Department of HUMAN SERVICES

For Human Services use only:

General Letter No. 8-AP-490
Employees' Manual, Title 8
Medicaid Appendix

August 1, 2020

PRESCRIBED DRUGS MANUAL TRANSMITTAL NO.

ISSUED BY: Division of Medical Services

SUBJECT: ***Prescribed Drugs Manual, Provider-Specific Policies*** Contents Page 1, revised; pages 9 and 13, revised; pages 18, 19, 20, 21, 26, 50, revised; and the following forms:

470-5259	*Request for Prior Authorization: Anti-Diabetic Non-Insulin Agents*, revised
470-4095	*Request for Prior Authorization: Antihistamines*, revised
470-5600	*Request for Prior Authorization: Aripiprazole Tablets with Sensor (Abilify MyCite)*, new
470-4117	*Request for Prior Authorization: Benzodiazepines*, revised
470-4522	*Request for Prior Authorization: Biologicals for Arthritis*, revised
470-4524	*Request for Prior Authorization: Biologicals for Plaque Psoriasis*, revised
470-5142	*Request for Prior Authorization: Buphrenorphine/Naloxone*, obsolete
470-5591	*Request for Prior Authorization: Cannabidiol (Epidiolex)*, new
470-5554	*Request for Prior Authorization: CGRP Inhibitors*, revised
470-4551	*Request for Prior Authorization: Chronic Pain Syndromes*, revised
470-4116	*Request for Prior Authorization: CNS Stimulants and Atomoxetine*, revised
470-5015	*Request for Prior Authorization: Dalfampridine (Ampyra)*, revised
470-5330	*Request for Prior Authorization: Deferasirox*, revised
470-5497	*Request for Prior Authorization: Dupilumab (Dupixent)*, revised
470-5410	*Request for Prior Authorization: Eluxadoline (Viberzi)*, revised
470-4098	*Request for Prior Authorization: Erythropoiesis Stimulating Agents*, revised
470-4849	*Request for Prior Authorization: Febuxostat (Uloric)*, revised
470-4099	*Request for Prior Authorization: Granulocyte Colony Stimulating Factor*, revised

470-4100	*Request for Prior Authorization: Growth Hormones*, revised
470-4850	*Request for Prior Authorization: Hematopoietics / Chronic ITP*, revised
470-5040	*Request for Prior Authorization: Immunomodulators-Topical*, revised
470-4111	*Request for Prior Authorization: Insulin*, *Pre-Filled Pen,* revised
470-5175	*Request for Prior Authorization: Janus Kinase (JAK) Inhibitors*, revised
470-4898	*Request for Prior Authorization: Lidocaine Patch*, revised
470-5435	*Request for Prior Authorization: Lupron Depot- Adult*, revised
470-5424	*Request for Prior Authorization: Mepolizumab (Nucala)*, revised
470-4705	*Request for Prior Authorization: Modified Formulations*, revised
470-5060	*Request for Prior Authorization: Multiple Sclerosis Agents*, revised
470-4105	*Request for Prior Authorization: Muscle Relaxants*, revised
470-4107	*Request for Prior Authorization: Non-Parenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products*, revised
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
470-5601	*Request for Prior Authorization: Ospemifene (Osphena)*, new
470-5399	*Request for Prior Authorization: PCSK9 Inhibitors*, revised
470-4327	*Request for Prior Authorization: Pulmonary Arterial Hypertension Agents*, revised
470-4328	*Request for Prior Authorization: Sedative/Hypnotics Non-Benzodiazepine*, revised
470-4113	*Request for Prior Authorization: Serotonin 5-HT-1 Receptor Agonists*, revised
470-4899	*Request for Prior Authorization: Short Acting Opioids*, revised
470-5188	*Request for Prior Authorization: Testosterone Products*, revised
470-5426	*Request for Prior Authorization: Topical Acne and Rosacea Products*, 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 3 forms for requesting drug prior authorization.
- Remove the following form for requesting drug prior authorization:
  - 470-5142, Request for Prior Authorization: Buprenorphine/naloxone
- Add automatic refill policy.
- Add requirement of ensuring billing to correct Medicaid ID.
- Update prescriber guideline of prescribing one-month supply of prescription and nonprescription medication.
- Add one-time dispensing fee for maintenance medications.
- Update age edit chart.

Date Effective

Upon receipt.

Material Superseded

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

Page	Date
Chapter III	
Contents Page 1	August 1, 2019
9, 13,	August 1, 2018
18, 19, 20, 21, 26, 50	August 1, 2019
470-4095	6/14
470-4098	1/19
470-4099	6/19
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470-4105	10/11
470-4107	6/16
470-4109	1/19
470-4111	1/19
470-4113	6/18
470-4116	6/19
470-4117	7/15
470-4327	1/19
470-4328	6/19
470-4522	6/19
470-4524	6/19
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470-4849	11/09
470-4850	6/19
470-4898	4/18
470-4899	7/19
470-5015	1/19
470-5040	6/19
470-5060	1/19

470-5142	7/19
470-5174	6/19
470-5175	1/19
470-5188	6/19
470-5259	6/19
470-5330	10/16
470-5399	1/19
470-5410	1/19
470-5423	6/19
470-5424	10/16
470-5426	6/19
470-5435	1/17
470-5497	1/18
470-5534	1/19
470-5554	1/19
470-5591	10/19
470-5600	1/20
470-5601	1/20

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.

Page

- Develop and implement policies and procedures for delivery of prescriptions in accordance with state law, including:
  - Establishment of effective controls against diversion of prescription drugs, as required by Iowa Code § 155A.15(2)(i); and
  - Policies and procedures regarding shipment or other delivery to ensure accountability, safe delivery, and compliance with temperature requirements, as required by 657 Iowa Administrative Code 8.15(2).
  - Maintain a record documenting receipt and delivery of the covered outpatient prescribed drug to the Medicaid member or the member's representative, as required by 441 IAC 79.3(1)"a"(2) and 79.3(2)"c"(3).
- Automatic refills are not allowed. A request specific to each medication is required. All prescription refills should be initiated by a request at the time of fill by the prescriber, Medicaid member or agent of the member, based on continued medical necessity.
- Ensure only medications prescribed to that beneficiary are billed using the beneficiary's identification (ID) number. If medications are needed to treat remaining family members, each prescription must be billed accordingly to each family member's Medicaid ID number.

c. Patient Counseling

Pharmacists must offer to discuss with each Medicaid member or the member's caregiver presenting a prescription those matters that, in the pharmacist's professional judgment, will enhance or optimize drug therapy. Appropriate elements of patient counseling may include:

- The name and description of the drug
- The dosage form, dose, administration route and duration of therapy
- The intended use of the drug, if known and expected action
- Directions and precautions for preparation, administration, and use
- Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance and the action required if they occur
- Techniques for self-monitoring drug therapy
- Proper storage

a. Prescriber Qualifications

Payment is made for drugs prescribed by a legally qualified enrolled practitioner within the limits prescribed by law and in policies established by the Department.

Prescriptions by a therapeutically certified optometrist are limited to the following:

- Topical and oral antimicrobial agents
- Topical and oral antihistamines
- Topical and oral antiglaucoma agents
- Topical and oral analgesic agents, including controlled substances
- Topical anesthetic agents
- Topical anti-inflammatory agents

b. Prescriber Guidelines

Prescribers should review the therapy of their Medicaid patients for utilization of nonpreferred drugs and wherever medically appropriate, change patients to preferred drugs. New therapy should be initiated on a preferred drug unless a nonpreferred drug is medically necessary.

When a nonpreferred drug is medically necessary, the prescriber should request a prior authorization. See PRIOR AUTHORIZATION REQUIREMENTS for information on criteria for prior authorization and procedures.

In writing prescriptions, when it is not therapeutically contraindicated, the prescriber should prescribe a quantity of prescription medication not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three month quantities.

2. Drugs Excluded From Coverage

Medicaid payment will **not** be made for:

- Drugs used to cause anorexia, weight gain or weight loss.
- Drugs used for cosmetic purposes or hair growth.
- Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed in section B.7.

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)
- Aripiprazole Tablets with Sensor (Abilify MyCite)
- 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
- Calcifediol (Rayaldee)
- Cannabidiol (Epidiolex)

- CGRP inhibitors
- 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
- Fifteen Day Initial Prescription Supply Override
- GLP-1 Agonist/Basal Insulin Combinations
- Granulocyte colony stimulating factor agents
- Growth hormones
- Hematopietics/Chronic ITP
- 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

- Mepolizumab (Nucala)
- Methotrexate injection
- Miconazole-zinc oxide-white petrolatum (Vusion)
- 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
- Ospemifene (Osphena)
- 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)
- 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)

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**

Additional 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*.

- 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.

A one-time professional dispensing fee will be reimbursed per one-month or three-month period, accounting for the refill tolerance of 90% consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

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).

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.
Buprenorphine Sublingual tablet	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
Buprenorphine/Naloxone Sublingual tablet	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.

Iowa Department of Human Services

Request for Prior Authorization
ANTIHISTAMINES-ORAL

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must 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 oral antihistamines.
Patients 21 years of age and older must have three unsuccessful trials with oral antihistamines that do not require prior authorization, prior to the approval of a non-preferred oral antihistamine. Two of the trials must be with cetirizine and loratadine.
Patients 20 years of age and younger must have an unsuccessful trial with cetirizine and loratadine prior to the approval of a non-preferred oral antihistamine. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred 1st Generation Antihistamines (no PA required)

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

Non- Preferred 1st Generation Antihistamines (PA required)

- ☐ Carbinoxamine Maleate
- ☐ Clemastine Fumarate
- ☐ Dexchlorpheniramine maleate

Preferred 2nd Generation OTC Antihistamines (no PA required)

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

Non-Preferred 2nd Generation Antihistamines (PA required)

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

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

Diagnosis:_____

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

_____

_____

Medical or contraindication reason to override trial requirements:_____

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

Attach lab results and other documentation as necessary.

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

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

Iowa Department of Human Services

Request for Prior Authorization
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
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 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
☐ Epogen ☐ Retacrit

Non-Preferred
☐ Aranesp ☐ Procrit
☐ Mircera

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

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
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
☐ Neupogen

Non-Preferred
☐ Fulphila ☐ Leukine ☐ Nivestym ☐ Zarxio
☐ Granix ☐ Neulasta ☐ Udenyca

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

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
GROWTH HORMONES

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 therapy with growth hormones. Requests will only be considered for FDA approved dosing. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. The following FDA approved indications for Growth Hormone therapy are considered not medically necessary and requests will be denied; Idiopathic Short Stature (ISS) and Small for Gestational Age (SGA). If the criteria for coverage are met, initial requests will be given for 12-months, unless otherwise stated in criteria. Additional prior authorizations will be considered upon documentation of clinical response to therapy and patient continues to meet the criteria for the submitted diagnosis.

Preferred
- ☐ Norditropin
- ☐ Nutropin AQ Pen
- ☐ Nutropin AQ NuSpin

Non- Preferred
- ☐ Genotropin
- ☐ Humatrope
- ☐ Omnitrope
- ☐ Saizen
- ☐ Tev-Tropin
- ☐ Zorbtive

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Number of vials per month: _____ Estimate length of therapy: _____

Previous Growth Hormone Therapy (include drug name(s), strength, and exact date ranges): _____

_____

_____

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

_____

☐ **Children with Growth Hormone Deficiency**

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

Iowa Department of Human Services

Request for Prior Authorization
GROWTH HORMONES

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No

Height:_____ Weight:_____ Height percentile at time of diagnosis:_____ Weight percentile:_____

Is standard deviation 2.0 or more below mean height for chronological age? ❑ Yes ❑ No

MRI diagnosis: _____ Date:_____

Growth rate per year _____

Pertinent Medical History including growth pattern, diagnostic test, treatment plan, and response so far: _____

_____

Please provide 2 stimuli tests and results:

_____

_____

☐ **Pediatric Chronic Kidney Disease**

1.Is prescribed by or in consultation with a nephrologist; and
2.Standard deviation of 2.0 or more below mean height for chronological age; and
3. No expanding intracranial lesion or tumor diagnosed by MRI; and
4. Growth rate below five centimeters per year; and
5. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
6. Epiphyses open.

Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No

Height:_____ Weight:_____ Height percentile at time of diagnosis:_____ Weight percentile:_____

Is standard deviation 2.0 or more below mean height for chronological age? ❑ Yes ❑ No

MRI diagnosis: _____ Date:_____

Growth rate per year _____

Is prescriber a nephrologist? ☐ Yes ☐ No If no, note consultation with nephrologist:

Consultation date:_____ Physician name & phone:_____

☐ **Turner's Syndrome**

1.Chromosomal abnormality showing Turner's syndrome; and
2. Prescribed by or in consultation with an endocrinologist; and
3.Standard deviation of 2.0 or more below mean height for chronological age; and
4. No expanding intracranial lesion or tumor diagnosed by MRI; and
5. Growth rate below five centimeters per year; and
6. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
7. Epiphyses open.

Chromosomal abnormality showing Turner's syndrome? ☐ Yes (attach results) ☐ No

Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No

Height:_____ Weight:_____ Height percentile at time of diagnosis:_____ Weight percentile:_____

Is standard deviation 2.0 or more below mean height for chronological age? ❑ Yes ❑ No

MRI diagnosis: _____ Date:_____

Growth rate per year _____

Is prescriber an endocrinologist? ☐ Yes ☐ No If no, note consultation with endocrinologist:

Consultation date:_____ Physician name & phone:_____

Iowa Department of Human Services

Request for Prior Authorization
GROWTH HORMONES

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Prader Willi Syndrome**
1.Diagnosis is confirmed by appropriate genetic testing (attach results); and
2. Prescribed by or in consultation with an endocrinologist; and
3. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
4. Epiphyses open.

Diagnosis confirmed by genetic testing? ☐ Yes (attach results) ☐ No
Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No
Is prescriber an endocrinologist? ☐ Yes ☐ No If no, note consultation with endocrinologist:

Consultation date:_____ Physician name & phone:_____

☐ **Noonan Syndrome**
1.Diagnosis is confirmed by appropriate genetic testing (attach results); and
2. Prescribed by or in consultation with an endocrinologist; and
3. Standard deviation of 2.0 or more below mean height for chronological age; and
4. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
5. Epiphyses open.

Diagnosis confirmed by genetic testing? ☐ Yes (attach results) ☐ No
Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No
Is prescriber an endocrinologist? ☐ Yes ☐ No If no, note consultation with endocrinologist:

Consultation date:_____ Physician name & phone:_____

Height:_____ Weight:_____ Height percentile at time of diagnosis:_____ Weight percentile:_____
Is standard deviation 2.0 or more below mean height for chronological age? ❑ Yes ❑ No

☐ **SHOX (Short Stature Homeobox)**
1.Diagnosis is confirmed by appropriate genetic testing (attach results); and
2. Prescribed by or in consultation with an endocrinologist; and
3. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
4. Epiphyses open.

Diagnosis confirmed by genetic testing? ☐ Yes (attach results) ☐ No
Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No
Is prescriber an endocrinologist? ☐ Yes ☐ No If no, note consultation with endocrinologist:

Consultation date:_____ Physician name & phone:_____

Iowa Department of Human Services

Request for Prior Authorization
GROWTH HORMONES

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Adults with Growth Hormone Deficiency**

1. Patients who were growth hormone deficient during childhood (childhood onset) and who have continued deficiency; or
2. Patients who have growth hormone deficiency (adult onset) as a result of pituitary or hypothalamic disease (e.g. panhypopituitarism, pituitary adenoma, trauma, cranial irradiation, pituitary surgery); and
3. Failure of at least one growth hormone stimulation test as an adult with a peak growth hormone value of ≤ 5 mcg/L after stimulation.

- o Childhood Onset
- o Adult Onset: provide pituitary or hypothalamic disease diagnosis: _____

Please provide stimuli test, date and result: _____

☐ **Adults with AIDS Wasting/Cachexia**

1. Greater than 10% of baseline weight loss over 12 months that cannot be explained by a concurrent illness other than HIV infection; and
2. Patient is currently being treated with antiviral agents; and
3. Patient has documentation of a previous trial and therapy failure with an appetite stimulant (i.e. dronabinol or megestrol).

Has patient experienced > 10% weight loss over 12 months?

☐ Yes Baseline weight & date:_____ Current weight & date: _____ ☐ No

Does patient have concurrent illness other than HIV infection contributing to weight loss? ❑ Yes ❑ No

Current antiviral treatment: Drug name, dosing & trial dates: _____

_____

Appetite stimulant trial:

Drug Name and Dose: _____ Trial dates: _____

Failure reason: _____

☐ **Short Bowel Syndrome**

If the request is for Zorbtive [somatropin (rDNA origin) for injection] approval will be granted in patients receiving specialized nutritional support. Zorbtive therapy should be used in conjunction with optimal management of Short Bowel syndrome. PA will be considered for a maximum of 4 weeks.

Provide nutritional support plan: _____

_____

☐ **Renewals (in addition to above criteria)**

Clinical response to therapy: _____

_____

_____

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
MUSCLE RELAXANTS

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 muscle relaxants. Payment for non-preferred muscle relaxants is authorized only for cases where there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. ×If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.

Preferred

Baclofen
Chlorzoxazone
Cyclobenzaprine
Methocarbamol
Orphenadrine ER/CR
Tizanidine

Non-Preferred

- ☐ Amrix×
- ☐ Carisoprodol
- ☐ Carisoprodol/ASA
- ☐ Carisoprodol/ASA/Codeine
- ☐ Cyclobenzaprine ER×
- ☐ Dantrium
- ☐ Skelaxin
- ☐ Soma
- ☐ Zanaflex
- ☐ Other **(specify)**_____

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

Diagnosis:_____

Preferred Trial 1: Drug Name_____ Strength_____ Dosage Instructions_____

Trial date from:_____ Trial date to:_____

Specify failure:_____

Preferred Trial 2: Drug Name_____ Strength_____ Dosage Instructions_____

Trial date from:_____ Trial date to:_____

Specify failure:_____

Preferred Trial 3: Drug Name_____ Strength_____ Dosage Instructions_____

Trial date from:_____ Trial date to:_____

Specify failure:_____

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: _____ 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

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

Request for Prior Authorization
NON-PARENTERAL VASOPRESSIN DERIVATIVES OF POSTERIOR PITUITARY HORMONE PRODUCTS

(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-parenteral vasopressin derivatives of posterior pituitary hormone products. No PA is required for members 6 years of age or older when dosed within established quantity limits for desmopressin acetate tablets. Payment for preferred non-parenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses: 1. Diabetes Insipidus, 2. Hemophilia A, and 3. Von Willebrand's disease.
Requests for desmopressin nasal spray for the treatment of nocturnal enuresis will not be considered. Payment for non-preferred non-parenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial(s) and therapy failure with the preferred agent(s). Please refer to the Selected Brand-Name Drugs prior authorization form if requesting a non-preferred brand-name product.

Preferred
- ☐ Desmopressin Nasal Solution
- ☐ Desmopressin Nasal Spray
- ☐ Desmopressin Tablets
- ☐ Stimate Nasal Spray

Non-Preferred
- ☐ DDAVP Acetate Nasal Solution
- ☐ DDAVP Acetate Nasal Spray
- ☐ DDAVP Tablets

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

Diagnosis:
- ☐ **Diabetes insipidus**
- ☐ **Hemophilia A**
- ☐ **Von Willebrand's disease**
- ☐ **Other** (please specify)_____
- ☐ **Nocturnal enuresis***

*If **nocturnal enuresis**, is patient 6 years old or older? ❑ Yes ❑ No

Please specify exact date range of last drug-free interval: From: _____To:_____

Previous 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

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
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)
Naproxen Tab
Naproxen EC/ER
Naproxen Sod 550mg
Salsalate
Sulindac
Voltaren Gel

Non-Preferred (PA required for all products)

☐ Arthrotec
☐ Celebrex
☐ Celecoxib
☐ Diclofenac ER/XR*
☐ Diclofenac Epolamine
☐ EC-Naprosyn
☐ Etodolac CR/ER/XR
☐ Fenoprofen
☐ Flector Patch
☐ indomethacin ER*
☐ ketoprofen ER
☐ Meclofenamate Sod
☐ Naprelan
☐ Naproxen Susp
☐ Oxaprozin
☐ Pennsaid
☐ Piroxicam
☐ Qmiiz ODT
☐ Tivorbex
☐ Tolmetin Sod
☐ Vivlodex
☐ 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
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)

☐ Humulin R U-500 Kwikpen ☐ Insulin Lispro KwikPen ☐ Lantus SoloSTAR

☐ Levemir FlexTouch ☐ Novolog FlexPen/PenFill ☐ Novolog Mix Flexpen

PA Required:

Non-Preferred (available in vial)

☐ Admelog SoloSTAR
☐ Apidra SoloSTAR
☐ Fiasp FlexTouch
☐ Humalog KwikPen
☐ Humulin Mix 50/50 Pen
☐ Humulin Mix 75/25 Pen
☐ Humulin N KwikPen
☐ Humulin 70/30 KwikPen
☐ Tresiba Flextouch

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
SEROTONIN 5-HT1 RECEPTOR AGONISTS

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 preferred serotonin 5-HT1-receptor agonists for quantities exceeding 12 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. * Requests for non-preferred combination products may only be considered after documented separate trials and therapy failures with the individual ingredients. For consideration, the following information must be supplied: 1. The diagnosis requiring therapy. 2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

Preferred (PA required after 12 doses in 30 days)

- ☐ Naratriptan
- ☐ Rizatriptan ODT
- ☐ Rizatriptan Tablets
- ☐ Sumatriptan Inj
- ☐ Sumatriptan Nasal Spray
- ☐ Sumatriptan Tablets
- ☐ Zomig NS

Non- Preferred (PA required from Day 1)

- ☐ Almotriptan
- ☐ Amerge
- ☐ Axert
- ☐ Eletriptan
- ☐ Frova
- ☐ Frovatriptan
- ☐ Imitrex Inj/NS/Tabs
- ☐ Maxalt
- ☐ Maxalt MLT
- ☐ Onzetra Xsail
- ☐ Relpax
- ☐ Sumatriptan-Naproxen*
- ☐ Tosymra
- ☐ Treximet*
- ☐ Zembrace
- ☐ Zolmitriptan
- ☐ Zomig Tabs
- ☐ Zomig ZMT

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:_____

If Migraine, please **document the current prophylactic therapy or 2 previous trials and therapy failures with two different prophylactic medications** including drug names, strength, exact date ranges and failure reasons:

_____

_____

Medical or contraindication reason to override trial requirements: _____

Previous migraine therapy (include drug/dose/duration):_____

_____

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
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
- ☐ Armodafinil
- ☐ Atomoxetine
- ☐ Dexmethylphenidate ER Caps
- ☐ Dexmethylphenidate Tabs
- ☐ Dextroamphetamine ER Caps
- ☐ Dextroamphetamine Tabs
- ☐ Methylin Solution
- ☐ Methylphenidate IR Tabs
- ☐ Methylphenidate ER Tabs
- ☐ Methylphenidate Solution
- ☐ Modafinil
- ☐ Quillichew ER
- ☐ Quillivant XR
- ☐ Vyvanse

Non-Preferred
- ☐ Adderall
- ☐ Adderall XR
- ☐ Adhansia XR*
- ☐ Adzenys ER Susp
- ☐ Adzenys XR ODT
- ☐ Amphetamine Sulfate Tabs
- ☐ Aptensio XR*
- ☐ Concerta
- ☐ Cotempla*
- ☐ Daytrana
- ☐ Desoxyn
- ☐ Dexedrine
- ☐ Dyanavel XR
- ☐ Evekeo
- ☐ Focalin
- ☐ Focalin XR
- ☐ Jornay PM
- ☐ Methylphenidate CD*
- ☐ Methylphenidate Chew
- ☐ Methylphenidate ER 72mg Tabs
- ☐ Methylphenidate ER Caps*
- ☐ Methylphenidate LA Caps*
- ☐ Mydayis*
- ☐ Nuvigil
- ☐ Procentra
- ☐ Provigil
- ☐ Ritalin
- ☐ Ritalin LA*
- ☐ Strattera
- ☐ Sunosi

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:

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

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

_____

Children: Provide medical necessity for the need of more than one unit 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
BENZODIAZEPINES

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 benzodiazepines. Payment for non-preferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. Prior authorization will be approved for up to 12 months for certain documented diagnoses and a 3 month period for all other diagnoses. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determine if the use of a benzodiazepine is appropriate for this member. For patients taking concurrent opioids, the prescriber must document the following: 1) The risks of using opioids and benzodiazepines concurrently has been discussed with the patient. 2) Documentation as to why concurrent use is medically necessary is provided. 3) A plan to taper the opioid or benzodiazepine is provided, if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

- ☐ Alprazolam
- ☐ Chlordiazepoxide
- ☐ Clobazam
- ☐ Clonazepam
- ☐ Clorazepate
- ☐ Diazepam
- ☐ Estazolam
- ☐ Flurazepam
- ☐ Lorazepam
- ☐ Oxazepam
- ☐ Temazepam 15 & 30mg

Non-Preferred

- ☐ Ativan
- ☐ Alprazolam ER
- ☐ Alprazolam ODT
- ☐ Clonazepam ODT
- ☐ Dalmane
- ☐ Doral
- ☐ Halcion
- ☐ Klonopin
- ☐ Klonopin Wafers
- ☐ Librium
- ☐ Onfi
- ☐ Restoril
- ☐ Sympazan
- ☐ Temazepam 7.5/22.5mg
- ☐ Tranzene
- ☐ Triazolam
- ☐ Xanax
- ☐ Xanax XR

☐ Other **(specify)**_____

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

Diagnosis:

- ❑ **Generalized anxiety disorder**
- ❑ **Panic attack with or without agoraphobia**
- ❑ **Seizure**
- ❑ **Other (please specify)** _____
- ❑ **Non-progressive motor disorder**
- ❑ **Dystonia**

Trial 1 with preferred agent: Drug Name_____ Strength_____

Dosage instructions_____ Trial Date from_____ Trial Date to_____

Trial 2 with preferred agent: Drug Name_____ Strength_____

Dosage instructions_____ Trial Date from_____ Trial Date to_____

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

☐ No ☐ Yes Date Reviewed:_____

Is benzodiazepine use appropriate for patient based on PMP review ? ☐ No ☐ Yes

Iowa Department of Human Services

Request for Prior Authorization
BENZODIAZEPINES

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Patients taking concurrent opioids:

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 opioid or benzodiazepine or medical rationale why not appropriate: _____

_____

_____

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
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

- ☐ Ambrisentan
- ☐ Epoprostenol
- ☐ Sildenafil
- ☐ Tadalafil
- ☐ Tracleer
- ☐ Ventavis

Non-Preferred

- ☐ Adcirca
- ☐ Adempas
- ☐ Bosentan
- ☐ Flolan
- ☐ Letairis
- ☐ Opsumit
- ☐ Orenitram
- ☐ Remodulin
- ☐ Revatio
- ☐ Sildenafil Susp
- ☐ Tracleer SolTab
- ☐ Trepostinil
- ☐ 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	**Non-Preferred**			
☐ Eszopiclone	☐ Ambien	☐ Edluar	☐ Ramelteon	☐ Zolpidem ER
☐ Zaleplon	☐ Ambien CR	☐ Intermezzo	☐ Rozerem	☐ Zolpidem SL Tab
☐ Zolpidem	☐ Belsomra	☐ Lunesta	☐ Sonata	☐ 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: _____

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
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

☐ Cimzia ☐ Skyrizi ☐ Taltz
☐ Siliq ☐ 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
CHRONIC PAIN SYNDROMES

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 pregabalin (Lyrica®) and milnacipran (Savella™). These drugs will be considered for their FDA indication(s) and other conditions as listed in the compendia. Requests for doses above the manufacturer recommended dose will not be considered. The trial examples below are not an all inclusive list. Please refer to the Preferred Drug List (PDL) located at www.iowamedicaidpdl.com for a complete list of preferred drugs in these therapeutic classes. For patients with a chronic pain diagnosis who are currently taking opioids, as seen in pharmacy claims, a plan to decrease and/or discontinue the opioid(s) must be provided with the initial request. Initial authorization will be given for three (3) months. Requests for renewal must include an updated opioid treatment plan and documentation of improvement in symptoms and quality of life. Requests for non-preferred brand drugs, when there is a preferred A-rated bioequivalent generic product available, are also subject to the Selected Brand Name prior authorization criteria and must be included with this request. Payment will be considered under the following conditions:

Preferred (no PA required within quantity limit)
☐ Duloxetine

Non-Preferred
☐ Cymbalta ☐ Lyrica ☐ Savella

Preferred (PA required)
☐ Pregabalin

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

☐ **Fibromyalgia (*Lyrica® or Savella™*):** A diagnosis of fibromyalgia with the following documented trials:

a) A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following preferred generic agents: tricyclic antidepressant (amitriptyline, nortriptyline) or SNRI (duloxetine, venlafaxine er).

Gabapentin Trial Dose: _____Trial start date: _____ Trial end date: _____

Reason for Failure: _____

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

Reason for Failure: _____

b) Documented non-pharmacologic therapies (such as cognitive behavior therapies, exercise, etc,)

Non-Pharmacological Treatments Tried: _____

Request for Prior Authorization-*Continued*
CHRONIC PAIN SYNDROMES

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Post-Herpetic Neuralgia (*Lyrica*®):** A diagnosis of post-herpetic neuralgia with the following documented trials:

A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant (amitriptyline, nortriptyline), topical lidocaine, or valproate. .

Gabapentin Trial Dose: _____Trial start date: _____ Trial end date: _____

Reason for Failure: _____

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

Reason for Failure: _____

☐ **Diabetic Peripheral Neuropathy (*duloxetine or Lyrica*®):** A diagnosis of diabetic peripheral neuropathy with the following documented trials:

A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant (amitriptyline, nortriptyline) or duloxetine.

Gabapentin Trial Dose: _____Trial start date: _____Trial end date: _____

Reason for Failure: _____

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

Reason for Failure: _____

☐ **Partial Onset Seizures, as adjunct therapy (*Lyrica*®)**

☐ **Neuropathic Pain associated with spinal cord injury (*Lyrica*®)**

☐ **Other Diagnosis of Use:**_____

Must complete for chronic pain diagnosis:

Initial Requests:

Does the member have current opioid use? ☐ Yes Name/Dose:_____ ☐ No

If yes, provide specific plan, including time line, to decrease and/or discontinue opioid use: _____

_____

Renewal Requests:

Does the member have current opioid use? ☐ Yes Name/Dose:_____ ☐ No

If yes, provide updated opioid treatment plan: _____

_____

Document improvement in symptoms and quality of life: _____

_____

Other relevant information: _____

Attach lab results and other documentation as necessary.

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

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

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
MODIFIED FORMULATIONS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

Payment for a non-preferred isomer, prodrug or metabolite will be considered when the following criteria are met: 1) Previous trial with a preferred parent drug of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance and 2) Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis if available. The required trials may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.

☐ Horizant (trial of gabapentin) ☐ Invega / Paliperidone ER (trial of risperidone) ☐ Trilipix (trial of Tricor)

☐ Xopenex HFA / levalbuterol tartrate (trial of albuterol HFA) ☐ Xopenex Nebs / levalbuterol nebs (trial of albuterol nebs)

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

☐ Abilify Discmelt (Abilify soln) ☐ Aricept ODT (Aricept tabs) ☐ Baqsimi (Glucagen) ☐ Binosto (alendronate tabs)

☐ Clozapine ODT / Fazaclo (clozapine tabs) ☐ Ezallor (rosuvastatin tabs) ☐ Lamotrigine ODT (lamotrigine chew tabs)

☐ Metoclopramide ODT (metoclopramide soln) ☐ Remeron SolTab (mirtazapine tabs)

☐ Risperdal M-Tab (risperidone soln) ☐ Sitavig (acyclovir oral susp) ☐ Spritam (levetiracetam soln)

☐ Sympazan (clobazam susp) ☐ Zyprexa Zydis (Zyprexa tabs)

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

Diagnosis: _____

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

Failure Reason: _____

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

Failure Reason: _____

Medical Necessity for alternative delivery system: _____

Failure Reason of preferred alternative delivery system: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

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

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

Iowa Department of Human Services

Request for Prior Authorization
FEBUXOSTAT (ULORIC®)

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 febuxostat (*Uloric*®). Payment for febuxostat (*Uloric*®) will only be considered for cases in which symptoms of gout still persist while currently using 300mg per day of a preferred allopurinol product unless documentation is provided that such a trial would be medically contraindicated.

Non-Preferred

☐ Febuxostat ☐ Uloric

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

Diagnosis: _____

Treatment failure with allopurinol:

Trial Drug Name: _____ Trial Drug Strength: _____

Trial start date: _____ Trial end date: _____

Reason for failure: _____

_____

Possible drug interactions/conflicting drug therapies:_____

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.

470-4849 (Rev. 1/20)

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
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 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) (Doptelet, 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
LIDOCAINE PATCH

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

Prior authorization is required for topical lidocaine patches. Payment will be considered only for cases in which there is a diagnosis of pain associated with post-herpetic neuralgia. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.

Preferred
☐ Lidocaine 5% Patch

Non-Preferred
☐ Lidoderm

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

Diagnosis: _____

Other relevant information: _____
_____

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
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
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
- ☐ Meperidine
- ☐ 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

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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**

☐ Dalfampridine ER ☐ Ampyra

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**

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Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR FIFTEEN DAY INITIAL PRESCRIPTION SUPPLY OVERRIDE
This form is used for both preferred and non-preferred agents
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

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

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Designated drugs are limited to a fifteen day initial supply. These drugs have been identified with high side effect profiles, high discontinuation rates, or frequent dose adjustments. The initial prescription supply limit ensures cost effectiveness without waste of unused medications. These drugs are identified on the Fifteen Day Initial Prescription Supply Limit list located on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab. Documentation of medical necessity, excluding patient convenience, is required for consideration of the fifteen day initial supply override.

Drug Name	**Strength**	**Dosing Instructions**	**Quantity**
_____	_____	_____	_____

Diagnosis:_____

Medical Necessity Documentation:

Please note: reasons other than patient convenience are required.

_____

_____

_____

_____

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
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
☐ Pimecrolimus ☐ Protopic

Non-Preferred
☐ Elidel ☐ 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
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) Request is for FDA approved dosing; and 4) A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis; and 5) 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 **Non-Preferred**

☐ Aubagio ☐ Gilenya ☐ Tecfidera ☐ Mavenclad ☐ Mayzent

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: _____

For patients initiating therapy with cladribine (Mavenclad):

- Patient's current weight; Weight: _____ Date obtained: _____
- Does patient have a current malignancy; ☐ Yes ☐ No
- Patient is up to date on all age appropriate malignancy screening; ☐ Yes ☐ No
- Pregnancy has been excluded in females of reproductive potential: ☐ Yes ☐ No
- Women and men of reproductive potential have been advised to use contraception during treatment and for 6 months after the last dose in each treatment course; ☐ Yes ☐ No
- Women have been instructed to not breastfeed while being treated and for 10 days after the last dose:
  ☐ Yes ☐ No
- Does patient have HIV infection; ☐ Yes ☐ No
- Does patient have an active chronic infection (e.g. hepatitis or tuberculosis); ☐ Yes ☐ No
- No more than two yearly treatment courses (i.e. two treatment courses consisting of two treatment cycles) will be considered.
  Document patient's prior treatment, if applicable: _____

  _____

Request for Prior Authorization
MULTIPLE SCLEROSIS AGENTS-ORAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

For patients initiating therapy with siponimod (Mayzent):

- Does patient have a CYP2C9*3/*3 genotype; ☐ Yes ☐ No
- Does patient have a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III/IV heart failure; ☐ Yes ☐ No
- Does patient have a presence of Mobitz Type II 2nd degree, 3rd degree AV block or sick sinus syndrome, unless the patient has a functioning pacemaker ☐ 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
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

☐ Amitiza ☐ Linzess 145mcg & 290mcg ☐ Movantik

Non-Preferred

☐ Linzess 72mcg ☐ Motegrity ☐ 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:_____

Request for Prior Authorization
ORAL CONSTIPATION AGENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

☐ **Chronic Idiopathic Constipation:** (Amitiza, Linzess, Motegrity 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
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 ☐ Rinvoq ☐ 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, Rinvoq. 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
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
- ☐ Testosterone Cypionate
- ☐ Testosterone Enanthate
- ☐ Testosterone Gel 1% Packets

Non-Preferred

- ☐ Androgel
- ☐ Android
- ☐ Aveed
- ☐ Axiron
- ☐ Depo-Testosterone
- ☐ Fortesta
- ☐ Methitest
- ☐ 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
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 meets the FDA approved age; 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

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

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Request for Prior Authorization
ANTI-DIABETICS 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

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Iowa Department of Human Services

Request for Prior Authorization
Deferasirox

(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 deferasirox. Requests will only be considered for FDA approved dosing. Payment will be considered under the following conditions:
1) Patient does not have a serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance < 40mL/min; and 2) Patient does not have a poor performance status; and 3) Patient does not have a high-risk myelodysplastic syndrome; and 4) Patient does not have advanced malignancies; and 5) Patient does not have a platelet count < 50 x 10^9/L.

Preferred

☐ Exjade

Non-Preferred

☐ Deferasirox ☐ Jadenu

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Patient has a diagnosis of iron overload related to anemia:

☐ Yes (attach documentation) ☐ No (provide diagnosis): _____

Indicate member's current deferasirox treatment status: ☐ Initial ☐ Continuation

Patient's current weight in kg: _____ Date obtained: _____

Serum Creatinine greater than 2 times the age-appropriate upper limit of normal?

☐ Yes ☐ No Date obtained: _____

Creatinine Clearance: _____ Date obtained: _____

Platelet Count: _____ Date obtained: _____

Serum Ferritin: _____ Date obtained: _____
(attach labs dated within 30 days of request)

Does patient have poor performance status? ☐ Yes ☐ No

Does patient have high-risk myelodysplastic syndrome? ☐ Yes ☐ No

Does patient have advanced malignancies? ☐ Yes ☐ No

Request for Prior Authorization-*Continued*
DEFERASIROX

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Transfusional Iron Overload (in addition to above):**

Initiation of Therapy: 1) Patient is 2 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Patient has documentation of a recent history of frequent blood transfusions that has resulted in chronic iron overload; and 4) Serum ferritin is consistently > 1000 mcg/L (attach lab results dated within past month); and 5) Starting dose does not exceed: Exjade- 20mg/kg/day or Jadenu- 14mg/kg/day. Calculate dose to the nearest whole tablet. 6) Initial authorizations will be considered for up to 3 months. Continuation of therapy:
1) Serum ferritin has been measured within 30 days of continuation therapy request (attach lab results); and
2) Ferritin levels are > 500mcg/L and 3) Dose does not exceed: Exjade- 40mg/kg/day or Jadenu- 28mg/kg/day.

Initial Requests:

Patient has a recent history of frequent blood transfusions resulting in chronic iron overload?

☐ Yes (provide recent transfusion dates) _____ ☐ No

Serum ferritin consistently > 1000 mcg/L: ☐ Yes ☐ No

☐ **Non-Transfusional Iron Overload (in addition to above)**

Initiation of therapy: 1) Patient is 10 years of age or older; and 2) Patient has documentation of iron overload related to anemia (attach documentation); and 3) Serum ferritin and liver iron concentration (LIC) has been measured within 30 days of initiation (attach lab results); and 4) Serum ferritin levels are > 300mcg/L. 5) LIC are > 5mg Fe/g dw; and 6) Dose does not exceed: Exjade- 10mg/kg/day (if LIC is ≤ 15mg Fe/g dw) or 20mg/kg/day (if LIC is > 15mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is ≤ 15mg Fe/g dw) or 14mg/kg/day (if LIC is > 15mg Fe/g dw). 7) Initial authorizations will be considered for up to 6 months. Continuation of Therapy:
1) Serum ferritin and LIC have been measured within 30 days of continuation therapy request; and 2) Serum ferritin levels are ≥ 300mcg/L; and 3) LIC is ≥ 3mg Fe/g dw; and 4) Dose does not exceed: Exjade- 10mg/kg/day (if LIC is 3 to 7mg Fe/g dw) or 20mg/kg/day (if LIC is > 7mg Fe/g dw) or Jadenu- 7mg/kg/day (if LIC is 3 to 7mg Fe/g dw) or 14mg/kg/day (if LIC is > 7mg Fe/g dw).

Initial & Renewal Requests:

LIC: _____ Date obtained: _____ (attach labs dated within 30 days of request)

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
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:

☐ Praluent 75mg every 2 weeks for 8 weeks (4 doses)
☐ 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 ezetimibe (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 ezetimibe (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 ezetimibe (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

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
- If repeat LDL-C at goal – continue therapy at 150mg every 2 weeks for 24 weeks
- If repeat LDL-C not at goal – discontinue treatment

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
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 meets the FDA approved age; 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.

Non-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

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

☐ Pradaxa

Non-Preferred (PA required)

☐ Savaysa

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
MEPOLIZUMAB (NUCALA)

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 mepolizumab (Nucala). Requests will not be considered with concurrent use of omalizumab. Payment will be considered under the following conditions: 1) Patient meets the FDA approved age; and 2) Patient has a diagnosis of severe asthma with an eosinophilic phenotype; and 3) Patient has a pretreatment blood eosinophil count of ≥150 cells per mcL within the previous 6 weeks or blood eosinophils of ≥300 cells per mcL within 12 months prior to initiation of therapy; and 4) Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and 5) Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and 6) A pretreatment forced expiratory volume in 1 second (FEV_1) <80% predicted; and 7) Prescriber is an allergist, immunologist, or pulmonologist.

If the criteria for coverage are met, an initial authorization will be given for 3 months to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met: 1) Patient continues to receive therapy with an ICS, LABA and LTRA; and 2) Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or 3) Patient has experienced a decrease in administration of rescue medication (albuterol); or 4) Patient has experienced a decrease in exacerbation frequency; or 5) Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ Nucala Auto-Injector ☐ Nucala Prefilled Syringe

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Pretreatment blood eosinophil count (attach lab): _____ Date Obtained: _____

OR

Blood eosinophil count obtained within 12 months prior to initiation of treatment (attach lab): _____

Date Obtained: _____

Pretreatment Baseline ppFEV$_1$: _____ Date Obtained: _____

Iowa Department of Human Services

Request for Prior Authorization
MEPOLIZUMAB (NUCALA)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

Document current use of:

High-dose inhaled corticosteroid: Drug Name:_____ Strength:_____

Dosing Instructions:_____ Trial start date:_____

Long-Acting Beta2-Agonist: Drug Name:_____ Strength:_____

Dosing Instructions:_____ Trial start date:_____

Leukotriene Receptor Antagonist: Drug Name:_____ Strength:_____

Dosing Instructions:_____ Trial start date:_____

Does patient have a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA? ☐ No ☐ Yes (provide dates):_____

Prescriber's specialty: ☐ Allergist ☐ Immunologist ☐ Pulmonologist ☐ Other:_____

Will the patient be taking omalizumab in combination with mepolizumab? ☐ No ☐ Yes

For Renewals Only:

Does patient continue to receive therapy with an ICS, LABA and LTRA? ☐ No ☐ Yes

Please indicate if the patient has experienced any of the following (check all that apply):

☐ Reduction in asthma signs and symptoms including:
- wheezing
- chest tightness
- coughing
- shortness of breath

☐ Decrease in administration of rescue medications (albuterol)

☐ Decrease in exacerbation frequency

☐ Increase in ppFEV$_1$ from the pretreatment baseline Current ppFEV$_1$:_____ Date Obtained:_____

Please describe:_____

_____

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
TOPICAL ACNE AND ROSACEA 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 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	☐	Soolantra
☐	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

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Iowa Department of Human Services

Request for Prior Authorization
LUPRON DEPOT – ADULT

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 (leuprolide acetate). Payment will be considered for patients under the following conditions:

1) Patient meets the FDA approved age; and

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

3) Patient has a diagnosis of endometriosis for which concurrent therapy with a preferred NSAID and at least one preferred 3 month continuous course of hormonal contraceptive has failed; or

4) Patient has a diagnosis of uterine leiomyomata with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively; or

5) Patient has a diagnosis of advanced prostate cancer.

Therapy will be limited as follows:

- **Endometriosis** – initial 6 month approval. If symptoms of endometriosis recur after the first course of therapy, a second course of therapy with concomitant norethindrone acetate 5mg daily will be considered. Retreatment is not recommended for longer than one additional 6 month course.
- **Uterine leiomyomata** – 3 month approval.
- **Advanced prostate cancer** – initial 6 month approval. Renewal requests must document suppression of testosterone levels towards a castrate level of < 50 ng/dL (attach lab).

Preferred

☐ Lupron Depot

Strength	Dosage Instructions	Quantity	Days Supply

Setting to be administered:

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

Request for Prior Authorization
LUPRON DEPOT- ADULT

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Endometriosis**. Payment will be considered for patients for which concurrent therapy with a preferred NSAID and at least one preferred 3 month continuous course of hormonal contraceptive has failed.

NSAID trial: Drug name/dose:_____

Trial dates:_____ Reason for failure:_____

Continuous hormonal contraceptive trial: Drug name/dose:_____

Trial dates:_____ Reason for failure:_____

Renewal requests only:

Will member be prescribed concomitant norethindrone acetate 5mg daily? ☐ No ☐ Yes

☐ **Uterine Leiomyomata**. Payment will be considered for patients with anemia (hematocrit < 30 g/dL or hemoglobin < 10 g/dL) that did not respond to treatment with at least a one month trial of iron and is to be used preoperatively.

Iron trial: Drug name/dose:_____

Trial dates:_____ Reason for failure:_____

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

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

Is Lupron Depot to be used preoperatively? ☐ No ☐ Yes

☐ **Advanced Prostate Cancer**

Renewal requests only:

Most recent Testosterone Level (attach results):_____

Date this level was obtained:_____

☐ **Other Diagnosis**_____

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

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Iowa Department of Human Services

Request for Prior Authorization

Dupilumab (Dupixent)

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 Dupixent (dupilumab). Payment will be considered under the following conditions:

1) Patient is within the FDA labeled age for indication; and
2) Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
   a. Is prescribed by or in consultation with a dermatologist, allergist, or immunologist; and
   b. Patient has failed to respond to good skin care and regular use of emollients; and
   c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
   d. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
   e. Patient has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and
   f. Patient will continue with skin care regimen and regular use of emollients; or
3) Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) OR with oral corticosteroid dependent asthma; and
   a. Is prescribed by or in consultation with an allergist, immunologist, or pulmonologist; and
   b. Has a pretreatment forced expiratory volume in 1 second (FEV_1) ≤ 80% predicted; and
   c. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long acting $beta_2$ agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and
   d. Patient must have one of the following, in addition to the regular maintenance medications defined above:
      i. Two (2) or more exacerbations in the previous year, or
      ii. Require daily oral corticosteroids for at least 3 days; and
4) Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorizations will be given for 16 weeks to assess the response to treatment. Requests for continuation of therapy will require documentation of a positive response to therapy. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Iowa Department of Human Services

Request for Prior Authorization

Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Non-Preferred

☐ Dupixent

Strength	Usage Instructions	Quantity	Day's Supply

Diagnosis: _____

☐ **Moderate-to-Severe Atopic Dermatitis**

Is prescriber a dermatologist, allergist, or immunologist?

☐ Yes specialty: _____

☐ No If no, note consultation with dermatologist, allergist, or immunologist:

Consultation date: _____ Physician name, specialty & phone: _____

_____

Did patient fail to respond to good skin care and regular use of emollients?

☐ Yes ☐ No If yes, provide documentation below:

Provide skin care regimen, including name and dates of emollient use: _____

_____

Will patient continue skin care regimen and regular use of emollients? ☐ Yes ☐ No

Preferred medium to high potency topical corticosteroid trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Topical immunomodulator trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Cyclosporine or Azathioprine trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

☐ **Moderate-to-Severe Asthma with an Eosinophilic Phenotype**

Does patient have pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks?

☐ Yes (attach results) ☐ No

Iowa Department of Human Services

Request for Prior Authorization

Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Does patient have oral corticosteroid dependent asthma?

☐ Yes ☐ No

Is prescriber an allergist, immunologist, or pulmonologist?

☐ Yes specialty: _____

☐ No If no, note consultation with allergist, immunologist, or pulmonologist:

Consultation date:_____ Physician name, specialty & phone:_____

_____

Does patient have a pretreatment $FEV_1 \leq 80\%$ predicted?

☐ Yes (attach results) ☐ No

Document current treatment with a high-dose ICS given in combination with a controller medication:

High-Dose ICS Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Controller Medication Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Does patient have one of the following?

Two (2) or more exacerbations in the previous year? ☐ Yes ☐ No

Require daily oral corticosteroids for at least 3 days? ☐ Yes ☐ No

Renewal requests:

Document positive response to therapy:_____

_____

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 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 ☐ Ingrezza ☐ Tetrabenazine ☐ 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.*

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 a FDA approved or compendia indicated diagnosis under the following conditions:

1. **Patient has one of the following diagnoses:**
   - a. **Chronic Migraine, defined as:**
     - i. **≥ 15 headache days per month for a minimum of 3 months; and**
     - ii. **≥ 8 migraine headache days per month for a minimum of 3 months; or**
   - b. **Episodic Migraine, defined as:**
     - i. **4 to 14 migraine days per month for a minimum of 3 months; or**
   - c. **Episodic Cluster Headache, defined as:**
     - i. **Occurring with a frequency between one attack every other day and 8 attacks per day; and**
     - ii. **With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods of ≥ 3 months; and**
     - iii. **Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting < 3 months, for at least 1 year); and**
2. **Patient meets the FDA approved age for submitted diagnosis; and**
3. **Patient has been evaluated for and does not have medication overuse headache; and**
4. **For Episodic and Chronic Migraine, 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]; or**
5. **For Episodic Cluster Headache, patient has documentation of:**
   - a. **A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and**
   - b. **A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy.**
6. **The requested dose does not exceed the maximum FDA labeled dose for the submitted diagnosis; and**
7. **Lost, stolen, or destroyed medication replacement requests will not be authorized.**

Request for Prior Authorization
CGRP Inhibitors

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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, reduced weekly cluster headache attack frequency).
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ Aimovig ☐ Ajovy ☐ Emgality

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:

☐ **Chronic Migraine (must document each criterion below):**

1. Patient has ≥ 15 headache days per month for a minimum of 3 months
   Number of headache days each month:

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

2. Patient has ≥ 8 migraine headache days per month for a minimum of 3 months
   Number of migraine headache days each month:
   Month 1: _____ Month 2: _____ Month 3: _____

☐ **Episodic Migraine:**

1. Patient has 4 to 14 migraine headache days per month for a minimum of 3 months
   Number of migraine headache days each month:
   Month 1: _____ Month 2: _____ Month 3: _____

Chronic or Episodic Migraine 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:_____

☐ **Episodic Cluster Headache (must document each criterion below):**

1. Occurs with a frequency between one attack every other day and 8 attacks per day:
   Frequency: _____:
2. Patient has at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods of ≥ 3 months:

Request for Prior Authorization
CGRP Inhibitors

(PLEASE PRINT – ACCURACY IS IMPORTANT)

# of cluster periods: _____ Length of cluster periods: _____

Does patient have pain-free remission periods? ☐ Yes ☐ No

If yes, length of pain-free remission periods: _____

3. Does patient have chronic cluster headache? ☐ Yes ☐ No

Episodic Cluster Headache treatment failures:

Glucocorticoid Trial: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

_____

Verapamil Trial: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

_____

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

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

_____

_____

For chronic or episodic migraine: number of headache/migraine days per month since start of therapy:

_____

For episodic cluster headache: number of cluster periods 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.*

Department of HUMAN SERVICES

Request for Prior Authorization
Cannabidiol (Epidiolex)

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 cannabidiol (Epidiolex). Payment will be considered under the following conditions:

1) Patient meets the FDA approved age; and
2) Baseline serum transaminases (ALT and AST) and total bilirubin levels have been obtained prior to initiating therapy (attach results); and
3) A diagnosis of Lennox-Gastaut syndrome with documentation of an adequate trial and inadequate response with at least two concomitant antiepileptic drugs (AEDs) from the following: valproic acid, lamotrigine, topiramate, felbamate, rufinamide, clobazam; or
4) A diagnosis of Dravet syndrome with documentation of an adequate trial and inadequate response with at least two concomitant AEDs from the following: clobazam, valproic acid, levetiracetam, topiramate; and
5) Is prescribed by or in consultation with a neurologist; and
6) The total daily dose does not exceed 20mg/kg/day.

If criteria for coverage are met, initial requests will be approved for three months. Additional PA requests will be considered when the following criteria are met:

1) Documentation of clinical response to therapy (i.e. reduction in the frequency of seizures); and
2) The total daily dose does not exceed 20mg/kg/day.

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

Non-Preferred

☐ Epidiolex

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Patient weight (kg): _____ **Date obtained:** _____

Request for Prior Authorization
Cannabidiol (Epidiolex) *(Continued)*
(PLEASE PRINT – ACCURACY IS IMPORTANT)

Is prescriber a neurologist?

☐ Yes ☐ No If no, note consultation with neurologist:

Consultation date:_____ Physician name & phone:_____

_____

Have baseline serum transaminases (ALT and AST) and total bilirubin been obtained prior to initiating therapy?

☐ Yes (attach results) ☐ No

☐ **Lennox-Gastaut syndrome**

Document an adequate trial and inadequate response with at least two concomitant AEDs from the following: valproic acid, lamotrigine, topiramate, felbamate, rufinamide, clobazam.

Trial #1 drug name and dose:_____

Trial dates:_____ Failure reason:_____

_____

Trial #2 drug name and dose:_____

Trial dates:_____ Failure reason:_____

_____

☐ **Dravet syndrome**

Document an adequate trial and inadequate response with at least two concomitant AEDs from the following: clobazam, valproic acid, levetiracetam, topiramate.

Trial #1 drug name and dose:_____

Trial dates:_____ Failure reason:_____

_____

Trial #2 drug name and dose:_____

Trial dates:_____ Failure reason:_____

_____

Renewals

Document clinical response to therapy:_____

_____

_____

Patient weight (kg):_____ **Date obtained:**_____

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
Aripiprazole Tablets with Sensor (Abilify MyCite)

(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 aripiprazole tablets with sensor (Abilify MyCite). Payment will be considered under the following conditions:

1) Patient has a diagnosis of Schizophrenia, Bipolar I Disorder, or Major Depressive Disorder; and
2) Patient meets the FDA approved age for use of the Abilify MyCite device; and
3) Dosing follows the FDA approved dose for the submitted diagnosis; and
4) Documentation of patient adherence to generic aripiprazole tablets is less than 80% within the past 6 months (prescriber must provide documentation of the previous 6 months' worth of pharmacy claims for aripiprazole documenting non-adherence); and
5) Documentation of all the following strategies to improve patient adherence have been tried without success:
   a) Utilization of a pill box
   b) Utilization of a reminder device (e.g., alarm, application, or text reminder)
   c) Involving family members or friends to assist
   d) Coordinating timing of dose with dosing of another daily medication; and
6) Documentation of a trial and intolerance to a preferred long-acting aripiprazole injectable agent; and
7) Prescriber agrees to track and document adherence of Abilify MyCite through the web-based portal for health care providers and transition member to generic aripiprazole tablets after a maximum of 4 months use of Abilify MyCite. Initial approvals will be given for one month. Prescriber must review member adherence in the web-based portal and document adherence for additional consideration. If non-adherence continues, prescriber must document a plan to improve adherence. If adherence is improved, consideration to switch member to generic aripiprazole tablets must be considered. Note, the ability of the Abilify MyCite to improve patient compliance has not been established.
8) Requests will not be considered for patients in long-term care facilities.
9) A once per lifetime approval will be allowed.

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

Non-Preferred

☐ Abilify MyCite

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Request for Prior Authorization
Aripiprazole Tablets with Sensor (Abilify MyCite) *(Continued)*

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Is patient adherence to generic aripiprazole tablets less than 80% within the past 6 months?

☐ Yes (provide previous 6 months of pharmacy claims documenting non-adherence) ☐ No

Have the following strategies to improve patient adherence been tried without success?

Utilization of pill box ☐ Yes ☐ No

Utilization of a reminder device (e.g., alarm, application, or text reminder)

☐ Yes Device used:_____ ☐ No

Involving family members or friends to assist ☐ Yes ☐ No

Coordinating timing of dose with dosing of another daily medication ☐ Yes ☐ No

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

Prescriber agrees to track and document adherence of Abilify MyCite through the web-based portal for health care providers and transition member to generic aripiprazole tablets after a maximum of 4 months use of Abilify MyCite? ☐ Yes ☐ No

Preferred long-acting aripiprazole injectable trial:

Drug name and dose:_____

Trial dates:_____ Failure reason:_____

_____

Medical or contraindication reason to override trial requirements:_____

_____

_____

Renewals:

Prescriber has reviewed member adherence of Abilify MyCite through the web based portal?

☐ Yes Adherence rate:_____ ☐ No

If improved member adherence, consider switch to generic aripiprazole tablets. Provider rationale for continued Abilify MyCite use if not switching to generic aripiprazole tablets:_____

_____

_____

If member continues to be non-adherent, document plan to improve adherence:_____

_____

_____

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
Ospemifene (Osphena)

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 ospemifene (Osphena). Requests for a diagnosis of moderate to severe dyspareunia are considered not medically necessary and will be denied. Payment will be considered under the following conditions:

1) Patient is a post-menopausal woman with a diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy; and
2) Patient has documentation of an adequate trial and therapy failure with a preferred vaginal estrogen agent; and
3) Patient does not have any contraindications to ospemifene as listed in the FDA approved label; and
4) Will not be used with estrogens, estrogen agonist/antagonists, fluconazole, or rifampin; and
5) Patient does not have severe hepatic impairment (Child-Pugh Class C); and
6) Patient will be evaluated periodically as clinically appropriate to determine if treatment is still necessary as ospemifene should be used for the shortest duration consistent with treatment goals and risks for the individual woman; and
7) Dose does not exceed the FDA approved dose.

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

Initial requests will be approved for three months. Additional PAs will be considered upon documentation of clinical response to therapy.

Non-Preferred

☐ Osphena

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Request for Prior Authorization
Ospemifene (Osphena) *(Continued)*

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Is patient post-menopausal?

☐ Yes ☐ No

Does patient have contraindications to ospemifene as listed in the FDA approved label?

☐ Yes ☐ No

Will ospemifene be used with estrogens, estrogen agonist/antagonists, fluconazole or rifampin?

☐ Yes ☐ No

Does patient have severe hepatic impairment (Child-Pugh Class C)?

☐ Yes ☐ No

Will patient be evaluated periodically to determine if treatment with ospemifene is still necessary?

☐ Yes ☐ No

Preferred vaginal estrogen agent trial:

Drug name and dose:_____

Trial dates:_____ Failure reason:_____

_____

Medical or contraindication reason to override trial requirements:_____

_____

_____

Renewals:

Document clinical response to therapy:_____

_____

_____

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.*