
Failure reason:_____

If requesting continuation of tofacitinib 10mg twice daily dose, document adequate therapeutic benefit:

_____

_____

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.*

Iowa Department of Human Services

Request for Prior Authorization
LONG-ACTING OPIOIDS

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 all non-preferred long-acting opioids. PA is also required for members when the total daily opioid dose (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). Payment will be considered under the following conditions: 1) Patient has a diagnosis of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment; and 2) Patient has tried and failed at least two nonpharmacologic therapies; and 3) Patient has tried and failed at least two nonopioid pharmacologic therapies; and 4) There is documentation of a previous trial and therapy failure with one preferred long-acting opioid at a maximally tolerated dose, and 5) A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization, and 6) The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and determine if use of a long-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and 7) Patient has been informed of the common adverse effects and serious adverse effects of opioids. 8) Requests for long-acting opioids will only be considered for FDA approved dosing intervals; and 9) For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met: 1) Patient has experienced improvement in pain control and level of functioning; and 2) Prescriber has reviewed the patient's use of controlled substances on the Iowa PMP website and has determined continued use of a long-acting opioid is appropriate for this member; and 3) For patients taking concurrent benzodiazepines, the prescriber must document the following: a. the risks of using opioids and benzodiazepines concurrently has been discussed with the patient, and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Drug Name:_____ **Strength:**_____

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

Diagnosis:_____

Document non-pharmacologic therapies (such as physical therapy, weight loss, alternative therapies such as manipulation, massage, and acupuncture, or psychological therapies such as cognitive behavior therapy [CBT], etc,)

Non-Pharmacological Treatment Trial #1: _____

Trial Dates: _____ Failure reason: _____

Non-Pharmacological Treatment Trial #2: _____

Trial Dates: _____ Failure reason: _____

Document 2 nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants)

Nonopioid Pharmacologic Trial #1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Nonopioid Pharmacologic Trial #2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Request for Prior Authorization-*Continued*
LONG-ACTING OPIOIDS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Document 1 preferred long-acting opioid treatment failure including drug name, strength, exact date ranges and failure reason:

Preferred Long-Acting Narcotic Trial: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

*Please refer to the methadone dosing guidelines located at www.iadur.org under the Report Archive tab.

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

Is long-acting opioid use appropriate for patient based on PMP review and patient's risk for opioid addiction, abuse and misuse?
☐ No ☐ Yes

Has patient been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids?

☐ No ☐ Yes

Patients taking concurrent benzodiazepines:

Have the risks of using opioids and benzodiazepines concurrently been discussed with the patient? ☐ No ☐ Yes

Medical necessity for concurrent use: _____

_____

Provide plan to taper the benzodiazepine or medical rationale why not appropriate: _____

_____

Renewals

Has patient experienced improvement in pain control and level of functioning?

☐ No ☐ Yes (describe): _____

Updated prescriber review of patient's controlled substances use on the Iowa PMP website (since initial request):
☐ No ☐ Yes Date Reviewed:_____

Patients taking concurrent benzodiazepines:

Have the risks of using opioids and benzodiazepines concurrently been discussed with the patient? ☐ No ☐ Yes

Medical necessity for concurrent use: _____

_____

Provide plan to taper the benzodiazepine or medical rationale why not appropriate: _____

_____

Attach signed chronic opioid therapy management plan between the prescriber and patient.

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
LUMACAFTOR/IVACAFTOR (ORKAMBI™)

(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 Orkambi™ (lumacaftor/ivacaftor). Dual therapy with another cystic fibrosis transmembrane conductance regulator (CFTR) potentiator will not be considered. Payment will be considered for patients when the following criteria are met: 1) Patient meets the FDA approved age; and 2) Has a diagnosis of cystic fibrosis; and 3) Patient is homozygous for the *F508del* mutation in the *CFTR* gene as confirmed by a FDA-cleared CF mutation test; and 4) Baseline liver function tests (AST/ALT) and bilirubin levels are provided; and 5) Prescriber is a CF specialist or pulmonologist.

If the criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be granted for 6 months at a time if the following criteria are met: 1) Adherence to lumacaftor/ivacaftor therapy is confirmed; and 2) Liver function tests (AST/ALT) and bilirubin are assessed every 3 months during the first year of treatment and annually thereafter.

☐ **Orkambi** **Dosage instructions**_____ **Quantity**_____ **Days supply**_____

Initial Requests. **Attach the following test results:**

☐ FDA-cleared CF mutation test documenting patient is homozygous for the *F508del* mutation in the *CFTR* gene.

☐ Baseline liver function tests (AST/ALT) and bilirubin Result:_____

Prescriber specialty: ☐ CF Specialist ☐ Pulmonologist ☐ Other (specify):_____

Attach lab results and other documentation as necessary. Minimal required results to be submitted are the results of the gene mutation test and lab results.

Renewal Requests.

Is patient adherent to Orkambi? ☐ Yes ☐ No

Liver function tests (AST/ALT) and bilirubin will be assessed every 3 months during the first year of treatment and annually thereafter? ☐ Yes (attach most recent results) Date and result:_____ ☐ No

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

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Iowa Department of Human Services

Request for Prior Authorization
LUPRON DEPOT – PEDIATRIC

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 Lupron Depot - Pediatric. Payment will be considered for patients when the following is met:

1) Patient has a diagnosis of central precocious puberty (CPP); and

2) Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males; and

3) Patient is currently < 11 years of age for females or < 12 years of age for males; and

4) Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test is provided (attach results); and

5) Documentation of advanced bone age (defined as greater than or equal to two standard deviations above the gender/age related mean); and

6) Baseline evaluations including the following have been conducted and/or evaluated:

   a) Height and weight measurements; and

   b) Sex steroid (testosterone or estradiol) levels have been obtained; and

   c) Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor; and

   d) Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors; and

   e) Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor; and

   f) Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia; and

7) Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility.

When criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted at 6 month intervals until the patient is ≥ 11 years of age for females and ≥ 12 years of age for males. If therapy beyond the aforementioned ages is required, documentation of medical necessity will be required.

Preferred

☐ Lupron Depot-Ped (1-Month)

Non-Preferred

☐ Lupron Depot-Ped (3-Month)

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Iowa Department of Human Services

Request for Prior Authorization
LUPRON DEPOT – PEDIATRIC

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

Patient has documentation of onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males? ☐ No ☐ Yes: provide age of onset and description:_____

Confirmation of diagnosis by a pubertal response to a gonadotropin-releasing hormone (GnRH) stimulation test?
☐ No ☐ Yes (attach results)

Documentation of advanced bone age (defined as ≥ two standard deviations above the gender/age related mean)? ☐ No ☐ Yes (attach results)

Baseline evaluations:

Height:_____ Date obtained:_____

Weight:_____ Date obtained:_____

Sex steroid (testosterone/estradiol) levels obtained? ☐ No ☐ Yes (attach results)

Appropriate diagnostic imaging of the brain has been conducted to rule out an intracranial tumor?
☐ No ☐ Yes (attach results)

Pelvic/testicular/adrenal ultrasound has been conducted to rule out steroid secreting tumors?
☐ No ☐ Yes (attach results)

Human chorionic gonadotropin levels have been obtained to rule out a chorionic gonadotropin secreting tumor?
☐ No ☐ Yes (attach results)

Adrenal steroid levels have been obtained to rule out congenital adrenal hyperplasia?
☐ No ☐ Yes (attach results)

Setting to be administered:

☐ Member's home by home health ☐ Long-term care facility ☐ Other:_____

Age override consideration:

Documentation of medical necessity for continued treatment beyond the following ages:
females ≥ 11 years of age and males ≥ 12 years of age:_____

_____

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.*

- Cholic acid (Cholbam)
- Chronic pain syndrome agents
- CNS Stimulants and Atomoxetine
- Concurrent IM/PO antipsychotic use
- Crisaborole (Eucrisa)
- Dalfampridine (Ampyra)
- Deferasirox
- Deflazacort (Emflaza)
- Dextromethorphan and Quinidine (Nuedexta)
- Dornase alfa (Pulmozyme)
- Dupilumab (Dupixent)
- Duplicate Therapy Edits
- Elagolix (Orilissa)
- Eluxadoline (Viberzi)
- Eplerenone (Inspra)
- Erythropoiesis stimulating agents
- Extended release formulations
- Febuxostat (Uloric)
- Fentanyl, short-acting products
- GLP-1 Agonist/Basal Insulin Combinations
- Granulocyte colony stimulating factor agents
- Growth hormones
- Hepatitis C treatments
- High dose opioids
- Idiopathic pulmonary fibrosis
- Immunomodulators, topical
- Insulin, pre-filled pens
- Isotretinoin (oral)
- Ivabradine (Corlanor)
- Ivacaftor (Kalydeco)
- Janus Kinase Inhibitors
- Ketorolac Tromethamine (Toradol)
- Lesinurad (Zurampic)
- Letermovir (Prevymis)
- Lidocaine patch (Lidoderm)
- Linezolid (Zyvox)
- Long acting opioids
- Lumacaftor/Ivacaftor (Orkambi)
- Lupron Depot – adult
- Lupron Depot – pediatric
- Methotrexate injection
- Mifepristone (Korlym)
- Modified formulations

- Multiple Sclerosis-oral agents
- Muscle relaxants
- Narcan (Naloxone) nasal spray
- Narcotic agonist-antagonist nasal sprays
- Nebivolol (Bystolic)
- New-to-market drugs
- Nocturnal Polyuria treatments
- Non-parenteral vasopressin derivatives of posterior pituitary hormone products
- Non-preferred drugs
- Nonsteroidal anti-inflammatory drugs
- Novel oral anticoagulants
- Oral constipation agents
- Oral immunotherapy
- Palivizumab (Synagis)
- PCSK9 inhibitors
- Potassium binders
- Proton pump inhibitors
- Pulmonary arterial hypertension agents
- Quantity limit override
- Repository Corticotropin injection (H.P. Acthar Gel)
- Rifaximin (Xifaxan)
- Roflumilast (Daliresp)
- Sapropterin dihydrochloride (Kuvan)
- Sedative/hypnotics-non-benzodiazepine
- Select oncology agents
- Selected brand-name drugs
- Serotonin 5-HT1 receptor agonists
- Short-acting opioids
- Sodium oxybate (Xyrem)
- Tasimelteon (Hetlioz)
- Testosterone products
- Tezacaftor/Ivacaftor (Symdeko)
- Thrombopoietin receptor agonists
- Topical acne and rosacea products
- Topical antifungals for onychomycosis
- Topical corticosteroids
- Valsartan/Sacubitril (Entresto)
- Vesicular Monamine Transporter (VMAT) 2 inhibitors
- Vitamins, minerals and multiple vitamins
- Vorapaxar (Zontivity)
- Vusion ointment

Iowa Department of Human Services

Request for Prior Authorization
MICONAZOLE-ZINC OXIDE-WHITE PETROLATUM (VUSION) OINTMENT
(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 miconazole-zinc oxide-white petrolatum (Vusion) ointment. Payment will only be considered for cases in which there is documentation of previous trials and 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.

Non-Preferred

☐ Miconazole-Zinc Oxide-White Petrolatum ☐ Vusion

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

Diagnosis:

_____

Treatment failure with over-the counter miconazole 2% cream (payable with a prescription):

Trial start date: _____ Trial end date: _____ Reason for failure: _____

_____

Treatment failure with nystatin cream or ointment:

Trial start date: _____ Trial end date: _____ Reason for failure: _____

_____

Medical or contraindication reason to override trial requirements: _____

_____

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
MULTIPLE SCLEROSIS AGENTS-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 complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

For patients initiating therapy with a preferred oral medication, a manual prior authorization is not required if a preferred injectable interferon or non-interferon is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided:
1) A diagnosis of relapsing forms of multiple sclerosis, and 2) Patient meets the FDA approved age; and 3) A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis; and 4) Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent. The required trial may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred

☐ Aubagio ☐ Gilenya ☐ Tecfidera

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Treatment failure with interferon or non-interferon:

Trial Drug Name & Dose: _____ Trial Dates: _____

Reason for failure: _____

Possible drug interactions/conflicting drug therapies:_____

For patients initiating therapy with fingolimod (Gilenya):

- Patient has a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure: ☐ Yes ☐ No

Request for Prior Authorization
MULTIPLE SCLEROSIS AGENTS-ORAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

- Patient has a history or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome: ☐ Yes ☐ No If yes, patient has a pacemaker: ☐ Yes ☐ No
- Patient has a baseline QTc interval ≥ 500ms: ☐ Yes ☐ No
- Patient is being treated with Class Ia or Class III anti-arrhythmic drugs: ☐ Yes ☐ No

For patients initiating therapy with teriflunomide (Aubagio):

- Patient has severe hepatic impairment: ☐ Yes ☐ No
- Patient has a negative pregnancy test if female of childbearing age: ☐ Yes ☐ No
  If yes, provide date of pregnancy test: _____
- If female of childbearing age, specify plan for contraception: _____
- Patient is taking leflunomide: ☐ Yes ☐ No

For patients initiating therapy with dimethyl fumarate (Tecfidera):

- Patient has a low lymphocyte count documented by a recent (within 6 months) CBC:
  ☐ Yes ☐ No Lab Date: _____
- For renewal, documentation of an updated CBC: Lab date: _____

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.*

Department of HUMAN SERVICES

Request for Prior Authorization
Nocturnal Polyuria Treatments

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 nocturnal polyuria agents. Payment will be considered for patients when the following criteria are met:

1) Patient meets the FDA approved age; and
2) Patient has a diagnosis of nocturnal polyuria as confirmed by a 24-hour collection which notes the presence of greater than 33% of 24-hour urine production occurring at night; and
3) Patient wakens at least 2 times at night to void; and
4) Patient has attempted fluid restriction in the evenings without improvement in nocturnal polyuria; and
5) Patient is not taking a diuretic in the evening; and
6) Patient does not have any of the following contraindications; and
   a) Current or previous history of hyponatremia; and
   b) Primary nocturnal enuresis; and
   c) Polydipsia; and
   d) Concomitant use with loop diuretics, systemic or inhaled glucocorticoids; and
   e) Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion; and
   f) Estimated glomerular filtration rate < 50 mL/min/1.73 m^2; and
   g) Illnesses that can cause fluid or electrolyte imbalance; and
   h) New York Heart Association (NYHA) Class ll-lV congestive heart failure; and
   i) Uncontrolled hypertension.

Initial requests will be considered for 3 months. Requests for continuation of therapy will require the following:

1) Patient continues to meet above criteria; and
2) Patient has experienced a decrease in nocturnal voiding; and
3) There is not evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalances).

Non-Preferred

☐ Nocdurna ☐ Noctiva

Strength	Dosage Instructions	Quantity	Days Supply

Request for Prior Authorization
Nocturnal Polyuria Treatments

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Diagnosis:_____

Was diagnosis confirmed by a 24-hour collection which notes 33% of 24-hour urine production occurring at night? ☐ Yes (attach results) ☐ No

☐ **Initial Requests:**

Does patient waken at least 2 times at night to void? ☐ Yes ☐ No

Has patient attempted fluid restriction in the evenings without improvement in nocturnal polyuria?
☐ Yes ☐ No

Is patient taking a diuretic in the evening? ☐ Yes ☐ No

Does patient have any of the following contraindications? ☐ Yes ☐ No

- Current or previous history of hyponatremia
- Primary nocturnal enuresis
- Polydipsia
- Concomitant use with loop diuretics, systemic or inhaled glucocorticoids
- Known or suspected syndrome of inappropriate antidiuretic hormone (SIADH) secretion
- Estimated glomerular filtration rate < 50 mL/min/1.73 m^2
- Illnesses that can cause fluid or electrolyte imbalance
- New York Heart Association (NYHA) Class ll-lV congestive heart failure
- Uncontrolled hypertension

☐ **Renewal Requests (all criteria above, plus the following):**

Has patient experienced a decrease in nocturnal voiding? ☐ Yes ☐ No

Is there evidence of toxicity (e.g., hyponatremia, fluid retention, or electrolyte imbalance)?
☐ Yes ☐ No

Attach lab results and other documentation as necessary.

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

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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 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
Pennsaid
Salsalate
Sulindac
Voltaren Gel

Non-Preferred (PA required for all products)

☐ Arthrotec
☐ Celebrex
☐ Celecoxib
☐ Diclofenac ER/XR*
☐ EC-Naprosyn
☐ Etodolac CR/ER/XR
☐ Fenoprofen
☐ Flector Patch
☐ Indomethacin ER*
☐ Ketoprofen ER
☐ Meclofenamate Sod
☐ Naprelan
☐ Oxaprosin
☐ Piroxicam
☐ Ponstel
☐ Tivorbex
☐ Tolmetin Sod
☐ Vivlodex
☐ 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.*

Iowa Department of Human Services

Request for Prior Authorization
NOVEL ORAL ANTICOAGULANTS

(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 not required for preferred novel oral anticoagulants (NOACs). Prior authorization is required for non-preferred NOACs. Requests for doses outside of the manufacturer recommended dose will not be considered. Payment will be considered for FDA approved or compendia indications under the following conditions: 1) Patient does not have a mechanical heart valve; and 2) Patient does not have active bleeding; and 3) For a diagnosis of atrial fibrillation or stroke prevention, patient has the presence of at least one additional risk factor for stroke, with a CHA_2DS_2-VASc score ≥1; and 4) A recent creatinine clearance (CrCl) is provided; and 5) A recent Child-Pugh score is provided; and 6) Patient's current body weight is provided; and 7) Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred NOACs. 8) For requests for edoxaban, documentation patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin). The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred (no PA required if within established quantity limits)

☐ Eliquis ☐ Xarelto (except 2.5mg Tabs)

☐ Pradaxa

Non-Preferred (PA required)

☐ Savaysa

☐ Xarelto 2.5mg Tabs

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Does patient have mechanical heart valve? ☐ Yes ☐ No

Does patient have active bleeding? ☐ Yes ☐ No

Patient body weight: _____ **Date obtained:** _____

Provide recent creatinine clearance (CrCl): _____ **Date obtained:** _____

Provide recent Child-Pugh score: _____ **Date completed:** _____

Request for Prior Authorization
NOVEL ORAL ANTICOAGULANTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Requests for a diagnosis of atrial fibrillation or stroke prevention:

Risk factor based CHA_2DS_2-VASc Score	
Risk Factors	**Score**
☐ Congestive heart failure	1
☐ Hypertension	1
☐ Age ≥ 75 years	2
☐ Age between 65 and 74 years	1
☐ Stroke / TIA / TE	2
☐ Vascular disease (previous MI, peripheral arterial disease or aortic plaque)	1
☐ Diabetes mellitus	1
☐ Female	1
Total	

Document 2 preferred NOAC trials:

Preferred NOAC Trial 1: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Preferred NOAC Trial 2: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Requests for edoxaban (Savaysa):

Provide documentation of 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin):

Drug name & dose:_____ Trial dates:_____

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
ORAL CONSTIPATION 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 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 under the following conditions:

1) **Patient meets the FDA approved age; and**

2) **Patient must have documentation of adequate trials and therapy failures with both of the following:**
   - **Stimulant laxative (senna) plus saline laxative (milk of magnesia); and**
   - **Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose).**

3) **Patient does not have a known or suspected mechanical gastrointestinal obstruction.**

If the criteria for coverage are met, initial authorization will be given for 12 weeks to assess the response to treatment. Requests for continuation therapy may be provided if the prescriber documents adequate response to treatment.

Preferred **Non-Preferred**

☐ Amitiza ☐ Movantik ☐ Linzess ☐ Relistor ☐ Symproic ☐ Trulance

Strength	Dosage Instructions	Quantity	Days Supply

Treatment failures:

Trial 1: Stimulant Laxative (senna) plus Osmotic Laxative (polyethylene glycol / lactulose)

Stimulant Laxative Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Osmotic Laxative Trial: Name/Dose:_____

Trial Dates:_____ Failure reason:_____

Trial 2: Stimulant Laxative (senna) plus Saline Laxative (milk of magnesia)

Stimulant Laxative Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Saline Laxative Trial: Name/Dose:_____ Trial Dates: _____

Failure reason:_____

Does patient have a known or suspected mechanical gastrointestinal obstruction: ☐ Yes ☐ No

Request for Prior Authorization
ORAL CONSTIPATION AGENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Chronic Idiopathic Constipation:** (Amitiza, Linzess, or Trulance)

- Patient has less than 3 spontaneous bowel movements (SBMs) per week:
  ☐ Yes ☐ No
- Patient has two or more of the following symptoms within the last 3 months:
  ☐ Straining during at least 25% of the bowel movements
  ☐ Lumpy or hard stools for at least 25% of bowel movements
  ☐ Sensation of incomplete evacuation for at least 25% of bowel movements
- Documentation the patient is not currently taking constipation causing therapies:
  Medication review completed: ☐ Yes ☐ No
  Current constipation causing therapies:
  ☐ Yes (please list) _____ ☐ No

☐ **Irritable Bowel Syndrome with Constipation:** (Amitiza, Linzess, or Trulance)

- Patient is female (Amitiza requests only): ☐ Yes ☐ No
- Patient has recurrent abdominal pain on average at least 1 day per week in the last 3 months associated with two (2) or more of the following:
  ☐ Related to defecation
  ☐ Associated with a change in stool frequency
  ☐ Associated with a change in stool form

☐ **Opioid-Induced Constipation with Chronic, Non-Cancer Pain:** (Amitiza, Movantik, Relistor, or Symproic)

- Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims: ☐ Yes ☐ No
- Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
  ☐ Hard to very hard stool consistency
  ☐ Moderate to very severe straining
  ☐ Sensation of incomplete evacuation

☐ **Other Diagnosis:** _____

☐ **Renewal Requests:** Provide documentation of adequate response to treatment: _____

_____

Requests for Non-Preferred Oral Constipation Agent: Document trial of preferred agent

Drug Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

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

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Iowa Department of Human Services

Request for Prior Authorization
PCSK9 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 PCSK9 Inhibitors. Payment for non-preferred PCSK9 Inhibitors will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent, when available for the submitted diagnosis. Payment will be considered under the following conditions: 1) Patient is 18 years of age or older (or, for Homozygous Familial Hypercholesterolemia (HoFH), patient is 13 years of age or older); and 2) Current use of a statin and documentation of adherence to prescribed lipid lowering medications for the previous 90 days is provided (further defined below, by diagnosis); and 3) Is to be prescribed as an adjunct to a low fat diet; and 4) A baseline and current lipid profile is provided. Baseline lipid profile is defined as a lipid profile obtained prior to pharmacologic therapy; and 5) Documentation patient has been counseled on importance of abstinence from tobacco and, if a current smoker, be encouraged to enroll in a smoking cessation program; and 6) Is prescribed by a lipidologist, cardiologist, or endocrinologist. 7) The 72-hour emergency supply rule does not apply to PCSK9 Inhibitors. 8) Prescriber and dispensing pharmacy will educate the patient on proper storage and administration. Improperly stored medications will not be replaced. 9) Lost or stolen medication replacement requests will not be authorized. 10) Goal is defined as a 50% reduction in untreated baseline LDL-C. 11) Is prescribed for one of the following diagnoses: Heterozygous Familial Hypercholesterolemia (HeFH), Clinical Atherosclerotic Cardiovascular Disease (ASCVD), or HoFH. The required trials (excluding the statin trial) may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Quantity Limits:

Praluent/Repatha for HeFH or ASCVD: One syringe/pen/autoinjector per fill (requires refill every 14 days)
Repatha for HoFH only: One three-pack per month

Initial Requests (please see below for renewal requests):

HeFH or ASCVD Drug and Dose Requested:

Preferred: ☐ Praluent 75mg every 2 weeks for 8 weeks (4 doses)
Non-Preferred: ☐ Repatha 140mg every 2 weeks for 8 weeks (4 doses)

HoFH Drug and Dose Requested:

☐ Repatha 420mg (3x140mg autoinjectors) every month for 3 months

Is patient on a low fat diet: ☐ Yes ☐ No

Has patient experienced ≥ 50% reduction in untreated baseline LDL-C with current therapies?
☐ Yes ☐ No

Attach baseline (prior to pharmacologic therapy) and current lipid profiles.

Request for Prior Authorization
PCSK9 INHIBITORS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Statin to be used as adjunct to PCSK9 inhibitor:_____ **Dose:**_____

Has patient been counseled on importance of abstinence from tobacco? ☐ Yes ☐ No

Is patient a current smoker or tobacco user: ☐ Yes ☐ No

If yes, has patient been encouraged to enroll in smoking cessation program? ☐ Yes ☐ No

Prescriber Specialty: ☐ Lipidologist ☐ Cardiologist ☐ Endocrinologist ☐ Other:_____

Prescriber and dispensing pharmacy will educate patient on proper storage and administration?
☐ Yes ☐ No

☐ **Heterozygous Familial Hypercholesterolemia (HeFH)**

1) Total cholesterol > 290mg/dL or LDL-C > 190mg.dL; *and*
   a) Presence of tendon xanthomas; *or*
   b) In first or second degree relative, one of the following: documented tendon xanthomas, MI at age ≤ 60 years, or total cholesterol > 290mg/dL; *or*
   c) Confirmation of diagnosis by gene or receptor testing (attach results); *and*
2) Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications.

Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), plus ezetimide (Zetia) 10mg daily, plus cholestyramine daily.

Total cholesterol:_____ Date obtained:_____

LDL-C:_____ Date obtained:_____

Presence of tendon xanthomas: ☐ Yes ☐ No

Any of the following present in first degree relative:
☐ Documented tendon xanthomas ☐ MI at age ≤ 60 years ☐ Total cholesterol > 290mg/dL

Diagnosis confirmed by gene or receptor testing? ☐ Yes (attach results) ☐ No

Statin 1 trial:
Dose:_____ Trial dates:_____
Failure reason:_____

Statin 2 trial:
Dose:_____ Trial dates:_____
Failure reason:_____

Plus concurrent ezetimibe (Zetia) trial:
Dose:_____ Trial dates:_____
Failure reason:_____

Plus concurrent cholestyramine trial:
Drug name & dose:_____ Trial dates:_____
Failure reason:_____

Medical or contraindication reason to override trial requirements:_____

_____

Request for Prior Authorization
PCSK9 INHIBITORS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Clinical Atherosclerotic Cardiovascular Disease (ASCVD)**
1) History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; *and*
2) Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications.

Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), plus ezetimide (Zetia) 10mg daily, plus cholestyramine daily.

History of any of the following: ☐ MI ☐ Angina
☐ Coronary or other arterial revascularization ☐ Stroke ☐ TIA ☐ PVD of atherosclerotic origin

Statin 1 trial:
Dose:_____ Trial dates:_____
Failure reason:_____

Statin 2 trial:
Dose:_____ Trial dates:_____
Failure reason:_____

Plus concurrent ezetimibe (Zetia) trial:
Dose:_____ Trial dates:_____
Failure reason:_____

Plus concurrent cholestyramine trial:
Drug name & dose:_____ Trial dates:_____
Failure reason:_____

Medical or contraindication reason to override trial requirements:_____
_____

☐ **Homozygous Familial Hypercholesterolemia (HoFH) –** Repatha only
1) Total cholesterol and LDL-C > 600mg/dL and triglycerides within reference range; or
2) Confirmation of diagnosis by gene or receptor testing (attach results); and 3) Unable to reach goal LDL-C with a minimum of two separate, chemically distinct statin trials used in combination with other lipid lowering medications.

Trials are defined as: concurrent use of a maximally tolerated dose of a statin (including atorvastatin and rosuvastatin), plus ezetimide (Zetia) 10mg daily, plus cholestyramine daily.

Total cholesterol:_____ Date obtained:_____
LDL-C:_____ Date obtained:_____
Triglycerides within reference range? ☐ Yes ☐ No (attach results)
Diagnosis confirmed by gene or receptor testing? ☐ Yes (attach results) ☐ No

Statin 1 trial:
Dose:_____ Trial dates:_____
Failure reason:_____

Statin 2 trial:
Dose:_____ Trial dates:_____
Failure reason:_____

Request for Prior Authorization
PCSK9 INHIBITORS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Plus concurrent ezetimibe (Zetia) trial:

Dose:_____ Trial dates:_____

Failure reason:_____

Plus concurrent cholestyramine trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Medical or contraindication reason to override trial requirements:_____

_____

Renewal Requests:

HeFH or ASCVD (Praluent or Repatha)

Lipid profile required at week 8, week 24, and every 6 months thereafter (attach results).

☐ Yes Most recent date obtained:_____ LDL-C:_____ ☐ No

Preferred: Praluent:

☐ LDL-C at goal – continue therapy at 75mg every 2 weeks for 24 weeks
☐ LDL-C not at goal – increase dose to 150mg every 2 weeks for 8 weeks (4 doses) and repeat LDL-C in 8 weeks
- o If repeat LDL-C at goal – continue therapy at 150mg every 2 weeks for 24 weeks
- o If repeat LDL-C not at goal – discontinue treatment

Non-Preferred: Repatha:

☐ LDL-C at goal – continue therapy at 140mg every 2 weeks for 24 weeks
☐ LDL-C not at goal – discontinue treatment

Patient continues therapy with a maximally tolerated statin dose and remains at goal? ☐ Yes ☐ No

Current Statin: Drug name:_____ Dose:_____

Patient has continued compliance with a low fat diet? ☐ Yes ☐ No

HoFH (Repatha only)

Lipid profile required after 3 months (third dose) and every 6 months thereafter (attach results).

☐ Yes Most recent date obtained:_____ LDL-C:_____ ☐ No

☐ LDL-C at goal – continue therapy at 420mg every month for 6 months
☐ LDL-C not at goal – discontinue treatment

Patient continues therapy with a maximally tolerated statin dose and remains at goal? ☐ Yes ☐ No

Patient has continued compliance with a low fat diet? ☐ Yes ☐ No

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
POTASSIUM BINDERS

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 non-preferred potassium binders. Payment will be considered under the following conditions:

1) **Patient is 18 years of age or older; and**
2) **Patient has a diagnosis of chronic hyperkalemia; and**
3) **Patient has documentation of a recent trial and therapy failure with sodium polystyrene sulfonate.**

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

Non-Preferred

☐ Lokelma ☐ Veltassa

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

Diagnosis:_____

Sodium polystyrene sulfonate trial: 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

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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 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 agents used to treat pulmonary hypertension.

Preferred

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

Non-Preferred

- ☐ Adcirca
- ☐ Adempas
- ☐ Flolan
- ☐ Opsumit
- ☐ Orenitram
- ☐ Remodulin
- ☐ Revatio
- ☐ Tadalafil
- ☐ Tracleer Sol Tab
- ☐ Tyvaso
- ☐ Uptravi
- ☐ 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.*

Iowa Department of Human Services

Request for Prior Authorization
SEDATIVE/HYPNOTICS-NON-BENZODIAZEPINE

(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

Preferred agents are available without prior authorization (PA) when dosed within the established quantity limits. Requests for doses above the manufacturer recommended dose will not be considered.

Prior authorization is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of a previous trial and therapy failure with, at a minimum, three (3) preferred agents. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be considered when the following criteria are met: 1) A diagnosis of insomnia, 2) Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued, 3) Enforcement of good sleep hygiene is documented, 4) All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses. 5) In addition to the above criteria, requests for suvorexant (Belsomra) will require documentation of a trial and therapy failure with at least one non-preferred agent, other than suvorexant, prior to consideration of coverage. 6) Non-preferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred
- ☐ Eszopiclone
- ☐ Zaleplon
- ☐ Zolpidem

Non-Preferred
- ☐ Ambien
- ☐ Ambien CR
- ☐ Belsomra
- ☐ Edluar
- ☐ Intermezzo
- ☐ Lunesta
- ☐ Rozerem
- ☐ Sonata
- ☐ Zolpidem ER
- ☐ Zolpidem SL Tab
- ☐ Zolpimist

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

Diagnosis_____ **Date of Diagnosis:** _____

Co-Morbid Conditions Contributing to Insomnia: _____

_____

Non-Pharmacological Treatments Tried: _____

Requests for Non-Preferred Drugs:

Eszopiclone Trial: Dose: _____ Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Zaleplon Trial: Dose: _____ Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Zolpidem Trial: Dose: _____ Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Iowa Department of Human Services

Request for Prior Authorization
SEDATIVE/HYPNOTICS-NON-BENZODIAZEPINE

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Requests for Belsomra (in addition to three (3) trials above):

Trial of Non-Preferred Agent: Drug Name & Dose: _____ Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Medical Necessity for alternative delivery system: _____

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

Attach lab results and other documentation as necessary (Required).

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
SHORT ACTING OPIOIDS

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

Preferred (*Please refer to the PDL for a complete list of preferred alternatives)

Acetaminophen/Codeine
Hydrocodone/APAP
Hydromorphone Tab
Meperidine Tab
Morphine Sulfate Tab
Oxycodone Cap/Tab
Oxycodone /APAP (5/325)
Oxycodone/ASA
Tramadol

Non-Preferred

- ☐ Butalbital/APAP/Caff/Codeine
- ☐ Butalbital/ASA/Caff/Codeine
- ☐ Combunox
- ☐ Hydrocodone/APAP (5/300, 7.5/300, 10/300)
- ☐ Hydrocodone/Ibuprofen
- ☐ Hydromorphone Inj
- ☐ Meperidine Syp/Inj
- ☐ Nucynta
- ☐ Opana
- ☐ Oxycodone/APAP (7.5/325, 10/325)
- ☐ Primlev
- ☐ Roxicodone
- ☐ Xodol
- ☐ Other **(**specify)_____

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

Diagnosis:_____

Request for Prior Authorization
SHORT ACTING OPIOIDS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Document non-pharmacologic therapies (such as physical therapy, weight loss, alternative therapies such as manipulation, massage, and acupuncture, or psychological therapies such as cognitive behavior therapy [CBT], etc,)

Non-Pharmacological Treatment Trial #1: _____
Trial Dates: _____ Failure reason: _____

Non-Pharmacological Treatment Trial #2: _____
Trial Dates: _____ Failure reason: _____

Document 2 nonopioid pharmacologic therapies (acetaminophen or NSAIDs)

Nonopioid Pharmacologic Trial #1: Name/Dose: _____ Trial Dates: _____
Failure reason: _____

Nonopioid Pharmacologic Trial #2: Name/Dose: _____ Trial Dates: _____
Failure reason: _____

Document trials with three preferred chemically distinct short acting opioids

Preferred Trial 1: Drug Name_____ Strength_____ Dosage Instructions_____
Trial start date:_____ Trial end date:_____
Failure reason:_____

Preferred Trial 2: Drug Name_____ Strength_____ Dosage Instructions_____
Trial start date:_____ Trial end date:_____
Failure reason:_____

Preferred Trial 3: Drug Name_____ Strength_____ Dosage Instructions_____
Trial start date:_____ Trial end date:_____
Failure reason:_____

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

Is short-acting opioid use appropriate for patient based on PMP review and patient's risk for opioid addiction, abuse and misuse? ☐ No ☐ Yes

Has patient been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids?

☐ No ☐ Yes

Patients taking concurrent benzodiazepines:

Have the risks of using opioids and benzodiazepines concurrently been discussed with the patient? ☐ No ☐ Yes

Medical necessity for concurrent use: _____

_____

Provide plan to taper the benzodiazepine or medical rationale why not appropriate: _____

_____

Request for Prior Authorization
SHORT ACTING OPIOIDS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Renewals

Has patient experienced improvement in pain control and level of functioning?

☐ No ☐ Yes (describe): _____

Updated prescriber review of patient's controlled substances use on the Iowa PMP website (since initial request):
☐ No ☐ Yes Date Reviewed:_____

Continued use of a short-acting opioid is appropriate for this member?

☐ No ☐ Yes (describe): _____

Patients taking concurrent benzodiazepines:

Have the risks of using opioids and benzodiazepines concurrently been discussed with the patient? ☐ No ☐ Yes

Medical necessity for concurrent use: _____

_____

Provide plan to taper the benzodiazepine or medical rationale why not appropriate: _____

_____

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.*

Iowa Department of Human Services

Request for Prior Authorization
SODIUM OXYBATE (XYREM®)

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 sodium oxybate (Xyrem®). Payment will be considered under the following conditions: 1) A diagnosis of cataplexy associated with narcolepsy verified by a recent sleep study (including 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; or 2) 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; and 3) Patient meets the FDA approved age; and 4) Is prescribed within the FDA approved dosing; and 5) Patient and provider are enrolled in the Xyrem REMS Program; and 6) Patient has been instructed to not drink alcohol when using Xyrem®; and 7) Patient has been counseled regarding the potential for abuse and dependence and will be closely monitored for signs of abuse and dependence; and 8) Requests for patients with concurrent use of a sedative hypnotic or a semialdehyde dehydrogenase deficiency will not be considered; and 9) The presciber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website prior to requesting prior authorization. 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: _____

Prescriber is enrolled in the Xyrem® REMS Program: ☐ Yes ☐ No

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

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

Patient has a semialdehyde dehydrogenase 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: ☐ Yes Date Reviewed:_____ ☐ No

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
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 will be considered with documentation of a specific testicular or hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism. Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis. Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for erectile dysfunction, infertility, and age-related hypogonadism will not be considered. Payment will be considered under the following conditions:

1) **Patient is male and 18 years of age or older (or 12 years of age 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 primary hypogonadism or hypogonadotropic hypogonadism (further defined below)**
    - **Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following: cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, toxic damage from alcohol or heavy metals**
    - **Hypogonadotropic hypogonadism: idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency, pituitary-hypothalamic injury from tumors, trauma, or radiation**
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 the patient has not experienced a hematocrit > 54% or an increase in PSA > 1.4ng/mL in the past 12 months.**

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

Iowa Department of Human Services

Request for Prior Authorization
TESTOSTERONE PRODUCTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Preferred

- ☐ Androderm
- ☐ Methitest
- ☐ Testosterone Cypionate
- ☐ Testosterone Enanthate
- ☐ Testosterone Gel 1% Packets

Non-Preferred

- ☐ Androgel
- ☐ Android
- ☐ Aveed
- ☐ Axiron
- ☐ Depo-Testosterone
- ☐ Fortesta
- ☐ Methyltestosterone
- ☐ Natesto
- ☐ Striant
- ☐ Testim
- ☐ Testosterone Gel 1.62%
- ☐ Testosterone Gel Pump
- ☐ Testosterone Topical Solution
- ☐ Testred
- ☐ Xyosted
- ☐ Vogelxo

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

Complete for diagnosis of hypogonadism:

☐ Primary Hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:

☐ Cryptorchidism ☐ Bilateral torsion ☐ Orchitis ☐ Vanishing testes syndrome ☐ Orchiectomy

☐ Klinefelter's syndrome ☐ Chemotherapy ☐ Toxic damage from alcohol or heavy metals

☐ Other: _____

☐ Hypogonadotropic Hypogonadism:

☐ Idiopathic gonadotropin or luteinizing hormone-releasing (LHRH) deficiency

☐ Pituitary-hypothalamic injury from tumors, trauma, or radiation

Please indicate setting in which medication is to be administered: _____

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:_____

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:_____

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.*

Iowa Department of Human Services

Request for Prior Authorization
TOPICAL ACNE AND ROSACEA PRODUCTS

(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 topical acne agents (topical antibiotics and topical retinoids) and topical rosacea agents. Payment for topical acne and topical rosacea agents will be considered under the following conditions:

1) Documentation of diagnosis.
2) For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid.
3) 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 acne agents of a different chemical entity from the requested topical class (topical antibiotic or topical retinoid).
4) Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical rosacea agent.
5) Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products.
6) Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis.
7) Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for the preferred tazarotene (Tazorac) product for a psoriasis diagnosis.
8) Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered.

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

Preferred			
☐	Acanya	☐	MetroGel 1%
☐	Adapalene Gel	☐	MetroLotion
☐	Azelex	☐	Metronidazole 0.75% Cream
☐	Clindamycin	☐	Retin-A
☐	Differin	☐	Tazorac
☐	Epiduo	☐	
☐	Erythromycin	☐	

Non-Preferred					
☐	Aczone	☐	Clindamycin/BPO	☐	Noritate
☐	Adapalene/Benzoyl Peroxide	☐	Clindamycin Phosphate-Tretinoin	☐	Onexton
☐	Adapalene Cream/Lotion/Sol	☐	Duac	☐	Plixda Pads
☐	Altreno Lotion	☐	Erythromycin/BPO	☐	Retin-A Micro
☐	Atralin	☐	Fabior	☐	Sodium Sulfa/Sulf
☐	Azelaic Acid Gel 15%	☐	Finacea	☐	Soolanta
☐	BenzaClin	☐	Klaron	☐	Tretinoin
☐	Benzamycin	☐	MetroCream	☐	Ziana
☐	Benzamycin Pak	☐	Metronidazole Gel & Lotion	☐	
☐	Cleocin T	☐	Other (specify)		

Strength	Dosage Form	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Iowa Department of Human Services

Request for Prior Authorization
TOPICAL ACNE AND ROSACEA PRODUCTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

If acne vulgaris, document concurrent benzoyl peroxide use:

Drug Name & Strength:_____

Dosing Instructions:_____ Start date:_____

Non-Preferred Topical Acne or Rosacea Products

Acne Diagnosis: Document trials with two preferred topical acne agents of a different chemical entity; if a non-preferred combination product is requested, the two trials must be preferred topical acne combination products

Rosacea diagnosis: Document trial with one preferred topical rosacea agent of a different chemical entity:

Preferred Trial 1: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Preferred Trial 2: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Medical or contraindication reason to override trial requirements:_____

_____

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
VALSARTAN/SACUBITRIL (ENTRESTO)

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 valsartan/sacubitril (Entresto). Requests above the manufacturer recommended dosing will not be considered. Payment will be considered for patients when the following criteria are met:

1) **Patient is 18 years of age or older; and**
2) **Patient has a diagnosis of NYHA Functional Class II, III, or IV heart failure; and**
3) **Patient has a left ventricular ejection fraction (LVEF) ≤40%; and**
4) **Patient is currently tolerating treatment with an ACE inhibitor or angiotensin II receptor blocker (ARB) at a therapeutic dose, where replacement with valsartan/sacubitril is recommended to further reduce morbidity and mortality; and**
5) **Is to be administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB (list medications patient is currently taking for the treatment of heart failure); and**
6) **Will not be used in combination with an ACE inhibitor or ARB; and**
7) **Will not be used in combination with aliskiren (Tekturna) in diabetic patients; and**
8) **Patient does not have a history of angioedema associated with the use of ACE inhibitor or ARB therapy; and**
9) **Patient is not pregnant; and**
10) **Patient does not have severe hepatic impairment (Child Pugh Class C); and**
11) **Prescriber is a cardiologist or has consulted with a cardiologist (telephone consultation is acceptable).**

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

Preferred

☐ Entresto

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

Diagnosis:_____

Request for Prior Authorization
VALSARTAN/SACUBITRIL (ENTRESTO)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Trial Information:

Is patient currently tolerating treatment with an ACE inhibitor or ARB at a therapeutic dose? ☐ Yes ☐ No

If Yes, Provide: Drug Name & Dose: _____ Therapy Start Date: _____

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

_____

Will Entresto be used in combination with ACE inhibitor or ARB? ☐ Yes ☐ No

Does patient have a history of angioedema associated with ACE inhibitor or ARB therapy? ☐ Yes ☐ No

Provide heart failure therapies to be used in conjunction with Entresto: _____

_____

If patient is diabetic, will Entresto be used in combination with aliskiren (Tekturna)? ☐ Yes ☐ No

Provide patient's left ventricular ejection fraction: _____ Date obtained: _____

Results: _____

If female of child-bearing years, confirmed negative serum pregnancy test? ☐ Yes ☐ No

If yes, please list Prescriber: _____ Date of pregnancy test: _____

Does patient have severe hepatic impairment (Child Pugh Class C)? ☐ Yes ☐ No

Is Prescriber a cardiologist? ☐ Yes ☐ No If no, note consultation with cardiologist:

Consultation date: _____ Physician name & phone: _____

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 Vesicular Monoamine Transporter (VMAT) 2 Inhibitors

(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 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 under the following conditions:

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

1. **Patient meets the FDA approved age; and**
2. **Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following:**
   a. **Involuntary athetoid or choreiform movements**
   b. **Documentation or claims history of current or prior chronic use (≥ 3 months or 1 month in patients ≥ 60 years old) of a dopamine receptor blocking agent (e.g., antipsychotic, metoclopramide, prochlorperazine, droperidol, promethazine, etc.)**
   c. **Symptoms lasting longer than 4-8 weeks; and**
3. **Prescribed by or in consultation with a neurologist or psychiatrist; and**
4. **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**
5. **Documentation of baseline AIMS (Abnormal Involuntary Movement Scale) Score (attach AIMS); and**
6. **For Ingrezza:**
   a. **Will not be used concurrently with MAO inhibitors (e.g., isocarboxazid, phenelzine, rasagiline, safinamide, selegiline, tranylcypromine, etc.) or strong CYP3A4 inducers (e.g., carbamazepine, phenytoin, phenobarbital, rifampin and related agents, St. John's wort, etc.); and**
   b. **Will not be used concurrently with other VMAT2 inhibitors; and**
   c. **Is prescribed within the FDA approved dosing; or**
7. **For Austedo:**
   a. **Patient is not suicidal, or does not have untreated/inadequately treated depression;**
   b. **Patient does not have hepatic impairment;**
   c. **Will not be used concurrently with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and**
   d. **Patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed 36mg per day (18mg twice daily); and**
   e. **Is prescribed within the FDA approved dosing.**

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

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

Request for Prior Authorization
Vesicular Monoamine Transporter
(VMAT) 2 Inhibitors

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Chorea associated with Huntington's disease (Austedo or tetrabenazine)

1. **Patient meets the FDA approve age; and**
2. **Patient has a diagnosis of Huntington's disease with chorea symptoms; and**
3. **Prescribed by or in consultation with a neurologist or psychiatrist; and**
4. **Is prescribed within the FDA approved dosing; and**
5. **Patient is not suicidal, or does not have untreated or inadequately treated depression; and**
6. **Patient does not have hepatic impairment; and**
7. **Patient does not have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and**
8. **For tetrabenazine, patients requiring doses above 50mg per day have been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor metabolizer or extensive metabolizer; and**
9. **In patients that are taking a strong CYP2D6 inhibitor (e.g., quinidine, paroxetine, fluoxetine, bupropion) or are poor CYP2D6 metabolizers, the daily dose does not exceed the following:**
   a. **Austedo – 36mg per day (18mg single dose) or**
   b. **Tetrabenazine – 50mg per day (25mg single dose)**

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

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

Preferred **Non-Preferred**

☐ Austedo ☐ Tetrabenazine ☐ Ingrezza ☐ Xenazine

Strength	Dosing Instructions	Quantity	Days' Supply

☐ **Tardive Dyskinesia** (Austedo or Ingrezza):

- Patient has ALL of the following:
  - ☐ Involuntary athetoid or choreiform movement
  - ☐ Documentation of a dopamine receptor blocking agent:
    Drug name & dose:_____ Trial dates:_____
  - ☐ Symptoms lasting longer than 4-8 weeks; date of onset:_____
- Is prescriber a: ☐ neurologist ☐ psychiatrist ☐ other:_____
  If other, note consultation date with a neurologist or psychiatrist:_____
  Physician name, phone & specialty:_____
- Has prescriber evaluated the patient's current medications for consideration of a dose reduction, withdrawal, or change of the dopamine receptor blocking agent causing the TD? ☐ Yes ☐ No
- Baseline AIMS score (attach results):_____ Date conducted:_____
- For Ingrezza:
  Does patient have concurrent therapy with MAO inhibitors, strong CYP3A4 inducers, or other VMAT2 inhibitors? ☐ Yes ☐ No

Request for Prior Authorization
Vesicular Monoamine Transporter
(VMAT) 2 Inhibitors

(PLEASE PRINT – ACCURACY IS IMPORTANT)

- For Austedo:
  Is patient suicidal or have untreated or inadequately treated depression? ☐ Yes ☐ No
  Does patient have hepatic impairment? ☐ Yes ☐ No
  Does patient have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors?
  ☐ Yes ☐ No
  Is patient taking a strong CYP2D6 inhibitor? ☐ Yes ☐ No
  Has patient been identified as a poor CYP2D6 metabolizer? ☐ Yes ☐ No

Renewal Requests:

Updated AIMS score from baseline (attach results):_____ Date conducted:_____

☐ **Chorea associated with Huntington's disease** (Austedo or Tetrabenazine):

- Is prescriber a: ☐ neurologist ☐ psychiatrist ☐ other:_____
  If other, note consultation date with a neurologist or psychiatrist:_____
  Physician name, phone & specialty:_____
- Is patient suicidal or have untreated or inadequately treated depression? ☐ Yes ☐ No
- Does patient have hepatic impairment? ☐ Yes ☐ No
- Does patient have concurrent therapy with MAO inhibitors, reserpine, or other VMAT2 inhibitors?
  ☐ Yes ☐ No
- Is patient taking a strong CYP2D6 inhibitor? ☐ Yes ☐ No
- Has patient been identified as a poor CYP2D6 metabolizer? ☐ Yes ☐ No
- For tetrabenazine doses above 50mg per day, has patient been tested and genotyped for the drug metabolizing enzyme CYP2D6 to determine if they are a poor or extensive metabolizer?
  ☐ Yes ☐ No

Renewal Requests:

Document improvement in chorea symptoms:_____

_____

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.*

The enrolled prescriber requests prior authorizations, not the pharmacy. The process is primarily 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**.

ditional prior authorization submission options include mail and electronic submission through the pharmacy provider portal.

- Mail: The prescriber should mail the prior authorization request to: Iowa Medicaid Enterprise, Pharmacy Medical PA, 611 Fifth Ave, Des Moines, Iowa, 50309.
- Pharmacy Provider Portal: This is a web-based tool that allows prescribers to create and submit a web prior authorization. Prescribers should contact the Iowa Medicaid Prior Authorization Helpdesk at (515) 256-4607 (local calls) or 877-776-1567 for additional information.

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 website http://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.

3. Completing a Prior Authorization Request

Each category of prior authorization uses a specific request form to reflect the criteria for approval. The following instructions refer to items common to all *Requests for Prior Authorization*.

IA MEDICAID MEMBER ID #: Copy this number directly from the member's *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven numeric digits and one alphabetical character).

PATIENT NAME: Provide the first and last name of the member. Use the *Medical Assistance Eligibility Card* for verification.

DATE OF BIRTH (DOB): Copy the member's date of birth directly from the *Medical Assistance Eligibility* Card. Use two digits for each: month, day, year (i.e., 04/11/67).

PATIENT ADDRESS: Enter the member's home address.

PRESCRIBER NUMBER: Enter the national provider identifier (NPI) of the prescribing practitioner.

PRESCRIBER NAME: Enter the name of the enrolled prescribing practitioner.

PRESCRIBER PHONE NUMBER: Enter the prescriber's office phone number.

PRESCRIBER ADDRESS: Enter the prescriber's office address.

PRESCRIBER FAX NUMBER: Enter the prescribing practitioner's office FAX number.

PHARMACY NAME: Enter the name of the pharmacy where the prescription will be filled.

PHARMACY ADDRESS: Enter the street address and city of the pharmacy.

PHARMACY PHONE NUMBER: Enter the phone number of the pharmacy.

PHARMACY NPI: Enter the pharmacy national provider identifier (NPI) number.

NDC: If available, enter the National Drug Code of the product being requested.

DRUG NAME: Provide the complete drug name of the product being requested.

STRENGTH: Enter the strength of the drug being requested.

DOSAGE INSTRUCTIONS: Enter the instructions for use for the requested product.

QUANTITY: Enter the quantity on the prescription (cannot exceed a one-month supply).

DAYS SUPPLY: Enter the number of days' supply requested (cannot exceed a one-month supply).

LENGTH OF THERAPY ON PRESCRIPTION (DATE RANGE): Provide an estimate of the duration of therapy. The prior authorization period granted will be subject to adjustment by the reviewer according to established criteria and individual consideration.

DIAGNOSIS: Enter the patient's diagnosis relevant to the requested product.

PREVIOUS THERAPY: Enter drug names, strengths, dosage instructions, and exact date ranges of other medications that have previously been tried and failed by patient.

PERTINENT LAB DATA: Enter any laboratory 909 data that may affect the outcome of this request.

OTHER MEDICAL CONDITIONS TO CONSIDER: Enter any other medical conditions the patient has that may help the Prior Authorization Unit make a decision.

POSSIBLE DRUG INTERACTIONS/CONFLICTING DRUG THERAPIES: If the patient is taking any other medications that may negatively affect the requested product, list them here.

PRESCRIBER SIGNATURE: The prescriber must sign the form and the signature must match the prescriber name listed at the top of the request form.

DATE OF SUBMISSION: Enter the date the prior authorization request was submitted.

4. Submitting a Prior Authorization Request

Completed drug prior authorization requests must be submitted **via FAX** to the IME Drug Prior Authorization Unit at 800-574-2515.

Regular working hours for the provider help desk are Monday through Friday, 8:00 a.m. to 5:00 p.m.

State-recognized holidays are as follows:

- New Year's Day
- Martin Luther King Jr.'s birthday
- Memorial Day
- Independence Day
- Labor Day
- Veterans' Day
- Thanksgiving Day
- The Friday following Thanksgiving
- Christmas Day

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction for prior authorization requests (278 transaction). However, there is no standard to use in submitting additional documentation electronically.

Therefore, if you submit a prior authorization request electronically, you must submit the additional documentation on paper using the following procedure:

- Complete form 470-3970, *Prior Authorization Attachment Control*. To view a sample of this form on line, click here.

  Complete the "attachment control number" with the same number submitted on the electronic prior authorization request. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the request, please contact the person in your facility responsible for electronic claims billing.

- **Staple** the additional information to the *Prior Authorization Attachment Control*.

- **Fax** the form with attachments to the Prior Authorization Unit at 800-574-2515 **or mail** the information to:

  Iowa Medicaid Enterprise
  PO Box 36478
  Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

5. Prior Authorization Response

The pharmacist reviewer will make a decision and respond within 24 hours of the request. In evaluating requests for prior authorization, the reviewer will consider the drug from the standpoint of published criteria only.

If a prior authorization request is denied, a letter of denial will be faxed to both the prescriber and the pharmacy. A letter of denial will be mailed to the member.

Upon approval of a prior authorization request, a letter of approval will be faxed to the prescriber and the pharmacy indicating the prior authorization number and dates of authorization.

NOTE: When approval of a request is granted, this does not indicate validity of the prescription, nor does it indicate that the member continues to be eligible for Medicaid. If you are not billing on the point-of-sale system, it is your responsibility to establish that the member continues to be eligible for Medicaid, either by:

- Calling the eligibility verification system (ELVS) at (515) 323-9639 (local calls) or 800-338-7752; or
- Checking the IME web portal; http://www.edissweb.com

D. BASIS OF PAYMENT FOR DRUGS

The amount of payment for drugs is based on several factors, in accordance with 441 IAC 79.1(8) and upper limits in 42 CFR 447.500 to 447.520.

340B actual acquisition cost (340B AAC) means the net cost of a drug paid by a pharmacy for drugs purchased through the 340B drug pricing program. A drug's 340B AAC includes discounts, rebates, chargebacks, and other adjustments to the price of the drug, but excludes dispensing fees.

Average actual acquisition cost (average AAC) is defined as retail pharmacies' average prices paid to acquire drug products.

- Average AAC is determined by the Department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies.
- Surveys are conducted at least once every six months, or more often at the Department's discretion.
- The average AAC is calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the Department is published on the Iowa Medicaid Enterprise website.
- If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span is used.

Federal upper limit (FUL) is defined as the upper limit for multiple-source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services, as described in 42 CFR 447.514.

For drugs with no established FUL, the Department determines the allowable average actual acquisition cost in accordance with the provisions of federal drug regulation 42 CFR 447.512. This basis of payment is also applicable to compounded prescriptions.

Professional dispensing fee is added to the ingredient cost to cover the pharmacist's professional services and costs associated with transferring the drug to a Medicaid member. The dispensing fee is set based on cost of dispensing surveys of Iowa Medicaid participating pharmacies.

1. Reimbursement Effective April 1, 2017

The Medicaid program relies on information published by **Medi-Span** to classify drugs as brand or generic.

a. Generic and Nonprescription Drugs

For covered **generic** prescription drugs and for covered **nonprescription** drugs shall be the lowest of the following, as of the date of dispensing:

- Average actual acquisition cost (average AAC) plus the professional dispensing fee.
- The federal upper limit (FUL) plus the professional dispensing fee.
- The total submitted charge (represented by the lower of gross amount due as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee).
- The provider's usual and customary charge to the general public.

b. Brand-Name Drugs

For covered **brand-name** prescription drugs shall be the lowest of the following, as of the date of dispensing:

- Average AAC plus the professional dispensing fee.
- The total submitted charge (represented by the lower of gross amount due as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee).
- The provider's usual and customary charge to the general public.

c. 340B Purchased Drugs

Reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

- The submitted 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee,
- Average AAC plus the professional dispensing fee,
- For generic prescription drugs and nonprescription drugs only, the FUL plus the professional dispensing fee,
- The total submitted charge (represented by the gross amount due as defined by the NCPDP standards definition), or
- The provider's usual and customary charge to the general public.

d. Federal Supply Schedule (FSS) Drugs

Reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

- The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee,
- Average AAC plus the professional dispensing fee,
- For generic prescription drugs and nonprescription drugs only, the FUL plus the professional dispensing fee,
- The total submitted charge (represented by the gross amount due as defined by the NCPDP standards definition), or
- The provider's usual and customary charge to the general public.

e. Nominal Price (NP) Drugs

Reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR 447.508 will be the lowest of:

- The provider's actual acquisition cost (not to exceed the NP price), submitted in the ingredient cost field, plus the professional dispensing fee,
- Average AAC plus the professional dispensing fee,
- For generic prescription drugs and nonprescription drugs only, the FUL plus the professional dispensing fee,
- The total submitted charge (represented by the gross amount due as defined by the NCPDP standards definition), or
- The provider's usual and customary charge to the general public.

f. Indian Health Facilities

Indian health facility pharmacies are paid a special daily rate for all Medicaid-covered services rended to American Indian or Alaskan native persons who are Medicaid-eligible. The pharmacies should bill at their usual and customary charge. Pharmacy claims will be paid at one pharmacy encounter rate payment per date of service.

2. Drugs Subject to Federal Upper Limit (FUL)

a. FUL Development

The Centers for Medicare and Medicaid Services (CMS) establishes federal upper limits (FUL) for reimbursement for multiple-source drugs. These reimbursement levels are updated periodically and are available on the Centers for Medicare and Medicaid Services web page at https://www.medicaid.gov/medicaid/prescription-drugs/federal-upper-limits/index.html.

b. Reimbursement for FUL Drugs

For the drug groups on the Preferred Drug List where brand-name products are preferred over generic products, the FUL rate will continue to apply when the generic version of the drug is dispensed.

However, the payment for preferred brand name products (which no longer require prior authorization before dispensing) equals the lower of the average acquisition cost (average AAC) or the submitted charges, as opposed to the FUL rate.

Nonpreferred brand products require prior authorization before dispensing. If authorized, payment equals the lower of the the average acquisition cost (average AAC) or the submitted charges, as opposed to the FUL rate with a prior authorization. The DAW=1 is no longer required for brand reimbursement.

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.

For prior authorization to be considered, evidence of a treatment failure with the bioequivalent generic drug must be provided. A copy of a completed form 470-4119, *Request for Prior Authorization: Selected Brand Name Drugs*, shall be considered as evidence of treatment failure.

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. Prior authorization **is not required** for brand name drugs that have been designated by the Department as **preferred** (payable) under the Iowa Medicaid Preferred Drug List (PDL).

3. Reimbursement for Unit-Dose Packaging

Additional reimbursement of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist. Unit-dose reimbursements are permitted only for patients with Plan 300 eligibility.

Claim the additional reimbursement by placing a "3" in "Unit Dose Indicator" (field 429-DT) for electronic claims, as explained under Point of Sale Claim Submission, or a "09" in the Basis Cost (field 80) on the paper claim form, as explained under Paper Claim Submission. The additional reimbursement will be automatically added, possibly resulting in reimbursement that is higher than your submitted charge.

Credits: Payment may be made only for unit-dose-packaged drugs that are **consumed** by the patient. Any previous charges for intact unit-dose packages returned to the pharmacy must be credited to the Medicaid program. Such credits may be shown on future billings. If no additional billings are to be made, direct a refund in the drug cost component.

In accordance with state and federal law, proper crediting to Iowa Medicaid is **required** for the return of unused medications upon therapy discontinuation or a member's discharge, transfer, or death.

Both the long-term-care pharmacy and the nursing facility are subject to financial review by the state to ensure that medications are being returned to the pharmacy when permitted by state and federal law and proper credits are applied to the Iowa Medicaid program.

4. Reimbursement for Vaccinations

a. Vaccine for Children (VFC) Program

In order for pharmacies who administer VFC influenza vaccinations for children age 18 and under to be reimbursed:

- Pharmacy must be enrolled in the VFC Program through the Iowa Department of Public Health and follow that process to qualify.
- Pharmacy must meet the Iowa Board of Pharmacy requirements to administer.
- Pharmacy must bill only for administration of influenza vaccinations. Claims must be submitted on a CMS 1500 claim form with appropriate codes. Reimbursement will be based on the physician fee schedule. No payment is made for the vaccine.

For more information, see the Iowa Department of Public Health web page: http://www.idph.iowa.gov/immtb/immunization

b. Other Vaccines

Reimbursement for vaccines is made in the same manner as for other prescription drugs. When administered by the pharmacy meeting the Iowa Board of Pharmacy requirements, no administration fee is paid.

5. Date of Birth Verification

Point of sale edits for the exact date of birth from the eligibility file for Iowa Medicaid members. Field # 304-C4 (Date of Birth) on the NCPDP Payer Sheet is mandatory. The NCPDP rejection message will state "09-Missing/ Invalid Date of Birth." Claims should be resubmitted with the correct date of birth for the member.

6. Override Codes

A 72-hour emergency supply of medication may be dispensed using prior authorization type code "1" as a point of sale override. The provision for a 72-hour supply can be used in an emergency situation only one time per member, per drug.

A seven-day override of the prior authorization requirement will be allowed while the prescriber is requesting prior authorization for certain mental health drugs. The override applies to drugs that are deemed to have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class. See the Preferred Drug List at: www.iowamedicaidpdl.com

The pharmacy may use a prior authorization type code "7" as a point of sale override for applicable mental health drugs. The seven-day provision can be used only one time per member, per drug, per 30 days.

7. Proper Reporting of NDCs

The Iowa Medicaid Program can cover only drugs from manufacturers who have signed national Medicaid drug rebate agreements with the Centers for Medicare and Medicaid Services (CMS). Drug companies sign the agreements for specific drug manufacturer codes called national drug codes (NDC).

Since rebates are determined by Iowa Medicaid's utilization data, it is imperative that pharmacies and providers bill Iowa Medicaid using the correct NDC number of the drug actually dispensed or administered. Reimbursement is only made for the specific NDC dispensed or administered.

If a provider is dispensing or administering one drug and billing for an NDC different from the drug being dispensed or administered, it is considered fraud, which can result in claims being recouped, sanctions, and termination of provider agreements. The Program Integrity Unit will be monitoring for this in their reviews.

Edit	Number and Message	Reason for the Denial	* Override Provided
Tablet Splitting	19 - M/I DAYS SUPPLY Additional text: MUST SPLIT TABLETS	Certain medications that are scored and easily halved should be split to facilitate more cost-effective use of the drugs.	PA required.
Therapeutic Duplication	88 - DUR REJECT MESSAGE Additional text: SITUATIONAL	If a second claim submitted is a therapeutic duplication of a drug already submitted and reimbursed.	PA required.

* Always verify that the quantity and days' supply on the claim are correct; then for an override contact: Pharmacy POS Help Desk at 877-463-7671 or (515) 256-4608 (local)

a. Age Edits

Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
Drugs FDA indicated for the treatment of Alzheimer's dementia (donepezil, galantamine, memantine, and rivastigmine)	Payable for members 40 years of age and older	PA is required for members under 40 years of age.
Aldara (imiquimod)	Payable for members 12 years of age and older	PA is required for members under 12 years of age.
Antipsychotics	Payable for members 5 years of age or older for risperidone and 6 years of age or older for all other anti-psychotics.	PA is required for members under 5 years of age for risperidone and under 6 years of age for all other antipsychotics.
Asmanex 110 mcg	Payable for members less than 12 years of age.	PA is required for members 12 years of age and older.

Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
Benznidazole	Payable for members 2 through 11 years of age.	PA is required for members under 2 years of age and over 11 years of age.
Brovana	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Clorazepate	Payable for members 9 years of age and older.	PA is required for members under 9 years of age.
CNS Stimulants: Adderall, Adzenys ODT, Desoxyn, Dexedrine, Dyanavel XR, Evekeo, Mydayis, Vyvanse	Payable for members 3 through 20 years of age.	PA is required for members under 3 years of age and over 20 years of age.
CNS Stimulants: Adderall XR, Dexedrine ER, Focalin, Focalin XR, Aptensio XR, Concerta, Cotempla XR ODT, Daytrana, Metadate CD, Methylin, QuilliChew, Quillivant XR, Ritalin IR/LA/SR	Payable for members 6 through 20 years of age.	PA is required for members under 6 years of age and over 20 years of age.
Codeine Containing Products	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Complera	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Edurant	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Eligard	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Erivedge	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.

Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
Femara (letrozole)	Payable for members 50 years of age and older.	PA is required for member under 50 years of age.
Flurazepam	Payable for members 15 years of age and older.	PA is required for members under 15 years of age.
Foradil	Payable for members 5 years of age and older.	PA is required for members under 5 years of age.
Guanfacine ER	Payable for members 6 through 17 years of age.	PA is required for members under 6 years of age and over 17 years of age.
Inlyta	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Isentress 25 mg and 100 mg chewable tablets	Payable for members less than 12 years of age.	PA is required for members 12 years of age and older.
Jakafi	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Nicotine Replacement Therapy	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Nuvigil (armodafinil)	Payable with a PA for members 17 years of age and older	PA is required for members under 17 years of age.
OTC Polyethylene glycol 3350 powder	Payable for members 0 to 12 years of age. PA required for members 13 to 18 years of age. Not covered for members 19 years of age or over.	PA is required for members 13-18 years of age.
Oxazepam	Payable for members 6 years of age and older.	PA is required for members under 6 years of age.

Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
Perforomist	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Provigil (modafinil)	Payable for members 16 years of age and older	PA is required for members under 16 years of age and 21 years of age and older
Revlimid	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Serevent	Payable for members 4 years of age and older.	PA is required for members under 4 years of age.
Singulair 4 mg granules	Payable for members less than 2 years of age	PA is required for members 2 years of age and older.
Smoking Cessation Therapy-Oral	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Stribild	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Tramadol Containing Products	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Veregen (sinecatechins)	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Zytiga	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.

b. Cost Effectiveness Edit

Drug	Dosage	Alternative
Buspirone tablet	30 mg	Deny. Use two buspirone 15 mg tablets.
Clindamycin capsule	300 mg	Deny. Use multiples of clindamycin 150 mg capsule.
Hydroxyzine pamoate capsules	100 mg	Deny. Use hydroxyzine pamoate 50 mg capsules.
Imipramine pamoate capsules		Deny. Use imipramine HCL tablets.
Prozac or fluoxetine HCL capsules	40 mg	Deny. Use two fluoxetine HCL 20 mg capsules.
Rheumatrex		Deny. Use methotrexate.

c. Dosage Form Edits

Form	Drug	Dosage	Alternative
Prozac tablets	fluoxetine	20 mg	Deny. Use the capsule dosage form.
Zantac capsules	ranitidine	150 mg	Deny. Use the tablet dosage form.
Zantac capsules	ranitidine	300 mg	Deny. Use the tablet dosage form.

d. Excessive Days Supply

The claim will be rejected if the supply submitted is more than 31 days. If there is a valid reason why a supply of more than 31 days is required, request an exception to policy.

e. Gender Edits

Drug Name/Class	Gender Edit
Prenatal vitamins	Payable for female members

f. High-Dollar Claims

All claims in excess of $5,000 submitted through the pharmacy point of sale system will be rejected with a denial message stating, "Claim exceeds $5,000, please call POS Help Desk at 877-463-7671 or (515) 256-4608 locally."

After verifying that the quantity and days' supply on the claim are correct, contact the Pharmacy POS Help Desk for consideration of an override. A technician or pharmacist will review the information submitted and determine if an override shall be issued.

As a part of this process, the Iowa Medicaid Program Integrity Unit may request additional medical documentation regarding the case from the prescriber or pharmacy. This policy is intended to help ensure that proper billing procedures are being followed.

g. Hospice Edits

For members enrolled in hospice, medications in the following therapeutic categories should be submitted to hospice for coverage consideration. If hospice does not provide payment for a medication in one of the below categories, or if the member is no longer enrolled in hospice, the pharmacy may call the POS Helpdesk for coverage consideration.

Analgesics — non-narcotic
Analgesics — opioid
Antianxiety agents
Antidiarrheals
Antiemetics
Antihistamines
Antispasmodics
Cough/Cold/Allergy
Hypnotics
Laxatives
Muscle relaxant combinations
Ophthalmic agents

h. Refill Too Soon

The claim will be denied if not enough time has elapsed for the member to use 90 percent of the supply issued under previously paid claim for that medication. An override will be considered if:

- There is a change in dose;
- The previously issued supply has been lost, stolen or destroyed; or
- The member is traveling and will not be able to pick up the next refill at the normal time.

i. Step Therapy Edits

Certain therapeutic drug classes are subject to step therapy edits as designated on the Preferred Drug List. Antipsychotics-Atypicals:

Step 1: Preferred generic drugs. No PA required.

Step 2: Preferred brand name drugs. No PA required if a preferred generic trial is found in the paid claims system in the past 12 months.

Step 3: Nonpreferred drugs. PA required.

j. Tablet Splitting

Certain medications that are scored and easily halved should be split to facilitate more cost-effective use of the drugs.

Drug Product	Quantity	Days' Supply	Comments
Lexapro 5 mg	15	30	Use 10 mg tablets to obtain 5 mg daily dose
Lexapro 10 mg	15	30	Use 20 mg tablets to obtain 10 mg daily dose

k. Therapeutic Duplication

If a second claim submitted is a therapeutic duplication of a drug already submitted and reimbursed, overlapping claims will be considered on an individual basis.

Deny regardless of prescriber	
Antipsychotics	Duplicate therapy edit on all antipsychotics for members 0 – 17 years of age. A 30 day grace period is allowed for transition between antipsychotic medications. After 30 days of concomitant use, provide prescriber verified documentation of the necessity of the duplication in the treatment plan.
Antipsychotics	After 12 weeks (84 days) of concomitant oral and injectable antipsychotic medication use for members 18 years of age and older, provide prescriber verified documentation of the necessity in the treatment plan.
Nonsteroidal anti-inflammatory drugs (NSAIDs)	After 60 days of concomitant use, provide prescriber verified documentation of the necessity of the duplication in the treatment plan.

9. Status Change for Preferred Brand Name Drugs

When the status of a previously preferred brand-name drug changes to nonpreferred, pharmacies are given a transition period of up to 30 days to allow utilization of existing stock of the brand-name product.

If additional stock remains beyond this period, pharmacies may call the Point of Sale (POS) Helpdesk at 877-463-7671 or 515-256-4608 (local) to request an override for the nonpreferred brand-name drug with a recent status change.

10. Travel or Vacation Supplies of Medication

Requests of medications for travel or vacation should be planned well in advance of the departure date.

The pharmacy can process the first month's prescriptions as usual, and then may call the Point of Sale (POS) Helpdesk at 877-463-7671 or 515-256-4608 (local) to obtain up to a one-month supply of medications to total up to a 60-day supply of medication.

Exceptions to policy will not be granted if other sources for payment are available.

11. 340B Drug Pricing Program

In order to become eligible to participate in the 340B Program, the provider must submit a request to the Office of Pharmacy Affairs (OPA) within the Health Resources and Services Administration (HRSA). The OPA website is http://www.hrsa.gov/opa/. The online registration is available at the following link: https://340bregistration.hrsa.gov/.

It is very important that the OPA has accurate and up-to-date information, particularly your exact name and street address. It your responsibility to:

- Contact the OPA with any changes in your information; and
- Tell your wholesaler or manufacturer that you are registered for 340B discount prices when you place an order.

Providers must enroll with Iowa Medicaid in order to bill and receive reimbursement for self-adminsitered drugs purchased through the 340B Program.

a. Covered Entity (CE)

The covered entity (CE) has full responsibility and accountability for compliance with all requirements to prevent diversion of covered drugs to individuals other than patients of the CE, and to prevent situations in which a drug is subject to both the 340B discount and a Medicaid rebate claim.

Use of a contract pharmacy arrangement (single or multiple) does not lessen a CE's duty to ensure that the 340B Program is being administered in compliance with the statute and HRSA guidelines.

It is imperative that all CEs participating in the 340B Program not only comply with program requirements but also be able to document compliance with those requirements in the event of an audit.

To prevent duplicate discounts, HRSA requires CEs to indicate on OPA website if they purchase drugs at 340B pricing for Medicaid patients (Medicaid Exclusion File), so Medicaid does not bill for rebates. HRSA directs CEs to follow state guidelines when billing for 340B drugs. CEs may not use a contracted pharmacy unless it has reached an agreement with the state Medicaid agency on a method to prevent duplicate discounts.

b. Iowa Medicaid Billing/Reimbursement for CE Outpatient In-House Pharmacy or Contracted Pharmacy

340B requirements below are reviewed through a postpayment review. Overbillings are subject to recoupment.

(1) 340B Covered Entities

The CE must decide if they are carving Medicaid "OUT" or "IN," and that decision applies to both fee-for-service and managed care claims.

All 340B CEs that use 340B drugs and serve Medicaid FFS members must do one of the following:

- Medicaid **CARVE OUT** all prescriptions from the 340B program when Medicaid is a payor for any portion of the claim:
  - Use non-340B drugs for all Medicaid members you serve.

- Bill Medicaid only for drugs purchased outside the 340B program billed in accordance with existing state Medicaid reimbursement methodologies, allowing rebates to be collected where appropriate.
- Do not list the 340B entity's NPI on the HRSA Medicaid Exclusion File.

This allows rebates to be collected by Medicaid where appropriate.

♦ Medicaid **CARVE IN** all prescriptions into the 340B program:

- Use 340B drugs for all Medicaid members you serve.
- Inform OPA at the time of 340B enrollment that you intend to purchase and dispense 340B drugs for Medicaid members.
- Do not bill Medicaid for 340B acquired drugs if your NPI is not listed on the HRSA Medicaid Exclusion File.
- Purchase all drugs billed to Medicaid on the CE's NPI under 340B unless the product is not eligible for 340B pricing.

This ensures these claims are excluded from Medicaid rebate.

♦ Billing:

Submit pharmacy claims for 340B-acquired drugs to Medicaid at your 340B AAC and with values of "08" in Basis of Cost Determination field 423-DN **OR** in Compound Ingredient Basis of Cost Determination field 490-UE **AND** also insert "20" in the Submission Clarification Code field 420-DK.

If the product is not eligible for 340B pricing do not include the basis of cost determination or submission clarification code values and bill at the regular Medicaid rate.

(2) 340B Contract Pharmacies

Contract pharmacies may not submit claims to Medicaid FFS for 340B-acquired drugs. A 340B contract pharmacy must **carve out** Medicaid FFS from its 340B operation.

12. Interpreter Services

Translation and interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for your pharmacy. The services must facilitate access to Medicaid covered services.

In order for translation and interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services.
- Interpreters may be employed or contracted by the billing provider.
- The interpretive services must facilitate access to Medicaid-covered services.

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services. Reimbursable time may include the interpreter's travel and wait time.

a. Documentation of the Service

The billing provider must document in the patient's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- The cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code Chapter 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care (www.ncihc.org)

The following are instructions for billing interpretive services when that service is provided by an outside commercial translation service.

- Bill code T1013 on the professional CMS-1500 claim form:
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at $1.70 per minute.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- Enter the number of minutes actually used for the provision of the service.
- Special note: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is NOT used and the units exceed 24 will be paid at 24 units.

G. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting. To view a sample of this form on line, click here.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid claims and denied claims:

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit less the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

A detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact IME Provider Services with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Field Descriptions

	Field Name	Field Description
A	R.A. No.	*Remittance Advice* number
B	Warrant Number	Check number (usually zeros). Contact IME for check number.
C	Provider Name	Name of the pay-to provider as registered with IME
D	Provider Address	Address registered with IME for the mailing of *Remittance Advice* and paper checks
E	Important IME Information	Reminders and updates from IME
F	Run Date	Date the *Remittance Advice* was created
G	Date Paid	Date the *Remittance Advice* was mailed and check was released
H	Prov. Number	National provider identifier (NPI) of the billing (pay-to) provider
I	Page	Page number

	Field Name	Field Description
J	Number of Claims	Number of claims processed for each defined status
K	Billed Amount of All Claims	Total dollar amount of claims billed for each defined status
L	Subtotal Amount Paid	Amount paid for each defined status
M	Amount of Deposit	Total check amount for claims paid on this *Remittance Advice*
N	EOB Code	Explanation of benefits (EOB) code or denial code
O	EOB Description	Description of the denial EOB
P	Number of Claims Posting EOB	Number of claims that denied for the EOB code described
Q	Total Billed Amt.	Total amount billed to Iowa Medicaid for claims in this status section
R	Total Other Sources	Third party insurance payment or spenddown amount applied for claims in this status section
S	Total Paid by Mcaid	Total amount paid by Medicaid for claims in this status section
T	Copay Amt.	Members' copayment amount (applied per date of service, when applicable) for claims in this status

1	Patient Name	Name of the member as shown on the Medical Assistance Eligibility Card (last name and first initial)
2	Recipient Ident Num	Member identification number (7 digits+letter)
3	Trans-Control-Number	17-digit transaction control number assigned to each claim
4	Dispense Date	Date of service
5	National Drug Code	11-digit NDC number
6	Sub Units	Number of units billed
7	Rx No.	Prescription number
8	Billed Amt.	Total amount billed to Iowa Medicaid for this claim
9	Other Sources	Third party insurance payment or spenddown amount applied to this claim
10	Paid by Mcaid	Total amount paid by Medicaid on this claim
11	Copay Amt.	Member's copay amount (applied per date of service, when applicable)

	Field Name	Field Description
12	Source of Payment	Allowed charge source codes are as follows: A Anesthesia B Billed charge C Percentage of charges D Inpatient per diem rate E EAC priced plus dispense fee F Fee schedule G FMAC priced plus dispense fee H Encounter rate I Prior authorization rate K Denied L Maximum suspend ceiling M Manually priced N Provider charge rate O Professional component P Group therapy Q EPSDT total over 17 R EPSDT total under 18 S EPSDT partial over 17 SP Not yet priced T EPSDT partial under 18 U Gynecology fee V Obstetrics fee W Child fee X Medicare or coinsurance deductibles Y Immunization replacement Z Batch bill APG 0 APG 1 No payment APG 3 HMO/PHP rate 4 System parameter rate 5 Statewide per diem 6 DRG auth or new 7 Inlier/outlier adjust 8 DRG ADR inlier 9 DRG ADR
13	EOB	Explanation of benefits (EOB) code, if denied. A description of the code can be found on the summary page of the *Remittance Advice* (Field O).

	Field Name	Field Description
14	Practitioner	Name of prescribing provider
15	Drug Name	Name and dosage of drug dispensed
16	Adj-R	Reason code indicating the reason for the adjustment
17	TCN-to-Credit	17-digit TCN number of the claim being credited