Department of HUMAN SERVICES

For Human Services use only:

General Letter No. 8-AP-494
Employees' Manual, Title 8
Medicaid Appendix

April 16, 2021

PRESCRIBED DRUGS MANUAL TRANSMITTAL NO. 21-1

ISSUED BY: Division of Medical Services

SUBJECT: ***Prescribed Drugs Manual, Provider-Specific Policies***, Title, Contents page i, Title 2, Contents page 1, Contents page 2 and 3, 1, 2, 3-5, 6 and 7, 8, 9, 10-12, 13, 14, 15, 16-17, 18-21, 22-25, 26, 27-30, 31-45, 46, 47 and 48, 49, 50, 51-64, revised; and the following forms:

470-4113 *Request for Prior Authorization: Acute Migraine Treatments*, revised and renamed from *Serotonin 5-HT-1 Receptor Agonists*
470-5636 *Request for Prior Authorization: Adenosine Triphosphate-Citrate Lyase Inhibitors*, new
470-5259 *Request for Prior Authorization: Anti-Diabetic Non-Insulin Agents*, revised
470-4094 *Request for Prior Authorization: Anti-Fungal Drugs-Oral/Injectable*, revised
470-4522 *Request for Prior Authorization: Biologicals for Arthritis*, revised
470-4521 *Request for Prior Authorization: Biologicals for Axial Spondyloarthritis*, revised and renamed from *Biologicals for Ankylosing Spondylitis*
470-4524 *Request for Prior Authorization: Biologicals for Plaque Psoriasis*, revised
470-5554 *Request for Prior Authorization: CGRP Inhibitors*, revised
470-4551 *Request for Prior Authorization: Chronic Pain Syndromes*, removed
470-4116 *Request for Prior Authorization: CNS Stimulants and Atomoxetine*, revised
470-5627 *Request for Prior Authorization: Cystic Fibrosis Agents*, new
470-5423 *Request for Prior Authorization: Direct Oral Anticoagulants*, revised and renamed from *Novel Oral Anticoagulants*
470-5497 *Request for Prior Authorization: Dupilumab (Dupixent)*, revised
470-4099 *Request for Prior Authorization: Granulocyte Colony Stimulating Factor*, revised
470-4850 *Request for Prior Authorization: Hematopoietics / Chronic ITP*, revised

470-5270 *Request for Prior Authorization: Hepatits C Treatments*, revised
470-5531 *Request for Prior Authorization: High Dose Opioids*, revised
470-5424 *Request for Prior Authorization: IL-5 Antagonists,* revised and renamed *from Mepolizumab (Nucala)*
470-5409 *Request for Prior Authorization: Ivabradine (Corlanor),* revised
470-5117 *Request for Prior Authorization: Ivacaftor (Kalydeco)*, removed
470-4898 *Request for Prior Authorization: Lidocaine Patch*, revised
470-4275 *Request for Prior Authorization: Linezolid (Zyvox)*, revised
470-5366 *Request for Prior Authorization: Lumacaftor/Ivacaftor (Orkambi)*, removed
470-4705 *Request for Prior Authorization: Modified Formulations*, revised
470-5060 *Request for Prior Authorization: Multiple Sclerosis Agents*, revised
470-4109 *Request for Prior Authorization: Nonsteroidal Anti-Inflammatory Drugs*, revised
470-5637 *Request for Prior Authorization: Peanut (Arachis Hypogaea) Allergen Powder-dnfp (Palforzia)*, new
470-5346 *Request for Prior Authorization: Pirfenidone (Esbriet) and Nintedanib (Ofev)*, revised and renamed from *Idiopathic Pulmonary Fibrosis Agents*
470-5425 *Request for Prior Authorization: Potassium Binders*, revised
470-4112 *Request for Prior Authorization: Proton Pump Inhibitors*, revised
470-4328 *Request for Prior Authorization: Sedative/Hypnotics Non-Benzodiazepine*, revised
470-4899 *Request for Prior Authorization: Short Acting Opioids*, revised
470-5188 *Request for Prior Authorization: Testosterone Products*, revised
470-5549 *Request for Prior Authorization: Tezacaftor/Ivacaftor (Symdeko)*, removed
470-5426 *Request for Prior Authorization: Topical Acne and Rosacea Products*, revised
470-5398 *Request for Prior Authorization: Valsartan/Sacubitril (Entresto)*, revised
470-5628 *Request for Prior Authorization: Voxelotor (Oxbryta)*, new

Summary

The Prescribed Drug manual is revised to:

- Revise 25 forms for requesting drug prior authorization.
- Add 4 forms for requesting drug prior authorization.
- Revise and rename 4 forms for requesting drug prior authorization.

- Remove the following forms for requesting drug prior authorization:
  - 470-4551, Request for Prior Authorization: Chronic Pain Syndromes
  - 470-5117, Request for Prior Authorization: Ivacaftor (Kalydeco)
  - 470-5366, Request for Prior Authorization: Lumacaftor/Ivacaftor (Orkambi)
  - 470-5549, Request for Prior Authorization: Tezacaftor/Ivacaftor (Symdeko)
- Update paper claim submission requirements for Nominal Price and Federal Supply Schedule claims.
- Add maximum daily edit information.
- Update formatting and style throughout.

Date Effective

January 1, 2021.

Material Superseded

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

Page	Date
Chapter III	
Title page 1	
Contents page i	July 1, 2014
Title page 2	
Contents page 1	August 1, 2020
Contents page 2 and 3	August 1, 2019
1	August 1, 2018
2	August 1, 2019
3-5	August 1, 2018
6 and 7	August 1, 2019
8	August 1, 2018
9	August 1, 2020
10-12	August 1, 2018
13	August 1, 2020
14	August 1, 2018
15	August 1, 2019
16-17	August 1, 2018
18-21	August 1, 2020
22-25	August 1, 2019
26	August 1, 2020
27-30	August 1, 2019
31-45	August 1, 2018
46	August 1, 2019
47 and 48	August 1, 2018

49	August 1, 2019
50	August 1, 2020
51-64	August 1, 2019

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.

Prescribed Drugs

Provider Manual

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III. Provider-Specific Policies

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. GENERAL PHARMACY GUIDELINES

This manual gives general information about Medicaid drug coverage and billing policies. For more detailed information, see the following websites:

www.iadur.org	Drug Utilization Review (DUR) Commission
www.dhs.iowa.gov/ime/about	Iowa Medicaid Enterprise (IME)
www.iowamedicaidpdl.com	Pharmaceutical and Therapeutics (P&T) Committee and Preferred Drug List (PDL)
www.mslc.com/Iowa	Pharmacy Reimbursement
www.iowamedicaidpos.com	Point of Sale (POS) system for pharmacy claims

1. Definitions

340B Program means the federal 340B Drug Pricing program as set forth in Section 340B of the Public Health Service (PHS) Act (1992) and managed by Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). The program allows certain designated facilities to purchase prescription medications at discounts, so these facilities can offer some medications to their patients at reduced prices.

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

340B Covered entity (CE) means facilities and programs listed in the 340B statute as eligible to purchase drugs through the 340B program and appear on the HRSA 340B database.

340B Contract pharmacies means a pharmacy under contract with a CE that lacks its own pharmacy. The contract pharmacy is authorized to dispense 340B-discounted drugs on behalf of the CE.

- **Active Pharmaceutical Ingredient (API)** means any substance that is intended for incorporation into a finished drug product and is intended to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body pursuant to 21 CFR 207.1. Active pharmaceutical ingredient does not include intermediates used in the synthesis of the substance.

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

Compendium of drug information means one of the following:

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

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

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

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

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

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

Excipient means an inactive substance used in drug compounding.

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

Fee-for-Service (FFS) means providers bill Iowa Medicaid directly for prescriptions they provide to FFS members.

Grandfather clause means a clause creating an exemption based on previously existing circumstances. The Pharmaceutical and Therapeutics Committee considered select therapeutic classes for grandfathering existing drug regimens. For claims processing, "drug history" means the most recent 90-day period. If a patient has a history with a specific drug within these classes, the prescriber is not required to obtain prior authorization even if the drug has a nonpreferred status on the Preferred Drug List.

Legend drugs are drugs that bear the federal caution: "Federal Law Prohibits Dispensing a Drug Without a Prescription."

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

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

Medicaid Carve-In means a 340B entity has elected to use drugs purchased at 340B prices to bill for Medicaid patients. If an entity chooses to use 340B drugs to bill Medicaid, it must indicate this on the Medicaid Exclusion File and list the appropriate Medicaid provider numbers or NPIs.

Medicaid Carve-Out means a 340B entity has elected to use non-340B drugs to bill for Medicaid patients. Entities may choose to do this so they can receive regular Medicaid reimbursement.

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

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

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

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

Nonrecommended drug means a drug placed on a voluntary list designed to inform prescribers of cost-effective alternatives and, if used, will be more costly to the Medicaid program. The drug does not require a prior authorization unless a number is in the comments column to indicate a prior authorization is required. A nonrecommended drug is designated "NR" on the Preferred Drug List.

Pharmaceutical and Therapeutics (P&T) Committee means a committee of nine members appointed by the Governor that is charged with developing and providing ongoing review of the Preferred Drug List pursuant to Iowa Code section 249A.20A.

Preferred drug means a drug on the Preferred Drug List that provides medical equivalency to the Medicaid member in a cost-effective manner (by virtue of OBRA '90 and Supplemental Rebate) and does not require a prior authorization. A preferred drug is designated "P" on the Preferred Drug List.

Preferred Drug List (PDL) means a list comprised of drugs recommended to the Iowa Department of Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that have been identified as being therapeutically equivalent within a drug class and that provide cost benefit to the Medicaid program.

Preferred drug with conditions means a drug is a "preferred" agent but before getting the drug a patient must meet medical criteria and guidelines that coincide with current prior authorization criteria. A preferred drug with conditions is designated "P" on the Preferred Drug List and has a number in the comments column to indicate a prior authorization is required, as defined on the first page of the Preferred Drug List (PDL).

Prior authorization (PA) means obtaining approval for a drug before the drug is provided to a member, as a precondition for provider reimbursement. Prior authorization is requested at the prescriber level and is primarily a prescriber fax-only system using the forms provided by the Iowa Medicaid Enterprise.

Professional dispensing fee means payment provided for the costs incurred by a pharmacy to dispense a drug. The fee reflects the pharmacist's professional services and costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid member.

Prospective drug utilization review (Pro-DUR) means a process in which a request for a drug product for a particular patient is screened for potential drug therapy problems before the product is dispensed.

Recommended drug means a drug placed on a voluntary list designed to inform prescribers of cost-effective alternatives and, if used, will result in a cost savings to the Medicaid program. The drug does not require a prior authorization unless a number is in the comments column to indicate a prior authorization is required. A recommended drug is designated "R" on the Preferred Drug List.

Recommended drug list (RDL) means a voluntary list of drugs recommended to the Department of Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that informs prescribers of cost-effective alternatives that do not require a prior authorization unless otherwise indicated in the comments column. The RDL is a component of the PDL.

Retrospective drug utilization review (Retro-DUR) means the process in which patient drug utilization is periodically reviewed to identify patterns of fraud, abuse, gross overuse, or inappropriate or unnecessary care.

Usual and customary charge means the fee that the provider typically charges the general public for the product or service.

Wholesale Acquisition Cost (WAC) represents the cost reported to Medi-Span by a manufacturer (updated in a number of ways) at which wholesalers purchase drug products from that manufacturer.

2. Entities Involved in Developing Medicaid Drug Policies

a. Drug Utilization Review Commission

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

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

b. Pharmaceutical and Therapeutics Committee

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

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

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

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

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

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

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

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

3. Pharmacies Eligible to Participate

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

a. Licensure

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

b. Survey Participation

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

- A pharmacy shall produce and submit all requested information in the manner and format requested by the Department or its designee at no cost to the Department or its designee.
- A pharmacy shall submit information to the Department or its designee within the time frame indicated following receipt of a request for information unless the Department or its designee grants an extension upon written request of the pharmacy.
- Any dispensing or acquisition cost information submitted to the Department that specifically identifies a pharmacy's individual costs shall be held confidential.

4. Pharmacist Responsibilities

a. Prospective Drug Utilization Review

Pharmacists shall review patient drug therapy at the point of sale to screen for potential drug therapy problems, following a prospective drug use review pursuant to rule 657 Iowa Administrative Code 8.21(155A), due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration
- Drug-allergy interactions
- Clinical abuse or misuse

b. Dispensing Requirements

Pharmacists are required to:

- Dispense drugs in accordance with cost and quantity requirements established by state law.
- Dispense the **least costly item** in stock that meets the order of the doctor or other practitioner, as shown on the prescription.
- Pharmacies must bill once each month for the month's supply, or once every three months for the three month supply of contraceptives.

- 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

- Prescription refill information, including the approximate date when refill will be allowed (generally, 90 percent of the prescription is used)
- Actions to be taken in the event of a missed dose
- Comments relevant to the patient's drug therapy, including any other information peculiar to the specific patient or drug

Patient counseling is required in accordance with federal law at 42 USC Section 1396r(g)(2)(A)(ii)(l) and state rules at 657 Iowa Administrative Code 6.14(155A).

d. Reason for Denial

The pharmacist should explain the reason for any **denial** of a requested drug or item to the member or caregiver. For example, denial could be due to one of the following:

- **Noncovered drug or item**. Explain why the drug or item is not covered and suggest alternatives to the member, caregiver, or practitioner.
- **Prior authorization requirement**. Explain the prior authorization process and requirements to the member or caregiver.

  When a patient presents a prescription for nonpreferred drug at a pharmacy and it is denied, contact the prescriber and ask if the prescriber wishes to choose a preferred drug.

  - If the prescriber wishes to change to a preferred drug, the prescriber may dictate the new prescription order.
  - If the prescriber views that the nonpreferred drug is medically necessary, the prescriber must obtain prior authorization.
- **Refill too soon**. Inform the member or caregiver of an approximate date the prescription can be refilled (after 90 percent of the previous supply is used).

  In special circumstances, such as a change in dose, travel, or lost, stolen or destroyed medication, that result in an early refill, contact the IME Pharmacy Point of Sale (POS) Unit at (515) 256-4608 (local calls) or 877-463-7671 with the information. This information will be reviewed to determine if an override can be given to allow payment.

- Non-controlled medications that are lost, stolen or destroyed after delivery to the member are limited to a one time override allowance per 12 month period. Overrides for the first occurrence of a lost, stolen or destroyed medication can be obtained by contacting the IME Pharmacy Point of Sale (POS) Unit at (515) 256-4608 (local calls) or 877-463-7671.
- Requests exceeding the one time override allowance for non controlled medications that are lost, stolen or destroyed after delivery to the member may be considered with additional documentation. Such requests involving stolen medications must include a copy of a police report.
- Override of refill too soon will not be allowed for controlled substances and/or tramadol containing products that are lost, stolen, or destroyed after delivery to the member.
- Override of refill limits will not be allowed for members residing in a long term care (LTC) facility.
- Prescription drugs that are not received by the member because they are lost or stolen in transit, before actual delivery to the member, or that are received in damaged or unusable condition will not be replaced through override of refill too soon. The original claim for the drug that was not properly delivered to the member should be reversed and a new claim for a replacement can then be submitted.

♦ **Plan limits exceeded**. Refer to the limits list posted on the website, www.iowamedicaidpdl.com, under "Billing/Quantity Limits." The number of doses should be reduced to meet the quantity limit.

If there are special circumstances where adherence to the quantity limit is not possible, the prescriber should complete form 470-4556, *Quantity Limit Override*, or form 470-5038, *Request for Fifteen Day Initial Prescription Supply Override*, and fax it to 1-800-574-2515. The clinical staff will review the information submitted and determine if an override can be given to allow payment.

If the member or caregiver is not satisfied with the explanation of the reason for a denial, refer the person to the member's DHS worker for assistance in filing an appeal or requesting an exception to policy. Appeal and exception requests may be filed on line through the following website: http://dhs.iowa.gov/appeals.

5. Drug Use Review

The drug use review (DUR) process was established to fulfill a federal requirement established by the federal Omnibus Budget Reconciliation Act of 1990. Iowa Medicaid has implemented both of the required DUR types:

- **Prospective drug utilization review** occurs when the pharmacist does the review of patient drug therapy at the point of sale. See Pharmacist Responsibilities.
- **Retrospective drug utilization review** occurs when the review takes place after the point of sale.

The retrospective DUR program provides ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and members, or associated with specific drugs.

B. COVERAGE OF SERVICES

Payment will be made for legend and nonprescription drugs when prescribed by a practitioner who is legally qualified to prescribe the item, subject to the limitations described in this manual.

1. Prescription Requirements

Prescription records are required for all drugs as specified in Iowa pharmacy and drug laws, including Iowa Code sections 124.308, 126, 155A.27, and 155A.29.

For Medicaid purposes, prescriptions are required for nonprescription drugs and are subject to the same provisions. This includes the record-keeping requirements on refills. Maintain prescriptions on file in such a manner that they will be readily available for audit by the Department.

Prescriptions executed in writing (nonelectronic) for prescription drugs must be presented on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23))

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.

- Drugs used for fertility purposes or for sexual or erectile dysfunction.
- Drugs prescribed for a use other than the drug's medically accepted use.
- Drugs classified as less than effective by the Centers for Medicare and Medicaid Services.
- Drugs marketed by manufacturers that have not signed a Medicaid rebate agreement.
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

3. Drugs for Medicare Eligibles

Prescription drugs for Medicaid members who also qualify for Medicare (referred to as "dual eligibles") are paid through Medicare Part D effective January 1, 2006. Medicaid does not cover any drugs covered under Medicare Part D for these members.

Iowa Medicaid covers drugs in the following categories for dual eligible members:

- Barbiturates (except when used in the treatment of epilepsy, cancer, or chronic mental health disorder diagnoses)
- Over-the-counter drugs (list posted at www.iowamedicaidpdl.com)
- Prescription vitamin and minerals, except prenatal vitamins and fluoride preparations

Iowa Medicaid will accept only secondary claims for these drugs. Medicaid should be listed as the secondary insurance for all dual eligibles. All claims should be submitted first to the primary insurance (Medicare Part D PDP).

Iowa Medicaid will **not** pay for any Medicare Part B drugs, such as:

- Oral immunosuppressant drugs,
- Inhalation drugs when used with a nebulizer,
- Oral chemotherapy drugs,
- Oral anti-emetic drugs,
- Blood clotting factors, or
- Epoetin.

A drug for which coverage is available to a dual eligible under Medicare Part A or Part B must be billed to Medicare Part A or Part B.

4. Preferred or Recommended Drugs

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

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

5. Nonpreferred Drugs

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

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

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

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

6. Newly Released Drugs

a. New Drug Entities

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

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

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

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

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

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

c. Existing PDL Drugs With Supplemental Rebates

Although the state discourages supplemental rebate offers on existing PDL drugs between annual bidding periods, it may entertain such bids and may accept them if they:

- Are determined to represent significant additional savings, or
- Would replace a delinquent manufacturer's product or a preferred drug pulled from the marketplace or significantly restricted by the FDA.

This interim preferred status will remain in effect until the P&T Committee reviews the drug at its next scheduled meeting.

Supplemental rebates will be invoiced only for approved drugs under contract. Draft preferred drugs with supplemental rebates will not be invoiced until approved by the Committee and accepted by the state. At that time, the supplemental rebates will be invoiced back to the effective date of the agreement, which is the date the drug began to benefit from preferred status.

7. Nonprescription Drugs

Payment will be made for nonprescription drugs or over-the-counter (OTC) drugs with a prescription, subject to prior authorization requirements as specified in the preferred drug list. These drugs are identified on the Nonprescription (OTC) Prescribed List by Therapeutic Category located on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab.

Nonprescription drugs cannot be billed to IME Medicaid POS for members residing in Nursing Facilities (NF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID), and Psychiatric Medical Institutions for Children (PMIC) facilities. These are considered 'stock items' and are to be included in the facility's Medicaid cost report and reimbursed through per diem calculations.

The only exclusions to this policy are as follows:

- OTC insulin: Bill dual eligible member's Medicare Part D plan; for the Medicaid only, bill Medicaid as a POS claim.
- Pseudoephedrine: Since these agents are classified as controlled substances in Iowa, for the dual eligible and Medicaid only, bill Medicaid as a POS claim.

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:

- Adenosine Triphosphate-Citrate Lyase Inhibitors
- 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)
- CNS Stimulants and Atomoxetine
- Concurrent IM/PO antipsychotic use
- Crisaborole (Eucrisa)
- Cystic fibrosis agents
- 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
- Isotretinoin (oral)
- Ivabradine (Corlanor)
- Janus Kinase Inhibitors
- Ketorolac Tromethamine (Toradol)
- Lesinurad (Zurampic)
- Letermovir (Prevymis)
- Lidocaine patch (Lidoderm)
- Linezolid (Zyvox)
- Long acting opioids
- 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
- Peanut (*Arachis Hypogaea*) allergen powder-dnfp (Palforzia)
- 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
- 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)
- Voxelotor (Oxbryta)

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*.

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

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

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

PATIENT ADDRESS: Enter the member's home address.

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

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

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

PRESCRIBER ADDRESS: Enter the prescriber's office address.

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

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

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

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

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

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

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

STRENGTH: Enter the strength of the drug being requested.

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

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

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

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

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

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

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

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

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

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

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

4. Submitting a Prior Authorization Request

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

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

State-recognized holidays are as follows:

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

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

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

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

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

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

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

  Iowa Medicaid Enterprise
  PO Box 36478
  Des Moines, IA 50315

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

5. Prior Authorization Response

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

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

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

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

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

D. BASIS OF PAYMENT FOR DRUGS

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

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

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

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

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

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

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

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).
- The provider's usual and customary charge to the general public.

b. Brand-Name Drugs

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

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

c. 340B Purchased Drugs

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

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

d. Federal Supply Schedule (FSS) Drugs

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

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

- The provider's usual and customary charge to the general public.

e. Nominal Price (NP) Drugs

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

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

f. Indian Health Facilities

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

2. Drugs Subject to Federal Upper Limit (FUL)

a. FUL Development

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

b. Reimbursement for FUL Drugs

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

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

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

Prior authorization is required for selected brand-name drugs as determined by the Department for which there is available, an "A" rated bioequivalent generic product as determined by the federal Food and Drug Administration.

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

The list of selected brand-name drugs includes the drugs on the Federal Upper Limit (FUL) list at http://www.mslc.com/Iowa/AACList.aspx. Prior authorization **is not required** for brand name drugs that have been designated by the Department as **preferred** (payable) under the Iowa Medicaid Preferred Drug List (PDL).

3. Reimbursement for Unit-Dose Packaging

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

Claim the additional reimbursement by placing a "3" in "Unit Dose Indicator" (field 429-DT) for electronic claims, as explained under Point of Sale Claim Submission, or a "09" in the Basis Cost (field 80) on the paper claim form, as explained under Paper Claim Submission. The additional reimbursement will

be automatically added, possibly resulting in reimbursement that is higher than your submitted charge.

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

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

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

4. Reimbursement for Vaccinations

a. Vaccine for Children (VFC) Program

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

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

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

b. Other Vaccines

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

E. BILLING SYSTEM

Iowa Medicaid Enterprise provides for on-line, real-time processing of Medicaid pharmacy claims. Through electronic submission, you are able to submit claims more accurately. You also receive your Medicaid payments sooner than if you submitted paper claims.

Point-of-sale (POS) transactions are handled by the Iowa Medicaid Enterprise Pharmacy Point of Sale (POS) Unit. POS will handle the overrides for prospective drug utilization review edits such as high dose, therapeutic duplication, refill too soon, excessive days supply, dose consolidation, duplicate claim, or immunosuppressant drugs.

Providers that wish to exercise the point of sale billing option must complete the Iowa DHS Point of Sale Agreement. Please visit www.iowamedicaidpos.com to complete this agreement. You may call the (Point of Sale) POS Helpdesk at 877-463-7671 or locally at 515-256-4608.

1. Point of Sale Claim Submission

For point-of-sale (POS) submitters, refer to your POS Payer Sheet for claim submission instructions explanation of the data fields for the electronic billing format. (To view the instruction on line, click here.)

The Afforable Care Act (ACA) requires that providers who prescribe or are indicated as a referring provider on a Medicaid claim must be enrolled as a participating provider in the program. Pharmacy claims submitted with a National Provider Identifier (NPI) that is not enrolled with the Iowa Medicaid program will be denied. Providers may contact Provider Services at 800-338-7909 or 256-4609 (local) for questions regarding provider enrollment.

The Iowa Medicaid Enterprise eliminated the procedure of paying pharmacy claims and then billing the primary insurance company on behalf of the members ("pay and chase") effective January 16, 2007, except for children under age 21 and pregnant women.

- **For members under age 21**, pharmacy claims may be processed through Pharmacy Point of Sale System with Iowa Medicaid as the primary insurer.

- **For members who are pregnant**, bill claims through the Pharmacy Point of Sale System with Iowa Medicaid as the primary insurer. To get a $0.00 copayment, enter code "2" in the pregnancy indicator code field (NCPDP field 335-2C).
- For **all other** Medicaid members with other prescription insurance, that insurance is primary and Medicaid is secondary.
  - Ask the member for the primary prescription insurance card.
  - If a member has primary pharmacy insurance, submit the claim to the primary insurance first and then the copay to Medicaid last, using a "8" in the OTHER COVERAGE CODE field (field 308-C8).
  - If a member has primary pharmacy insurance and the claim is not covered by the primary insurance, submit the claim to Medicaid using a "3" in the OTHER COVERAGE CODE field (field 308-C8).
  - If a member has Iowa Medicaid pharmacy insurance only (or does not have the primary prescription insurance information), enter a "1" in the OTHER COVERAGE CODE field (field 308-C8).

a. Claims Rejected Due to Other Insurance Coverage

When a claim is submitted with a blank field or a zero in the OTHER COVERAGE CODE field but the Iowa Medicaid eligibility file has third-party liability (TPL) information, the Medicaid claim will be denied and you will receive a rejection code of 41, "Submit to Primary Payer."

The Point-of-Sale System will give the policy number and the type of coverage. Most times the insurance company name is given. However, for the less common companies, a code is given in place of the name.

Use the primary prescription insurance billing information to bill the primary insurance. If necessary, you may contact the IME Provider Services for the name and address of the health insurance company.

After billing the other company, resubmit the claim with one of the following codes the OTHER COVERAGE CODE field:

- Use code **1** if the member states that there is no other insurance coverage. If the claim has already been rejected with a reject code of 41 "Submit to Primary Payer," Iowa Medicaid's eligibility file conflicts with the primary third-party insurance company's information. See Correction of Insurance Information.

- Use code **3** if other coverage does exist but the drug is not covered under the primary insurance plan.
- Use code **8** when payment is not collected. Example: The primary third-party insurance is 100 percent major medical.

b. Correction of Insurance Information

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

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

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

2. Claiming Payment for Retroactively Eligible Member

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

- The pharmacy's national provider identifier.
- The member's Iowa Medicaid number, name, and date of birth.

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

For medications payable on Iowa Medicaid, the POS staff will put an override on the point-of-sale system for the pharmacy to rebill the claims for reimbursement.

3. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- Complete form 470-3969, *Claim Attachment Control*. To view a sample of this form on line, click here.

  Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- **Staple** the additional information to form 470-3969. Do **not** attach a paper claim.
- Mail the *Claim Attachment Control* with attachments to:

  Medicaid Claims
  PO Box 150001
  Des Moines, IA 50315

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

4. Paper Claim Submission

Traditional Universal Claim forms are no longer accepted. The new universal claim forms PUCF-D01PT (VER 1.2) can be ordered by calling CommuniForm at 800-564-8140, or online at https://www.ncpdp.org/Products/Universal-Claim-Forms.

The following table contains information that will aid in the completion of the pharmacy claim form. The table follows the form by field name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional, or conditional on the individual member's situation.

FIELD NAME/DESCRIPTION	INSTRUCTIONS
1 – CARDHOLDER ID	**MANDATORY**. Enter the member's Medicaid ID number. Copy this directly from the *Medical Assistance Eligibility Card*. It consists of seven numeric characters followed by a letter, i.e., 1234567A.
2 – GROUP ID	**NOT USED**. Leave blank.
3 – LAST	**NOT USED**. Submit information under Patient segment.
4 – FIRST	**NOT USED**. Submit information under Patient segment.
5 – PLAN NAME	IAMED
6 – BIN NUMBER	011933
7 – PROCESSOR CONTROL NUMBER	IAPOP
8 – CMS PART D	**OPTIONAL**.
PATIENT	
9 – PATIENT'S LAST NAME	**REQUIRED**. Must be submitted.
10 – PATIENT'S FIRST NAME	**REQUIRED**. Must be submitted.
11 – PERSON CODE	**NOT USED**.
12 – DATE OF BIRTH	**REQUIRED**. Enter the member's birth date using a two-digit entry for each of the following: month, day, and year.
13 – PATIENT GENDER CODE	**REQUIRED**. Enter the gender.

FIELD NAME/DESCRIPTION	INSTRUCTIONS
14 – RELATIONSHIP TO CARDHOLDER	**NOT USED**.
15 – PATIENT RESIDENCE	**OPTIONAL**.
PHARMACY	
16 – DOCUMENT CONTROL NUMBER	**OPTIONAL**. For office use only.
17 – SERVICE PROVIDER ID	**MANDATORY**. Enter the pharmacy's national provider identifier (NPI).
18 – SERVICE PROVIDER ID QUALIFIER	**MANDATORY**. Enter "01" for national provider identifier (NPI).
19 – PHARMACY NAME	**REQUIRED**. Enter the pharmacy's name.
20 – PHONE NUMBER	**OPTIONAL**. Entering the pharmacy's area code and phone number may expedite processing of the claim.
21 – ADDRESS	**REQUIRED**. Enter the pharmacy's street address.
22 – CITY	**REQUIRED**. Enter the pharmacy's city.
23 – STATE	**REQUIRED**. Enter the pharmacy's state.
24 – ZIP	**REQUIRED**. Enter the pharmacy's zip code.
PRESCRIBER	
25 – SIGNATURE OF PROVIDER	**REQUIRED**. Enter the signature of the representative completing the form.
26 – DATE	**REQUIRED**. Enter the date of the completed claim.
27 – PRESCRIBER ID	**REQUIRED**. Enter the national provider identifier (NPI) of the prescribing practitioner.
28 – ID QUALIFIER	01 = NPI
29 – PRESCRIBER LAST NAME	**REQUIRED**.

FIELD NAME/DESCRIPTION	INSTRUCTIONS
PHARMACIST	
30 – PHARMACIST ID	**NOT USED**.
31 – ID QUALIFIER	**NOT USED**.
CLAIM	
32 – PRESCRIPTION SERV. REF# (RX NUMBER)	**MANDATORY**. Enter the prescription number you have assigned to the prescription being billed. This number must be **all numeric**. No alpha characters are allowed.
33 – PRESCRIPTION SERV. REF# (RX NUMBER) QUALIFIER	1 = RX BILLING
34 – FILL #	**REQUIRED**. Enter "00" for a new prescription, and 01-99 for refills.
35 – DATE WRITTEN	**REQUIRED**. Enter the date the prescription was written using a two-digit entry for each of the following: month, day, and year. **CCYYMMDD**
36 – DATE OF SERVICE	**MANDATORY**. Enter the date the prescription was filled using a two-digit entry for each of the following: month, day, and year. **CCYYMMDD**
37 – SUBMISSION CLARIFICATION	**OPTIONAL**. Enter "20" if 340B claim. Enter "08" if compound claim. Enter "58" if NP claim. Enter "59" if FSS claim.
38 – PRESCRIPTION ORIGIN	**OPTIONAL**.
39 – PHARMACY SERVICE TYPE	**NOT USED**.
40 – SPECIAL PACKAGING INDICATOR	**OPTIONAL**.

FIELD NAME/DESCRIPTION	INSTRUCTIONS
41 – PRODUCT/SERVICE ID	**MANDATORY**. Enter the national drug code (NDC) found on the drug's label. All of the numerals in the NDC, including the package size, must be current and exactly match the NDC of the product actually dispensed. Be careful to copy the NDC exactly as it appears, including leading zeros. If the product number is only three digits long, enter a leading zero. For a compound, "0" must appear in this field. List each ingredient, NDC, quantity, and charge in the COMPOUND section.
42 – PRODUCT/SERVICE ID QUALIFIER	00 = COMPOUND 03 = NDC
43 – PRODUCT DESCRIPTION	**REQUIRED**.
44 – QUANTITY DISPENSED	**REQUIRED**. Give the number of tablets, capsules, etc. or the **metric measurement** for liquids, creams, etc. Be sure the billed quantity, when divided by the number of days' supply, is an appropriate amount for that therapeutic class of drugs. If the quantity is a fractional amount, use a decimal point.
45 – DAYS SUPPLY	**REQUIRED**. Enter the number of days the prescription will last.
46 – DAW CODE (MAC OVERRIDE)	Leave blank.
47 – PRIOR AUTH # SUBMITTED	**CONDITIONAL**. Leave blank unless one of the following applies: 1 = 72 hour supply 4 = Pregnant 5 = Nursing facility vaccine 7 = Mental health drugs
48 – PA TYPE	**CONDITIONAL**. Enter code "2" if a number was entered in the "PRIOR AUTH # SUBMITTED" box. Otherwise, leave blank.

FIELD NAME/DESCRIPTION	INSTRUCTIONS
49 – OTHER COVERAGE CODE	**CONDITIONAL**. To determine whether the member has drug coverage under other insurance, check the member's eligibility using the Eligibility Verification System (ELVS) or the IME web portal. ♦ If a member has Iowa Medicaid pharmacy insurance only and no other primary insurance, leave this field blank or enter a zero. ♦ Enter code "1" if the member states there is no other insurance but the claim has already been rejected with a reject code of 41 "Submit to Primary Payer." Iowa Medicaid's eligibility file conflicts with the primary third-party insurance company's information. ♦ Enter code "3" if other coverage does exist and the drug is not covered under the primary insurance plan. NOTE: **Also allowed for Part D excluded drugs**. ♦ Enter code "8" when billing is for patient financial responsibility. Only the indicator "06 = Patient Pay Amount" will be accepted as an other payer-patient responsibility amount qualifier.
50 – DELAY REASON	**NOT USED**.
51 – LEVEL OF SERVICE	**NOT USED**.
52 – PLACE OF SERVICE	**OPTIONAL**.
53 – QUANTITY PRESCRIBED	**OPTIONAL**.
CLINICAL	
54 – DIAGNOSIS CODE	**NOT USED**.
55 – DIAGNOSIS CODE QUALIFIER	**NOT USED**.

FIELD NAME/DESCRIPTION	INSTRUCTIONS
DUR	
56 – DUR/PPS CODE REASON	Leave blank.
57 – DUR/PPS CODE SERVICE	Leave blank.
58 – DUR/PPS CODE RESULT	Leave blank.
59 – LEVEL OF EFFORT	Leave blank.
60 – PROCEDURE MODIFIER	Leave blank.
COB OTHER PAYMENTS	
COB1 – PRIMARY	
61 – OTHER PAYER ID	**REQUIRED FOR COB**. Primary payer.
62 – OTHER PAYER ID QUALIFIER	**REQUIRED FOR COB**. Primary payer.
63 – OTHER PAYER DATE	**REQUIRED FOR COB**. Primary payer. If the patient has other insurance coverage, enter the date the claim was paid or rejected by the other insurer.
64 – OTHER PAYER REJECT CODES	**CONDITIONAL**. If the patient has other insurance coverage but the claim was rejected, enter the rejection codes assigned by the other insurer (if known).
COB1 – SECONDARY	
65 – OTHER PAYER ID	**REQUIRED FOR COB**. Payer ID of primary payer.
66 – OTHER PAYER ID QUALIFIER	**REQUIRED FOR COB**.
67 – OTHER PAYER DATE	**REQUIRED FOR COB**. If the patient has other insurance coverage, enter the date the claim was paid or rejected by the other insurer.
68 – OTHER PAYER REJECT CODES	**CONDITIONAL**. If the patient has other insurance coverage but the claim was rejected, enter the rejection codes assigned by the other insurer (if known).

FIELD NAME/DESCRIPTION	INSTRUCTIONS
COMPOUND	
69 – DOSAGE FORM DESCRIPTION CODE	**MANDATORY**.
70 – DISPENSING UNIT FORM INDICATOR	**MANDATORY**.
71 – ROUTE OF ADMINISTRATION	**OPTIONAL**.
72 – INGREDIENT COMPONENT COUNT	**MANDATORY**.
73 – PRODUCT NAME	**REQUIRED**. Submit for each compound component.
74 – PRODUCT ID	**REQUIRED**. Submit for each compound component.
75 – PRODUCT ID QUALIFIER	**REQUIRED**. Submit for each compound component.
76 – INGREDIENT QTY	**REQUIRED**. Submit for each compound component.
77 – INGREDIENT DRUG COST	**OPTIONAL**. Submit for each compound component.
78 – BASIS OF COST	**OPTIONAL**. Submit for each compound component. Enter "08" if 340B claim. Enter "17" if FSS drugs. Enter "16" if NP drugs.
PRICING	
79 – USUAL & CUSTOMARY CHARGE	**REQUIRED**. Enter the usual and customary charge.
80 – BASIS OF COST DETERMINATION	**CONDITIONAL**. Enter code "09" to indicate unit dose drug. Enter "08" if 340B claim. Enter "17" if FSS drugs. Enter "16" if NP drugs. Otherwise, leave blank.
81 – INGREDIENT COST SUBMITTED	**REQUIRED**. Enter the pharmacy's submitted product component cost of the dispensed prescription. Amount also included in the gross amount due. 340B, FSS, and NP pricing submitted in this field when applicable.

FIELD NAME/DESCRIPTION	INSTRUCTIONS
82 – DISPENSING FEE SUBMITTED	**REQUIRED**. Enter the pharmacy's usual and customary dispensing fee. Enter zeros if no dispensing fee is charged for the prescription.
83 – PROFESSIONAL SERVICE FEE SUBMITTED	**REQUIRED**. Enter the pharmacy's usual and customary dispensing fee. Enter zeros if no dispensing fee is charged for the prescription.
84 – INCENTIVE AMOUNT SUBMITTED	Leave blank.
85 – OTHER AMOUNT SUBMITTED	Leave blank.
86 – SALES TAX SUBMITTED	**NOT USED**.
87 – GROSS AMOUNT DUE	**REQUIRED**. Enter the **total** charge for this item. The total claim charge must be equal to the sum of the submitted ingredient cost submitted and the submitted dispensing fee.
88 – PATIENT PAID AMOUNT	Leave blank.
89 – OTHER PAYER AMOUNT PAID #1	**NOT USED**.
90 – OTHER PAYER AMOUNT PAID #2	**NOT USED**.
91 – OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT #1	**REQUIRED FOR IA COB CLAIMS**.
92 – OTHER PAYER-PATIENT RESPONSIBILITY AMOUNT #2	**REQUIRED FOR IA COB CLAIMS**.
93 – NET AMOUNT DUE	**REQUIRED**. Enter the total price less the deductible amount. NOTE: If resubmitting a claim that is over 12 months old, the word "resubmit" must clearly appear on the claim to avoid denials for timely filing. This procedure can be used only if the original submission was within the last 12 months.

F. EDITS AND SPECIAL BILLING INFORMATION

1. Claims for Deceased Members

Submit claims for all Iowa Medicaid members using the dispensing date. Pharmacy claims must be billed before a member's date of death for claims processing. Failure to bill before the date of death may result in claim recoupment for any claims processed after that date of death.

2. Common Billing Errors

Medications can often be described using three measures: each, grams, and milliliters. It is important to choose the correct unit of measure when billing.

Medication	Correct Unit for Billing	Quantity	Days' Supply
Bactroban cream (mupirocin)	Grams	Varies; should be divisible by 15 grams	Varies
Bactroban ointment (mupirocin)	Grams	Varies; should be divisible by 22 grames	Varies
Byetta 5 mcg (exenatide)	Ml (Submit in decimal format; do not round)	1.2 ml	30
Byetta 10 mcg (exenatide)	Ml (Submit in decimal format; do not round)	2.4 ml	30
Copaxone (glatiramer)	Each	1	30
Diastat ACDL gel (diazepam)	Each (kit contains 2 syringes; bill # of kits)	1	Varies
Enbrel 25 mg	Each	1	1
Enbrel 25 mg/0.5 ml (etanercept)	Ml (Submit in decimal format; do not round)	Varies claims should be divisible by 0.5 ml	30
Enbrel SureClick (etanercept)	Ml (Submit in decimal format; do not round)	Varies should be divisible by .98 ml	30
Fragmin (dalteparin)	Ml (Submit in decimal format; do not round)	Varies	Varies

Medication	Correct Unit for Billing	Quantity	Days' Supply
Gamunex 10% (immune globulin)	Ml (Each vial is 10 ml)	Varies	Varies
Humira (adalimumab)	Each (kit contains 2 syringes)	2	30
Influenza vaccines	Ml (Submit in decimal format; do not round)	0.5 ml	1
Kineret (anakinra)	Ml (Submit in decimal format; do not round)	Varies; should be divisible by 0.67	30
Lovenox (enoxaparin)	Ml (Submit in decimal format; do not round)	Varies	Varies
Miacalcin NS (calcitonin)	Ml (Submit in decimal format; do not round)	3.7	30
Nascobal (cyanocobalamin)	Ml (Submit in decimal format; do not round)	Varies; claims should be divisible by 2.3 ml	30
Neupogen 400 mcg (filgrastim)	Ml (Submit in decimal format; do not round)	Varies; claims should be divisible by 1.6 ml	30
Neupogen 600 mcg (filgrastim)	Ml (Submit in decimal format; do not round)	Varies; claims should be divisible by 0.5 ml	30
Pegasys (peginterferon Alfa-2a)	Each (kit contains 4 syringes)	1	28
Peranex HC (lidocaine/ hydrocortisone)	Each	1	Varies
Proair HFA (albuterol)	Grams	8.5 grams	30
Proventil HFA (albuterol)	Grams	6.7 grams	30
Rebif pack (interferon Beta-1a)	Ml (Submit in decimal format; do not round)	4.2 ml	30
Rebif syringe (interferon Beta-1a)	Ml (Submit in decimal format; do not round)	6 ml	30
Remicade (infliximab)	Each	1	Varies
Restasis (cyclosporine)	Each	32/64	30
Risperdal Consta (risperidone)	Each	2	28

Medication	Correct Unit for Billing	Quantity	Days' Supply
Stadol nasal spray 10 mg/ml (butorphanol)	Ml (Submit in decimal format; do not round)	Varies; claims should be divisible by 2.5 ml	Varies
Synagis 50 mg (palivizumab)	Ml (Submit in decimal format; do not round)	0.5 ml	30
Synagis 100 mg (palivizumab)	Ml	1 ml	30
Ventolin HFA (albuterol)	Grams	18 grams	30
Xopenex HFA (levalbuterol)	Grams	Varies; claims should be divisible by 15 grams	Varies

3. Compounded Prescriptions

Iowa Medicaid will process claims for compounded prescriptions in the NCPDP D.Ø format using the multiple ingredient functionality. All applicable edits, including Preferred Drug List (PDL) rules, apply to each NDC submitted. Providers must submit the NDCs for the active ingredients dispensed to create the compound.

A dispensing fee will be added to the claim when a drug within the compound is reimbursed at EAC. There will be no additional fee paid to prepare the compounded prescription. Providers need to submit the quantity of the active ingredients used in the compound for reimbursement, not the quantity of the total amount of the compound made.

4. Coverage of Active Pharmaceutical Ingredients (APIs) and Excipients

Medicaid will cover certain API and excipient products, although the manufacturers have not entered into a rebate agreement with CMS. These products are identified on the API & Excipients Prescribed Drug list located on the website www.iowamedicaidpdl.com under the Preferred Drug Lists tab. Pharmacies shall provide these products and bill Medicaid through the point of sale system. Prior authorizations (PA) will be submitted through the Pharmacy PA system. Payment will be made in the same manner as prescription drugs.

5. Date of Birth Verification

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

6. Override Codes

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

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

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

7. Proper Reporting of NDCs

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

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

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

8. Prospective Drug Utilization Review (Pro-DUR)

The goal of Prospective DUR is to identify potential drug therapy concerns to allow the pharmacist to use professional judgment regarding the need for intervention, such as whether or not to contact the prescribing physician. The following prospective DUR edits will cause claims to deny:

Edit	Number and Message	Reason for the Denial	* Override Provided
Age Edits	75 - PRIOR AUTHORIZATION REQUIRED	Certain medications are payable only for specific age groups.	PA required.
Cost Effective-ness	75 - PRIOR AUTHORIZATION REQUIRED	Certain strengths should be substituted with more cost-effective strengths of the same medication.	PA required.
Dosage Form	75 - PRIOR AUTHORIZATION REQUIRED Additional text: NONPREFERRED	Certain dosage forms should be substituted with more cost-effective dosage forms of the same medication.	PA required.
Excessive Days Supply	19 - M/I DAYS SUPPLY Additional text: EXCEEDS ALLOWABLE DAYS SUPPLY	The supply submitted is more than 31 days.	Request an exception to policy if there is a valid reason why a supply more than 31 days is required.
15-Day Initial Prescription Supply Limit	76 - PLAN LIMITS EXCEEDED	The supply submitted is more than 15 days on select drugs.	PA required. See Quantity Limit Override.
Gender Edits	70 –PRODUCT/ SERVICE NOT COVERED – GENDER-SPECIFIC DRUG	Certain medications are payable only for a specific gender.	PA required.

Edit	Number and Message	Reason for the Denial	* Override Provided
High Dollar Claims	78 - COST EXCEEDS MAXIMUM Additional text: CLAIM EXCEEDS $5,000.00, PLEASE CALL POS HELPDESK	All claims submitted in excess of $5,000 will be rejected. After verifying that the quantity and days' supply of the claim are correct, contact the Pharmacy POS Help Desk. See below.	A one-time override will be granted if quantity and days' supply are accurate and consistent. Additional medical documentation is required for longer overrides.
Hospice Edits	75 - PRIOR AUTHORIZATION REQUIRED – NOT COVERED FOR HOSPICE MEMBER	If member has hospice coverage and medication is required to be paid by hospice.	Override may be considered if hospice does not provide payment. Call POS Helpdesk.
Incarcer-tion Edit	65 - PATIENT IS NOT COVERED Service not covered for recipient, limited benefits for date	Pharmacy claims submitted through POS for members identified as being incarcerated will reject.	No override provided. Member must update incarceration status, if applicable.
Maximum Daily Limits	76 - PLAN LIMITS EXCEEDED	If the total daily limit exceeds the established limit.	PA required.
Quantity Limits	76 - PLAN LIMITS EXCEEDED	If the quantity submitted exceeds the established quantity limit.	PA required. See Quantity Limit Override.
Refill Too Soon	79 - REFILL TOO SOON Additional text: RX NUMBER/FILL DATE/NPI OR NABP/DATE FOR NEXT FILL	If less than 90% of the previously paid claim for that medication has not been used. See Refill Too Soon.	If there is a change in dose; lost, stolen or destroyed drug; or travel.
Step Therapy Edits	75 - PRIOR AUTHORIZATION REQUIRED	Certain therapeutic drug classes are subject to step therapy edits as designated on the Preferred Drug List.	PA required.

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

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

a. Age Edits

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

Drug Name/Class	Age Edit	Prior Authorization (PA) Requirement
Benznidazole	Payable for members 2 through 11 years of age.	PA is required for members under 2 years of age and over 11 years of age.
Brovana	Payable for members 18 years of age and older.	PA is required for members under 18 years of age.
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.

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

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

b. Cost Effectiveness Edit

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

c. Dosage Form Edits

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

d. Excessive Days Supply

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

e. Gender Edits

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

f. High-Dollar Claims

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

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

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

g. Hospice Edits

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

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

h. Maximum Daily Edits

Drug Name/Class	Edit	Prior Authorization (PA) Requirement
Opioids	Maximum morphine milligram equivalents (MME) 90 per day	PA is required for members exceeding 90 MME per day. See High Dose Opioid PA form.

i. Refill Too Soon

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

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

j. Step Therapy Edits

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

Step 1: Preferred generic drugs. No PA required.

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

Step 3: Nonpreferred drugs. PA required.

k. Tablet Splitting

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

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

l. Therapeutic Duplication

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

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

9. Status Change for Preferred Brand Name Drugs

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

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

10. Travel or Vacation Supplies of Medication

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

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

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

11. 340B Drug Pricing Program

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

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

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

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

a. Covered Entity (CE)

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

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

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

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

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

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

(1) 340B Covered Entities

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

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

- Medicaid **CARVE OUT** all prescriptions from the 340B program when Medicaid is a payor for any portion of the claim:
  - Use non-340B drugs for all Medicaid members you serve.
  - Bill Medicaid only for drugs purchased outside the 340B program billed in accordance with existing state Medicaid reimbursement methodologies, allowing rebates to be collected where appropriate.
  - Do not list the 340B entity's NPI on the HRSA Medicaid Exclusion File.

  This allows rebates to be collected by Medicaid where appropriate.
- Medicaid **CARVE IN** all prescriptions into the 340B program:
  - Use 340B drugs for all Medicaid members you serve.
  - Inform OPA at the time of 340B enrollment that you intend to purchase and dispense 340B drugs for Medicaid members.
  - Do not bill Medicaid for 340B acquired drugs if your NPI is not listed on the HRSA Medicaid Exclusion File.
  - Purchase all drugs billed to Medicaid on the CE's NPI under 340B unless the product is not eligible for 340B pricing.

  This ensures these claims are excluded from Medicaid rebate.

- Billing:

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

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

(2) 340B Contract Pharmacies

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

12. Interpreter Services

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

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

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

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

a. Documentation of the Service

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

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

b. Qualifications

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

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

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

G. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

1. Remittance Advice Explanation

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

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

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

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

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

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

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

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

2. Remittance Advice Field Descriptions

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

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

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

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

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

Iowa Department of Human Services

Request for Prior Authorization
ACUTE MIGRAINE TREATMENTS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

No prior authorization (PA) is required for preferred acute migraine treatments, as indicated on the Preferred Drug List (PDL). PA is required for acute migraine treatments under the following conditions: 1) A diagnosis of acute migraine; and 2) Patient meets the FDA approved age for requested agent; and 3) For preferred acute migraine treatments where PA is required, as indicated on the PDL, documentation of previous trials and therapy failures with two preferred agents that do not require PA; and/or 4) For non-preferred acute migraine treatments, documentation of previous trials and therapy failures with two preferred agents that do not require PA. Requests for non-preferred CGRP inhibitors will also require documentation of a trial and therapy failure with a preferred CGRP inhibitor; and/or 5) For quantities exceeding the established quantity limit for each agent, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications; and/or 6) For non-preferred combination products, documentation of separate trials and therapy failures with the individual ingredients, in addition to the above criteria for preferred or non-preferred acute migraine treatments requiring PA. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred 5-HT1- Receptor Agonists
(PA required after 12 doses in 30 days)

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

Non- Preferred 5-HT-1 Receptor Agonists
(PA required from Day 1)

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

Preferred CGRP Inhbitors
(PA required)

- ☐ Nurtec (Quantity limit 15 doses per 30 days)

Non-Preferred CGRP Inhibitors
(PA required)

- ☐ Ubrelvy

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

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:

For Preferred Agents Requiring PA: document trials with two preferred agents that do not require PA

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

Failure reason: _____

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

Failure reason: _____

Iowa Department of Human Services

Request for Prior Authorization
ACUTE MIGRAINE TREATMENTS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

For Non-Preferred Agents Requiring PA: document trials with two preferred agents that do not require PA and a preferred GGRP inhibitor trial, if applicable

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

Failure reason:_____

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

Failure reason:_____

Preferred CGRP Inhibitor Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

For quantities exceeding the established quantity limit: document current prophylactic therapy or previous trials and therapy failures with two different prophylactic medications

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

Failure reason:_____

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

Failure reason:_____

For Non-Preferred Combination Products: document trials and therapy failures with the individual ingredients (in addition to above criteria for preferred or non-preferred treatments requiring PA)

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

Failure reason:_____

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

Failure reason:_____

Medical or contraindication reason to override trial requirements: _____
_____

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
ADENOSINE TRIPHOSPHATE-CITRATE LYASE 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 (PA) is required for adenosine triphosphate-citrate lyase (ACL) inhibitors. Payment will be considered under the following conditions:

1. **Patient meets the FDA approved age; and**
2. **Documentation of adherence to prescribed lipid lowering medications (including a maximally tolerated statin), prior to ACL inhibitor therapy, for the previous 90 days is provided (further defined below, by diagnosis); and**
3. **Documentation is provided that medication will be used in combination with a maximally tolerated statin; 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. **Patient will continue to follow an appropriate low fat diet; and**
6. **Is prescribed by or in consultation with a lipidologist, cardiologist, or endocrinologist; and**
7. **If patient is taking in combination with:**
    a. **Simvastatin, dose does not exceed 20mg per day; or**
    b. **Pravastatin, dose does not exceed 40mg per day; and**
8. **Concurrent use with a PCSK9 inhibitor will not be considered; and**
9. **Goal is defined as a 50% reduction in untreated baseline LDL-C; and**
10. **Is prescribed for one of the following diagnoses:**
    a. **Heterozygous Familial Hypercholesterolemia (HeFH):**
        i. **Documentation is provided verifying diagnosis (attach documentation/results), as evidenced by:**
            1. **Clinical manifestations of HeFH (e.g. tendon xanthomas, cutaneous xanthomas, arcus cornea, tuberous xanthomas, or xantehlasma): or**
            2. **Confirmation of diagnosis by gene or receptor testing: and**
        ii. **Documentation of untreated LDL-C ≥ 190 mg/dL: and**
        iii. **Patient is unable to reach LDL-C goal 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 (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily; or**
    b. **Clinical Atherosclerotic Cardiovascular Disease (ASCVD):**
        i. **History of MI, angina, coronary or other arterial revascularization, stroke, TIA, or PVD of atherosclerotic origin; and**
        ii. **Patient is unable to reach LDL-C goal with a minimum of two separate, chemically distinct statin**

Request for Prior Authorization
ADENOSINE TRIPHOSPHATE-CITRATE LYASE INHIBITORS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

trials used in combination with other lipid lowering medications. Trials are defined as: concurrent use of a maximally tolerated dose of a statin (must include atorvastatin and rosuvastatin), PLUS ezetimibe 10mg daily.

If criteria for coverage are met, requests will be approved for 3 months. Additional authorizations will be considered at yearly intervals under the following conditions:

a. **Patient continues therapy with a maximally tolerated statin dose and remains at goal; and**
b. **Patient continues to follow an appropriate low fat diet; and**
c. **Documentation of LDL reduction is provided.**

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

Non-Preferred

☐ Nexletol ☐ Nexlizet

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Attach baseline lipid profile (obtained prior to pharmacologic therapy)

Has patient been adherent to prescribed lipid lowering medications for the previous 90 days?

☐ Yes ☐ No

Will ACL inhibitor be used in combination with a maximally tolerated statin?

☐ Yes (document statin below) ☐ No

Concurrent Statin: Name/Dose:_____ Start Date: _____

Will patient continue to follow an appropriate low fat diet? ☐ Yes ☐ No

Will ACL inhibitor be used in combination with a PCSK9 inhibitor? ☐ Yes ☐ No

Is prescriber a lipidologist, cardiologist, or endocrinologist?

☐ Yes ☐ No (If no, note consultation with lipidologist, cardiologist, or endocrinologist)

Consultation Date: _____

Physician Name, Phone & Specialty: _____

Request for Prior Authorization
ADENOSINE TRIPHOSPHATE-CITRATE LYASE INHIBITORS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Trials:

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

Failure reason:_____

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

Failure reason:_____

Ezetimibe Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

☐ **Heterozygous Familial Hypercholesterolemia (HeFH):**

Attach documentation of one of the following:

- Clinical manifestations of HeFH (e.g. tendon xanthomas, cutaneous xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma)
- Confirmation of diagnosis by gene or receptor testing

☐ **Clinical Atherosclerotic Cardiovascular Disease (ASCVD):**

Does patient have history of any of the following:

- MI
- Angina
- Coronary or other arterial revascularization
- Stroke
- TIA
- PVD of atherosclerotic origin

☐ **Renewals:**

Is patient continuing therapy with a maximally tolerated statin and at goal? ☐ Yes ☐ No

Is patient currently following an appropriate low fat diet? ☐ Yes ☐ No

Current LDL (attach documentation): _____ Date obtained: _____

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
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 (PA) is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions: 1) Patient has an FDA approved or compendia indicated diagnosis; and 2) Patient meets the FDA approved or compendia indicated age; and 3) For the treatment of Type 2 Diabetes Mellitus, the patient has not achieved HgbA1C goals after a minimum three month trial with metformin at a maximally tolerated dose. 4) Requests for non-preferred anti-diabetic, non-insulin agents subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred drug in the same class. Requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document 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 PAs will be considered on an individual basis after review of medical necessity and documented continued improvement in symptoms (such as HgbA1C for Type 2 Diabetes).

Preferred DPP-4 Inhibitors and Combinations
(PA Required)

- ☐ 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
- ☐ Trijardy XR

Preferred Incretin Mimetics (PA required)

- ☐ Byetta
- ☐ Bydureon
- ☐ Trulicity
- ☐ Victoza

Non-Preferred Incretin Mimetics

- ☐ Adlyxin
- ☐ Bydureon BCise
- ☐ Ozempic
- ☐ Rybelsus

Preferred SGLT2 Inhibitors and Combinations
(No PA Required)

- ☐ Farxiga
- ☐ Invokamet
- ☐ Invokana
- ☐ Jardiance
- ☐ Synjardy

Non-Preferred SGLT2 Inhibitors and Combinations

- ☐ Invokamet XR
- ☐ Qtern
- ☐ Segluromet
- ☐ Steglatro
- ☐ Steglujan
- ☐ Synjardy XR
- ☐ Xigduo XR

Strength	Dosage Instructions	Quantity	Days Supply

Request for Prior Authorization
ANTI-DIABETICS NON-INSULIN AGENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Diagnosis: _____

☐ **Type 2 Diabetes Mellitus**

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: _____

_____

☐ **Other diagnosis:** _____

Trial of preferred drug in the same class: Drug Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

☐ **Renewals**

Document continued improvement in 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
ANTIFUNGAL DRUGS- ORAL / INJECTABLE

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

Prior authorization is not required for preferred antifungal therapy for a cumulative 90 days of therapy per 12-month period per patient. Prior authorization is required for all non-preferred antifungal therapy as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for a non-preferred antifungal will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). Payment for any antifungal therapy beyond this limit will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This prior authorization requirement does not apply to nystatin.

Preferred (PA required after 90 days)

- ☐ Clotrimazole Troche
- ☐ Fluconazole
- ☐ Griseofulvin Suspension
- ☐ Terbinafine
- ☐ Voriconazole
- ☐ Other: _____

Non-Preferred (PA required from Day 1)

- ☐ Cresemba
- ☐ Diflucan
- ☐ Grifulvin V
- ☐ Gris-Peg
- ☐ Griseofulvin Tablets
- ☐ Itraconazole
- ☐ Ketoconazole Tablets
- ☐ Lamisil
- ☐ Noxafil
- ☐ Onmel
- ☐ Oravig
- ☐ Posaconazole
- ☐ Sporanox
- ☐ Tolsura
- ☐ Vfend
- ☐ Other: _____

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:_____

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

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

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

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

Trial Date from_____ Trial Date to:_____

Medical or contraindication reason to override trial requirements:

_____

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

Attach lab results and other documentation as necessary.

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

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

Iowa Department of Human Services

Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

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

Pharmacy NPI	Pharmacy fax	NDC

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

Preferred
- ☐ Enbrel
- ☐ Humira
- ☐ Taltz (after step through one preferred TNF)

Non-Preferred
- ☐ Actemra
- ☐ Cimzia (prefilled syringe)
- ☐ Cosentyx
- ☐ Ilaris
- ☐ Kevzara
- ☐ Kineret
- ☐ Orencia
- ☐ Simponi
- ☐ Stelara

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

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

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

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

Requests for TNF Inhibitors:

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

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

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

Requests for Interleukins:

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

☐ **Rheumatoid arthritis (RA)** (Humira, Enbrel, Actemra, Cimzia, Kineret, Orencia, Simponi, Kevzara)-
Payment will be considered upon a trial and inadequate response to two preferred disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychoroquine, sulfasalazine, or leflunomide). Upon an unsuccessful methotrexate trial in patients with established RA, the combination trial with a second DMARD may be overridden if there is evidence of severe disease documented by radiographic erosions.

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

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

Radiographic evidence indicating erosions: ☐ Yes ☐ No

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

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

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

Payment will be considered upon a trial and inadequate response to intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

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

Failure reason: _____

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

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

Other medical conditions to consider: _____
Attach lab results and other documentation as necessary.

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

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

Iowa Department of Human Services

Request for Prior Authorization
BIOLOGICALS FOR AXIAL SPONDYLOARTHRITIS

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 axial spondyloarthritis conditions. Payment will be considered under the following conditions: 1) Patient has a diagnosis of ankylosing spondylitis (AS) or nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and 2) The requested dose does not exceed the maximum FDA labeled or compendia recommended dose for the submitted diagnosis; and 3) Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and 4) 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 5) Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least one month in duration: and 6) Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate; and 7) Requests for non-preferred biologicals for axial spondyloarthritis conditions will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents that are FDA approved or compendia indicated for the submitted diagnosis, when applicable.
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
☐ Enbrel ☐ Taltz (after step through one preferred TNF)
☐ Humira

Non-Preferred
☐ Cimzia ☐ Simponi
☐ Cosentyx

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

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

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

Request for Prior Authorization
BIOLOGICALS FOR AXIAL SPONDYLOARTHRITIS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

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

Reason for Failure: _____

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

Reason for Failure: _____

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

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

Requests for TNF Inhibitors:

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

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

Requests for Interleukins:

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

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

_____

Other medical conditions to consider: _____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

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

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

Iowa Department of Human Services

Request for Prior Authorization
BIOLOGICALS FOR 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

☐ Enbrel ☐ Humira
☐ Taltz (after step through one preferred TNF)

Non-Preferred

☐ Cimzia ☐ Siliq ☐ Stelara
☐ Cosentyx ☐ Skyrizi ☐ 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 III or IV 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
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.

Preferred
☐ Ajovy

Non-Preferred
☐ Aimovig ☐ 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.*

Iowa Department of Human Services

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

Request for Prior Authorization
CNS STIMULANTS AND ATOMOXETINE

(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
- ☐ Concerta
- ☐ Dexmethylphenidate ER Caps
- ☐ Dexmethylphenidate Tabs
- ☐ Dextroamphetamine EE Caps
- ☐ Dextroamphetamine Tabs
- ☐ Methylphenidate CD Caps
- ☐ Methylphenidate IR Tabs
- ☐ Methylphenidate ER Tabs
- ☐ Methylphenidate LA Caps
- ☐ Methylphenidate Solution
- ☐ Modafinil
- ☐ Quillichew ER
- ☐ Sunosi (step through armodafinil or modafinil)
- ☐ Vyvanse

Non-Preferred

- ☐ Adderall
- ☐ Adderall XR
- ☐ Adhansia XR*
- ☐ Adzenys ER Susp
- ☐ Adzenys XR ODT
- ☐ Amphetamine ER Suspension
- ☐ Amphetamine Sulfate Tabs
- ☐ Aptensio XR*
- ☐ Cotempla*
- ☐ Daytrana
- ☐ Desoxyn
- ☐ Dexedrine
- ☐ Dyanavel XR
- ☐ Evekeo
- ☐ Focalin
- ☐ Focalin XR
- ☐ Jornay PM
- ☐ Methylin Solution
- ☐ Methylphenidate Chew
- ☐ Methylphenidate ER 72mg Tabs
- ☐ Methylphenidate ER Caps*
- ☐ Methylphenidate XR Caps*
- ☐ Mydayis*
- ☐ Nuvigil
- ☐ Procentra
- ☐ Provigil
- ☐ Quillivant XR
- ☐ Ritalin
- ☐ Ritalin LA*
- ☐ Strattera

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
CYSTIC FIBROSIS 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

Prior authorization (PA) is required for oral cystic fibrosis agents. Payment will be considered for patients when the following criteria are met:

1) **Patient meets the FDA approved age; and**
2) **Patient has a diagnosis of cystic fibrosis (CF); and**
3) **Patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene confirmed by an FDA-cleared CF mutation test (attach test results) for which the requested drug is indicated; and**
4) **Prescriber is a CF specialist or pulmonologist; and**
5) **Baseline liver function tests (AST, ALT, and bilirubin) are provided; and**
6) **Requests for Trikafta will not be considered for patients with severe hepatic impairment (Child-Pugh Class C); and**
7) **Will not be used with other CFTR modulator therapies.**

If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met:

1) **Adherence to oral cystic fibrosis therapy is confirmed; and**
2) **Liver function tests (AST, ALT, and bilirubin) are assessed every 3 months during the first year of treatment and annually thereafter.**

Non-Preferred

☐ Kalydeco ☐ Orkambi ☐ Symdeko ☐ Trikafta

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

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

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

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

Request for Prior Authorization
CYSTIC FIBROSIS AGENTS, ORAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Will requested medication be used with other CFTR modulator therapies? ☐ No ☐ Yes

Trifakta Requests:

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

Renewal Requests:

Patient is adherent to oral cystic fibrosis therapy: ☐ Yes ☐ No

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

Attach lab results and other documentation as necessary.

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

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

Iowa Department of Human Services

Request for Prior Authorization
DIRECT ORAL ANTICOAGULANTS

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 not required for preferred direct oral anticoagulants (DOACs). Prior authorization is required for non-preferred DOACs. Requests will be considered for FDA approved dosing and length of therapy for submitted diagnosis. Requests for doses outside of the manufacturer recommended dose will not be considered. Payment will be considered for FDA approved or compendia indications for the requested drug under the following conditions: 1) Patient is within the FDA labeled age for indication; and 2) Patient does not have a mechanical heart valve; and 3) Patient does not have active bleeding; and 4) 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 5) A recent creatinine clearance (CrCl) is provided; and 6) A recent Child-Pugh score is provided; and 7) Patient's current body weight is provided; and 8) Patient has documentation of a trial and therapy failure at a therapeutic dose with at least two preferred DOACs; and 9) For requests for edoxaban, when prescribed for the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE), documentation patient has had 5 to 10 days of initial therapy with a parenteral anticoagulant (low molecular weight heparin or unfractionated heparin) is provided. 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)

☐ Bevyxxa

☐ 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
DIRECT 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 DOAC trials:

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

Failure reason:_____

Preferred DOAC 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) for diagnosis of DVT or PE:

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
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; or
4) Patient has a diagnosis of inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP); and
   a. Documentation dupilumab will be used as an add-on maintenance treatment; and
   b. Documentation of an adequate trial and therapy failure with at least one preferred medication from each of the following categories:
      i. Nasal corticosteroid spray; and

Request for Prior Authorization

Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

ii. Oral corticosteroid; and

5) 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.

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: _____

Iowa Department of Human Services

Request for Prior Authorization

Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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
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 ≤ 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

☐ **Inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)**

Will dupliumab be used as an add-on maintenance treatment?

☐ Yes (document concomitant maintenance treatment): Drug name & dose: _____

☐ No

Iowa Department of Human Services

Request for Prior Authorization

Dupilumab (Dupixent)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Document adequate trial and therapy failure with at least one preferred medication from each of the following categories:

Nasal Corticosteroid Spray Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Oral Corticosteroid Trial:

Drug name & dose:_____ Trial dates:_____

Failure reason:_____

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

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
☐ Fulphila ☐ Nivestym ☐ Ziextenzo
☐ Neupogen ☐ Nyvepria

Non-Preferred
☐ Granix ☐ Neulasta ☐ Zarxio
☐ Leukine ☐ Udencya

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
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

☐ Nplate ☐ Promacta

Non-Preferred

☐ Doptelet ☐ Mulpleta ☐ 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

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
HEPATITIS C TREATMENTS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

Prior authorization (PA) is required for hepatitis C treatments. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions: 1) Patient has a diagnosis of chronic hepatitis C; and 2) Patient's age and/or weight is within the FDA labeled age and/or weight; and 3) Patient has had testing for hepatitis C virus (HCV) genotype; and 4) Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and 5) Patient has been tested for hepatitis B (HBV) prior to initiating treatment of HCV and individuals with active HBV infection are treated (either at same time as HCV therapy or before HCV therapy is started); and 6) Patient's prior treatment history is provided (treatment naïve or treatment experienced); and 7) If patient has a history of non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and 8) Patient has abstained from the use of illicit drugs and alcohol for a minimum of three (3) months as evidenced by a negative urine confirmation test; and 9) HCV treatment is prescribed by or in consultation with a digestive disease, liver disease, or infectious disease provider practice; and 10) For patients on a regimen containing ribavirin, documentation of the following on the PA form: a) Patient is not a pregnant female or a male with a pregnant female partner; and b) Women of childbearing potential and their male partners must use two forms of effective contraception during treatment and for at least 6 months after treatment has concluded; and c) Monthly pregnancy tests will be performed during treatment; and 11) Prescriber has reviewed the patient's current medication list and acknowledged that there are no significant drug interactions with the HCV medication; and 12) Documentation is provided for patients who are ineligible to receive ribavirin. 13) Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved. 14) Patient does not have limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions. 15) If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on established length of therapy for the particular treatment (defined below). 16) Lost or stolen medication replacement requests will not be authorized. 17) The 72-hour emergency supply rule does not apply to hepatitis C treatments. 18) Only one treatment attempt will be allowed per calendar year, regardless of compliance.

Preferred:
- ☐ Mavyret
- ☐ sofosbuvir/velpatasvir
- ☐ Harvoni 45mg-200mg (3-11 y/o & < 35kg)
- ☐ Sovaldi 200mg (3-11 y/o & < 35kg)

Non-Preferred:
- ☐ Epclusa
- ☐ Harvoni
- ☐ ledipasvir/sofosbuvir
- ☐ Sovaldi
- ☐ Vosevi
- ☐ Zepatier

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

Instructions for completing the Hepatitis C Treatments PA form:

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

- Check ONE box in Section 1 – Treatment Regimen.
- Review and complete each numbered item in Section 2 – Supporting Documentation.
- Attach lab results, chart notes, and other documentation, sign, and fax the completed form to (800) 574-2515.

SECTION 1 – TREATMENT REGIMEN

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

Treatment naive

No cirrhosis

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks (for GT5/6 and/or HIV/HCV co-infection, 12 weeks is recommended)
- ❑ sofosbuvir/velpatasvir 400/100 mg, one tablet daily for 12 weeks

Compensated cirrhosis, HIV negative

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 8 weeks
- ❑ sofosbuvir/velpatasvir 400/100, one tablet daily for 12 weeks (for GT3, add weight based RBV if Y93H positive)

Compensated cirrhosis, HIV positive

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 12 weeks
- ❑ sofosbuvir/velpatasvir 400/100 mg, one tablet daily for 12 weeks (for GT3, add weight based RBV if Y93H positive)

Treatment experienced

Sofosbuvir-based regimen

- ❑ Mavyret 100/40 mg, three (3) tablets daily for 16 weeks

NS3/4 protease inhibitor inclusive regimen (e.g. Zepatier)

- ❑ Vosevi 400/100/100 mg, one tablet daily for 12 weeks

Mavyret

- ❑ Vosevi 400/100/100 mg, one tablet daily for 12 weeks (if compensated cirrhosis, add weight-based RBV)

Vosevi or sofosbuvir + Mavyret

- ❑ Vosevi 400/100/100 mg, one tablet daily + weight-based RBV for 24 weeks

GT 3 only: sofosbuvir/NS5A (e.g. Harvoni)

- ❑ Vosevi 400/100/100 mg, one tablet daily + weight-based RBV for 12 weeks

Re-infection of Allograft Liver after Transplant

DAA-treatment naïve, no decompensated cirrhosis

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

DAA-treatment experienced, no decompensated cirrhosis

- ❑ Vosevi 400/100/100 mg, one tablet daily for 12 weeks

IF multiple negative baseline characteristics, consider

- ❑ Vosevi 400/100/100 mg, one tablet daily + low dose RBV for 12 weeks

Treatment naïve, decompensated cirrhosis

- ❑ sofosbuvir/velpatasvir 400/100 mg, one tablet daily + low dose RBV for 12 weeks

Treatment experienced, decompensated cirrhosis (Child-Pugh B or C ONLY)

- ❑ sofosbuvir/velpatasvir 400/100 mg, one tablet daily + low dose RBV for 24 weeks

Decompensated Cirrhosis

No prior sofosbuvir or NS5A failure

- ❑ sofosbuvir/velpatasvir 400/100 mg + weight-based RBV daily for 12 weeks (low dose RBV recommended for Child-Pugh class C cirrhosis)
- ❑ sofosbuvir/velpatasvir 400/100 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for RBV)

Prior sofosbuvir or NS5A failure

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

Other Treatment Regimen
Genotype, treatment history, and extent of liver disease: _____ _____
Drug names, doses and durations:_____
Clinical rationale for selecting regimens other than those outlined above: _____ _____ _____

Abbreviations: RBV=ribavirin; DAA=direct acting antiviral

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

SECTION 2 – SUPPORTING DOCUMENTATION

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

Diagnosis:

1. Pretreatment viral load (**attach results**): _____ Date Obtained:_____

Patient History:

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

Prescriber Information:

7. Provider Practice: ☐Digestive Disease ☐Liver Disease ☐Infectious Disease ☐Other: _____
   If other, note consultation with Specialist:
   Consultation Date:_____ Physician Name, Phone & Specialty: _____

Regimens Containing Ribavirin:

8. If the patient is female and of childbearing potential, or the patient is male with a female partner of childbearing potential, the prescriber must acknowledge the following:
   - ❑ The patient is not pregnant (or a male patient with a pregnant female partner) and is not planning to become pregnant during treatment or within 6 months of stopping treatment.
   - ❑ Both partners will use two forms of effective contraception during treatment and for at least 6 months after stopping treatment.
   - ❑ Monthly pregnancy tests will be performed throughout treatment.
9. Complete blood count with differential (**attach results**)

10. If the patient is ineligible for ribavirin¶, select the appropriate reason from the list below:

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

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

Potentially Significant Drug Interactions:

11. By checking the following box, the prescriber attests that they have reviewed the patient's medications for potentially significant drug interactions with the Hepatitis C treatment on an electronic drug interaction website.

- ❑ **Website used: _____ Date completed: _____**

Attach lab results and other documentation

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

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Iowa Department of Human Services

Request for Prior Authorization
High Dose Opioids

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

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

Prior authorization is required for use of high-dose opioids ≥ 90 morphine milligram equivalents (MME) per day. (See CDC Guideline for Prescribing Opioids for Chronic Pain at https://www.cdc.gov/drugoverdose/prescribing/guideline.html.) Patients undergoing active cancer treatment or end-of-life care will not be subject to the criteria below. Payment will be considered when the following is met:

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

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

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

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

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

Drug name:_____ Strength:_____

Dosage instructions:_____ Quantity:_____ Days supply:_____

Drug name:_____ Strength:_____

Dosage instructions:_____ Quantity:_____ Days supply:_____

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

Initial Requests:

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

Non-pharmacological treatment trial #1:_____

Trial dates:_____ Failure reason:_____

Non-pharmacological treatment trial #2:_____

Trial dates:_____ Failure reason:_____

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

Nonopioid pharmacologic trial #1: Name/dose:_____

Trial dates:_____ Failure reason:_____

Nonopioid pharmacologic trial #2: Name/dose:_____

Trial dates:_____ Failure reason:_____

Document upward titration or conversion from other opioid medications:_____

_____

_____

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

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

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

Trial dates:_____ Failure reason:_____

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

Trial dates:_____ Failure reason:_____

Request for Prior Authorization
High Dose Opioids

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

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

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

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

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

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

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

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

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

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

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

<u>Renewals</u>:

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

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

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

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

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

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

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

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

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

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

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

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

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

Iowa Department of Human Services

Request for Prior Authorization
IL-5 ANTAGONISTS

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 IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. Payment will be considered under the following conditions:

1) Patient meets the FDA approved age for submitted diagnosis; and

2) Is dosed within FDA approved dosing for submitted diagnosis and age; and

3) Patient has a diagnosis of severe asthma with an eosinophilic phenotype; and

a) 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

b) 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

c) 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

d) A pretreatment forced expiratory volume in 1 second (FEV_1) <80% predicted in adults and < 90% in adolescents; or

4) Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis; and

a) Patient has documentation of an adequate trial and therapy failure with systemic glucocorticoids; and

b) One of the following:

i. Eosinophil count greater than 1000 cells/mcL; or

ii. Eosinophil count greater than 10% of the total leukocyte count; and

5) Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist.

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 when the following criteria are met:

Severe Asthma with an Eosinophilic Phenotype:

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.

Eosinophilic Granulomatosis with Polyangiitis:

1) Patient has demonstrated a positive clinical response to therapy (increase in remission time).

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
IL-5 ANTAGONISTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

Preferred

☐ Fasenra Auto-Injector

Non-Preferred

☐ Nucala Auto-Injector ☐ Nucala Prefilled Syringe

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:_____

Is prescriber and allergist, immunologist, pulmonologist, or rheumatologist?

❑ **Yes, document specialty:** _____

❑ **No** If no, note consultation with specialist:

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

Will the patient be taking requested medication in combination with another monoclonal antibody? ☐ No ☐ Yes

☐ **Severe Asthma with an Eosinophilic Phenotype:**

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:_____

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):_____

☐ **Eosinophilic Granulomatosis with Polyangiitis:**

Document trial of systemic glucocorticoid: Drug Name:_____ Strength:_____

Dosing Instructions:_____ Trial start & end date:_____

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

OR

Eosinophil count greater than 10% of the total leukocyte count (attach lab):_____ Date Obtained:_____

Iowa Department of Human Services

Request for Prior Authorization
IL-5 ANTAGONISTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

For Renewals Only:

Severe Asthma with an Eosinophilic Phenotype:

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:_____

_____

Eosinophilic Granulomatosis with Polyangiitis:

Has patient demonstrated a positive clinical response to therapy (increase in remission time)?

☐ No

☐ Yes, 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
IVABRADINE (CORLANOR®)

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 ivabradine. Only FDA approved dosing will be considered. Payment will be considered under the following conditions:

1) Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV); and
- **a) Patient is 18 years of age or older; and**
- **b) Patient has documentation of a left ventricular ejection fraction ≤ 35%; and**
- **c) Patient is in sinus rhythm with a resting heart rate of ≥70 beats per minute; and**
- **d) Patient has documentation of blood pressure ≥90/50 mmHg; or**

2) Patient has a diagnosis of stable symptomatic heart failure (NYHA/Ross class II to IV) due to dilated cardiomyopathy; and
- **a) Pediatric patient age 6 months and less than 18 years old; and**
- **b) Patient has documentation of a left ventricular ejection fraction ≤ 45%; and**
- **c) Patient is in sinus rhythm with a resting heart rate (HR) defined below:**
  - **i. 6 to 12 months – HR ≥ 105 bpm**
  - **ii. 1 to 3 years – HR ≥ 95 bpm**
  - **iii. 3 to 5 years – HR ≥ 75 bpm**
  - **iv. 5 to 18 years – HR ≥ 70 bpm; and**

3) Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g., carvedilol 50mg daily, metoprolol succinate 200mg daily, or bisoprolol 10mg daily), or weight appropriate dosing for pediatric patients, or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and

4) Patient has documentation of a trial and continued use with a preferred angiotensin system blocker at a maximally tolerated dose.

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

Non-Preferred

☐ Corlanor®

Strength	Dosage Instructions	Quantity	Days Supply

Request for Prior Authorization-*Continued*
IVABRADINE (CORLANOR®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Diagnosis:

☐ Stable, symptomatic heart failure (NYHA Class II to IV)): NYHA Class (≥ 18 years of age):_____

☐ Stable, symptomatic heart failure (NYHA/Ross Class II to IV) due to dilated cardiomyopathy (6 months to < 18 years of age):NYHA/Ross Class:_____

☐ Other:_____

Provide left ventricular ejection fraction:_____ Date obtained:_____

Provide resting heart rate in which patient is in sinus rhythm:

☐Resting heart rate:_____ Date obtained:_____

For diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV) in members ≥ 18 years of age:

Does patient have blood pressure ≥90/50mmHg?

☐ No ☐ Yes: Blood pressure:_____ Date obtained:_____

Treatment failure with maximally tolerated dose of beta-blocker with proven mortality benefit in a heart failure clinical trial:

Drug name & dose:_____ Trial dates:_____

Reason for failure:_____

Contraindication:_____

Trial and continued use with a preferred angiotensin system blocker at maximally tolerated dose:

Drug name & dose:_____ Trial dates:_____

Will an angiotensin system blocker be used concomitantly with ivabradine? ☐ No ☐ Yes

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
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
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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 ☐ ZTlido

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

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
LINEZOLID (ZYVOX®)

(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
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Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

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

1. **The patient has one of the following diagnostic criteria:**
   a. **Vancomycin-resistant Enterococcus (VRE); or**
   b. **Methicillin-resistant Staph aureus (MRSA); or**
   c. **Methicillin-resistant Staph epidermis (MRSE); or**
   d. **Other multiply resistant gram positive infection (e.g. penicillin resistant Streptococcus spp); and**
2. **Patient meets ONE of the following criteria:**
   a. **Patient is severely intolerant to vancomycin with no alternative regimens with documented efficacy available*, or**
   b. **VRE in a part of the body other than lower urinary tract**, or**
   c. **Patient discharged on linezolid and requires additional quantity (up to 10 days oral therapy will be allowed).**
3. **A current culture and sensitivity report is provided documenting sensitivity to linezolid.**

*** Severe intolerance to vancomycin is defined as:**

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

**** VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.**

Preferred	**Non-Preferred**
☐ Linezolid	☐ Zyvox

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

Diagnosis:

- ❑ **VRE**
  VRE in a body part other than lower urinary tract? ❑ Yes ❑ No If no,
  Patient has severe renal insufficiency? ❑ Yes ❑ No
  Is patient receiving hemodialysis? ❑ Yes ❑ No
  Does patient have known hypersensitivity to nitrofurantoin? ❑ Yes ❑ No
- ❑ **MRSA**
- ❑ **MRSE**
- ❑ **Other multiply resistant gram positive infection (specify):**_____

Does patient have a severe intolerance to vancomycin?

❑ Yes (select intolerance below)

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

Iowa Department of Human Services

Request for Prior Authorization
LINEZOLID (ZYVOX®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

❑ No

Was patient discharged on linezolid with additional quantity needed?
❑ Yes Discharge date: _____

❑ No

Attach a current culture and sensitivity report documenting sensitivity to linezolid.

Additional relevant information:
_____
_
_____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

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

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

Iowa Department of Human Services

Request for Prior Authorization
MODIFIED FORMULATIONS

(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
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Provider NPI	Prescriber name	Phone
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Pharmacy name	Address	Phone
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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) ☐ Alkindi (hydrocortisone tabs) ☐ Aricept ODT (Aricept tabs) ☐ Baqsimi (Glucagen)

☐ Binosto (alendronate tabs) ☐ Clozapine ODT / Fazaclo (clozapine tabs) ☐ Drizalma (duloxetine caps)

☐ 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
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

☐ Aubagio
☐ Dimethyl Fumarate
☐ Gilenya

Non-Preferred

☐ Bafiertam
☐ Mayzent
☐ Tecfidera
☐ Mavenclad
☐ Kesimpta
☐ Vumerity
☐ Zeposia

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:_____

Request for Prior Authorization
MULTIPLE SCLEROSIS AGENTS-ORAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

For patients initiating therapy with fingolimod (Gilenya) & ozanimod (Zeposia):

- 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
- 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), diroximel fumarate (Vumerity) & monomethyl fumarate (Bafiertam):

- 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

Request for Prior Authorization
MULTIPLE SCLEROSIS AGENTS-ORAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

- 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: _____

  _____

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 lll/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

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)

Celecoxib (COX-2)
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
- ☐ Diclofenac ER/XR*
- ☐ Diclofenac Epolamine
- ☐ EC-Naprosyn
- ☐ Etodolac CR/ER/XR
- ☐ Fenoprofen
- ☐ Flector Patch
- ☐ Indomethacin ER*
- ☐ Ketoprofen ER
- ☐ Licart
- ☐ Meclofenamate Sod
- ☐ Meloxicam Caps
- ☐ Naprelan
- ☐ Naproxen ER 750mg
- ☐ 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
PEANUT (*ARACHIS HYPOGAEA*) ALLERGEN POWDER-DNFP (PALFORZIA)

(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 Peanut (*Arachis hypogaea*) Allergen Powder-dnfp (Palforzia). Payment will be considered under the following conditions:

1. **Patient has a confirmed diagnosis of peanut allergy, as documented by a skin prick test to peanut ≥ 3 mm compared to control or a peanut-specific serum IgE ≥ 0.35 kUA/L (kilos of allergen-specific units per liter); and**
2. **Patient is 4 to 17 years of age at initiation of therapy or 4 years of age and older for continued up-dosing and maintenance therapy; and**
3. **Prescribed by or in consultation with an allergist or immunologist; and**
4. **Patient has access to injectable epinephrine: and**
5. **Will be used in conjunction with a peanut-avoidant diet; and**
6. **Patient does not have any of the following:**
    a. **Uncontrolled asthma; and/or**
    b. **A history of eosinophilic esophagitis or other eosinophilic gastrointestinal disease; and**
7. **Patient will adhere to the complex up-dosing schedule that requires frequent visits to the administering healthcare facility; and**
8. **The initial dose escalation and the first dose of each new up-dosing level is administered under the supervision of a health care professional in a health care setting with the ability to manage potentially severe allergic reactions, including anaphylaxis. Initial dose escalation and the first dose of all up-dosing levels is not to be billed to the Iowa Medicaid outpatient pharmacy program as the initial dose escalation is administered in the provider office and should be billed via the medical benefit and the first dose of all up-doing is provided via the Office Dose Kit; and**
9. **Follows FDA approved dosing; and**
10. **PA is required for all up-dosing dose levels (dose level 1 through 11); and**
11. **Maintenance dosing will be considered with documentation patient has successfully completed all dose levels of up-dosing.**

Non-Preferred

☐ Palforzia

Request for Prior Authorization
PEANUT (*ARACHIS HYPOGAEA*) ALLERGEN POWDER-DNFP (PALFORZIA)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Attach documentation of a skin prick or peanut-specific serum IgE test.

Is prescriber an allergist or immunologist? ☐ Yes ☐ No (If no, note consultation with allergist or immunologist)

Consultation Date: _____

Physician Name, Phone & Specialty: _____

Does patient have access to injectable epinephrine? ☐ Yes ☐ No

Will Palforzia be used in conjunction with a peanut-avoidant diet? ☐ Yes ☐ No

Does patient have any of the following:

- Uncontrolled asthma ☐ Yes ☐ No
- A history of eosinophilic esophagitis or other eosinophilic gastrointestinal disease ☐ Yes ☐ No

Will patient adhere to the complex up-dosing schedule that requires frequent visits to the administering healthcare facility? ☐ Yes ☐ No

Provide date of dose escalation for the requested dose provided by a health care professional in a health care setting: _____ Dose Level (1 through 11): _____

For maintenance dosing, has patient successfully completed all dose levels of up-dosing? (attach documentation) ☐ 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
PIRFENIDONE (ESBRIET) & NINTEDANIB (OFEV)

(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 pirfenidone (Esbriet®) and nintedanib (Ofev®). Dosing outside of the FDA approved dosing will not be considered. Concomitant use of pirfenidone and nintedanib will not be considered. Payment will be considered for patients when the following criteria are met:

1) Patient meets the FDA approved age; and

2) Is prescribed by a pulmonologist; and

3) Patient does not have hepatic impairment as defined below:

- **Nintedanib – Patient does not have moderate or severe hepatic impairment (Child-Pugh B or C); or**
- **Pifenidone – Patient does not have severe hepatic impairment (Child-Pugh C); and**

4) Patient does not have renal impairment as defined below:

- **Nintedanib – Patient does not have severe renal impairment (CrCl < 30 mL/min) or end-stage renal disease; or**
- **Pifenidone – Patient does not have end-stage renal disease requiring dialysis; and**

5) Patient does not utilize non-prescribed inhalants, such as vaping or other inhaled tobacco products, prior to initiating therapy and has been instructed to avoid tobacco products while using pirfenidone or nintedanib; and

6) Patient has a diagnosis of idiopathic pulmonary fibrosis (nintedanib or pirfenidone) as confirmed by one of the following (attach documentation):

- **a. Findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP); or**
- **b. A surgical lung biopsy demonstrating usual interstitial pneumonia (UIP); and**
- **c. Prescriber has excluded other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity; and**
- **d. Patient has documentation of pulmonary function tests within the prior 60 days with a forced vital capacity (FVC) ≥ 50% predicted; and**
- **e. Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30% predicted; or**

7) Patient has a diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) (nintedanib) as confirmed by the following (attach documentation);

- **a. Documentation of a chest high resolution computed tomography (HRCT) scan showing fibrosis affecting ≥ 10% of the lungs; and**
- **b. Patient has documented pulmonary function tests within the prior 60 days showing FVC ≥ 40% predicted; and**
- **c. Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30-89% predicted; or**

8) Patient has a diagnosis of chronic fibrosing interstitial lung disease with a progressive phenotype (nintedanib) as confirmed by the following (attach documentation):

Request for Prior Authorization
PIRFENIDONE (ESBRIET) & NINTEDANIB (OFEV)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

a. **Documentation of a chest high resolution computed tomography (HRCT) scan showing fibrosis affecting ≥ 10% of the lungs; and**

b. **Patient has documented pulmonary function tests within the prior 60 days showing FVC ≥ 45% predicted; and**

c. **Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30-79% predicted; and**

d. **Patient has at least one sign of clinical progression for interstitial lung disease within the last 24 months despite standard treatment with an agent other than nintedanib or pirfenidone:**

   i. **A relative decline in the FVC of at least 10% predicted; or**

   ii. **A relative decline in the FVC of 5-9% predicted combined with at least one of the following:**

      1. **Worsening respiratory symptoms; or**

      2. **Increased extent of fibrosis on HRCT; or**

   iii. **Worsening of respiratory symptoms and an increased extent of fibrotic changes on HRCT only.**

If criteria for coverage are met, initial authorizations will be given for 6 months. Additional authorizations will be considered at 6 month intervals when the following criteria are met:

1. **Adherence to pirfenidone (Esbriet®) or nintedanib (Ofev®) is confirmed; and**
2. **Documentation of a positive response to therapy, defined as meeting at least one of the following:**
   a. **Rate of lung function decline slowed; or**
   b. **Improved or no worsening of symptoms of cough or shortness of breath; and**
3. **Documentation is provided that the patient has remained tobacco-free; and**
4. **ALT, AST, and bilirubin are assessed periodically during therapy.**

Non-Preferred

☐ Esbriet ☐ Ofev

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

Is Prescriber a Pulmonologist? ☐ Yes ☐ No

Does patient have moderate to severe hepatic impairment? ☐ Yes, Child-Pugh B ☐ Yes, Child-Pugh C ☐ No

Does patient have moderate to severe renal impairment or end-stage renal disease? ☐ Yes ☐ No

CrCl:_____ Date obtained:_____ Is patient on dialysis? ☐ Yes ☐ No

Does patient utilize non-prescribed inhalants, such as vaping or other inhaled tobacco products, prior to initiating therapy? ☐ Yes ☐ No

Has patient been instructed to avoid tobacco products while using pirfenidone or nintedanib? ☐ Yes ☐ No

☐ **Idiopathic Pulmonary Fibrosis (nintedanib or pifenidone)**

Attach results of HRCT or surgical lung biopsy indicating usual interstitial pneumonia (UIP).

Has prescriber excluded other known causes of interstitial lung disease (ILD)? ☐ Yes ☐ No

Patient has pulmonary function test within the prior 60 days documenting a FVC ≥ 50% predicted:

☐ Yes (attach results) ☐ No

Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30% predicted? ☐ Yes (attach results) ☐ No

Request for Prior Authorization
PIRFENIDONE (ESBRIET) & NINTEDANIB (OFEV)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD) (nintedanib)**

Attach results of HRCT scan showing fibrosis affecting ≥ 10% of the lungs.

Patient has pulmonary function test within the prior 60 days showing FVC ≥ 40% predicted:

☐ Yes (attach results) ☐ No

Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30-89% predicted? ☐ Yes (attach results) ☐ No

☐ **Chronic Fibrosing Interstitial Lung Disease (nintedanib)**

Attach results of HRCT scan showing fibrosis affecting ≥ 10% of the lungs.

Patient has pulmonary function test within the prior 60 days showing FVC ≥ 45% predicted:

☐ Yes (attach results) ☐ No

Patient has a carbon monoxide diffusion capacity (%DLco) of ≥ 30-79% predicted? ☐ Yes (attach results) ☐ No

Patient has at least one sign of clinical progression of ILD within the last 24 months despite standard treatment with an agent other than nintedanib or pirfenidone:

- ☐ A relative decline in the FVC of at least 10% predicted
- ☐ A relative decline in the FVC of 5-9% predicted combined with at least one of the following
  - Worsening respiratory symptoms
  - Increased extent of fibrosis on HRCT
- ☐ A worsening of respiratory symptoms and an increased extent of fibrotic changes on HRCT only.

☐ **Renewal Requests:**

Patient is adherent to therapy: ☐ Yes ☐ No

Patient has remained tobacco-free: ☐ Yes ☐ No

Patient has a positive response to therapy, defined as meeting at least one of the following:

- ☐ Rate of lung function decline slowed
- ☐ Improved or no worsening of cough or shortness of breath

ALT, AST, and bilirubin are being assessed periodically: ☐ Yes ☐ No Most recent date obtained:_____

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
POTASSIUM BINDERS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

Prior authorization is required for potassium binders subject to clinical criteria. Payment will be considered under the following conditions:

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

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

Preferred

☐ Lokelma ☐ Veltassa

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

Diagnosis:_____

Sodium polystyrene sulfonate trial: Dose:_____ Trial dates:_____

Failure reason:_____

Medical or contraindication reason to override trial requirements:_____

_____

Attach lab results and other documentation as necessary.

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

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
PROTON PUMP INHIBITORS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

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

Preferred
- ☐ Dexilant
- ☐ Omeprazole Caps (RX)
- ☐ Nexium Oral Packet
- ☐ Pantoprazole

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

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

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

Trial Medications & Dates:_____

_____

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

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

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

Iowa Department of Human Services

Request for Prior Authorization
SEDATIVE/HYPNOTICS-NON-BENZODIAZEPINE

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

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

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

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

Preferred
- ☐ Eszopiclone
- ☐ Zaleplon
- ☐ Zolpidem

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

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

Diagnosis_____ **Date of Diagnosis:** _____

Co-Morbid Conditions Contributing to Insomnia: _____
_____

Non-Pharmacological Treatments Tried: _____

Requests for Non-Preferred Drugs:

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

Reason for Failure: _____

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

Reason for Failure: _____

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

Reason for Failure: _____

Request for Prior Authorization
SEDATIVE/HYPNOTICS-NON-BENZODIAZEPINE

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

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

Reason for Failure: _____

Medical Necessity for alternative delivery system: _____

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

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

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

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

Iowa Department of Human Services

Request for Prior Authorization
SHORT ACTING OPIOIDS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

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

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

Acetaminophen/Codeine
Hydrocodone/APAP
Hydromorphone Tab
Morphine Sulfate Tab
Oxycodone Cap/Tab
Oxycodone /APAP (5/325)
Oxycodone/ASA
Tramadol 50mg

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
- ☐ Prolate
- ☐ Roxicodone
- ☐ Tramadol 100mg
- ☐ 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

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

Medical necessity for concurrent use: _____

_____

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

_____

Renewals

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

☐ No ☐ Yes (describe): _____

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

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
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
- ☐ Jatenzo
- ☐ 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

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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	Non-Preferred				
☐ Acanya	☐ Aczone	☐ Benzamycin Pak	☐ Metronidazole Gel & Lotion		
☐ Adapalene Gel	☐ Adapalene/Benzoyl Peroxide	☐ Cleocin T	☐ Noritate		
☐ Azelex	☐ Adapalene Cream/Lotion/Sol	☐ Clindamycin/BPO	☐ Onexton		
☐ Clindamycin	☐ Aklief	☐ Clindamycin Phosphate-Tretinoin	☐ Plixda Pads		
☐ Differin	☐ Altreno Lotion	☐ Duac	☐ Retin-A Micro		
☐ Epiduo	☐ Amzeeq	☐ Erythromycin/BPO	☐ Sodium Sulfa/Sulf		
☐ Erythromycin	☐ Arazlo	☐ Fabior	☐ Soolantra		
☐ MetroGel 1%	☐ Atralin	☐ Finacea	☐ Tretinoin		
☐ MetroLotion	☐ Azelaic Acid Gel 15%	☐ Ivermectin cream	☐ Ziana		
☐ Metronidazole 0.75% Cream	☐ BenzaClin	☐ Klaron	☐ Zilxi		
☐ Retin-A	☐ Benzamycin	☐ MetroCream			
☐ Tazorac	☐ Other (specify)				

Strength	Dosage Form	Dosage Instructions	Quantity	Days Supply

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

Diagnosis: _____

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
VALSARTAN/SACUBITRIL (ENTRESTO)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

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

1) **Patient is within the FDA labeled age for indication; and**
2) **Patient has a diagnosis of NYHA Functional Class II, III, or IV heart failure; and**
   a) **Patient has a left ventricular ejection fraction (LVEF) ≤40%; and**
   b) **Patient is currently tolerating treatment with an ACE inhibitor or angiotensin II receptor blocker (ARB) at a therapeutic dose, where replacement with valsartan/sacubitril is recommended to further reduce morbidity and mortality; and**
   c) **Is to be administered in conjunction with other heart failure therapies, in place of an ACE inhibitor or other ARB (list medications patient is currently taking for the treatment of heart failure); or**
3) **Pediatric patient has a diagnosis of symptomatic heart failure (NYHA/Ross Class II to IV) due to systemic left ventricular systolic dysfunction with documentation of a left ventricular ejection fraction ≤ 40%; and**
4) **Will not be used in combination with an ACE inhibitor or ARB; and**
5) **Will not be used in combination with aliskiren (Tekturna) in diabetic patients; and**
6) **Patient does not have a history of angioedema associated with the use of ACE inhibitor or ARB therapy; and**
7) **Patient is not pregnant; and**
8) **Patient does not have severe hepatic impairment (Child Pugh Class C).**

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

Preferred

☐ Entresto

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

Diagnosis:_____

Request for Prior Authorization
VALSARTAN/SACUBITRIL (ENTRESTO)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

Does patient have a history of angioedema associated with ACE inhibitor or ARB therapy?

☐ Yes ☐ No

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

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

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

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

Adult Heart Failure Patients Only:

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

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

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

_____

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

_____

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
VOXELOTOR (OXBRYTA)

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 Oxbryta (voxelotor). Payment will be considered for patients when the following criteria are met:

1) **Patient meets the FDA approved age; and**
2) **Patient has a diagnosis of sickle cell disease (SCD); and**
3) **Requested dose is within the FDA approved dosing; and**
4) **Patient has experienced at least two sickle cell-related vasoocclusive crises within the past 12 months (documentation required); and**
5) **Patient has documentation of an adequate trial and therapy failure with hydroxyurea; and**
6) **Baseline hemoglobin (Hb) range is ≥5.5 to ≤10.5 g/dL; and**
7) **Is prescribed by or in consultation with a hematologist; and**
8) **Patient is not receiving concomitant blood transfusion therapy.**

If the criteria for coverage are met, an initial authorization will be given for 6 months. Additional approvals will be granted if the following criteria are met:

1) **Documentation of an increase in hemoglobin by ≥1 g/dL from baseline; and**
2) **Documentation of a decrease in the number of sickle cell-related vasoocclusive crises.**

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

Non-Preferred

☐ Oxbryta

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

Diagnosis: _____

Request for Prior Authorization-*Continued*
VOXELOTOR (OXBRYTA)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Treatment failures:

Hydroxyurea Trial:

Drug name & dose:_____ Trial dates:_____

Reason for failure:_____

Has patient experienced at least two sickle cell-related vasoocclusive crises within the past 12 months?

☐ No ☐ Yes (provide documentation)

Baseline Hb: _____ Date obtained: _____

Is Prescriber a hematologist?

❑ **Yes**

❑ **No** If no, note consultation with hematologist:

Consultation Date:_____ Physician Name & Phone: _____

Is patient receiving concomitant blood transfusion therapy? ☐ No ☐ Yes

<u>Renewal Requests</u>

Provide current Hb: _____ Date obtained: _____

Has patient experienced a decrease in the number of sickle cell-related vasoocclusive crises?

☐ No ☐ Yes

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.*