INFORMATIONAL LETTER NO. 2668-MC-FFS-D

DATE: February 28, 2025

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

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

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

RE: April 2025 Iowa Medicaid Pharmacy Program Changes

EFFECTIVE: April 1, 2025

1. **New Drug Prior Authorization (PA) Criteria** – See the complete PA criteria chart on the PDL website[1].
   - **Ensifentrine (Ohtuvayre)**
     Prior authorization (PA) is required for ensifentrine (Ohtuvayre). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for Food and Drug Administration (FDA) approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

[1] https://www.iowamedicaidpdl.com/pa-pdl/prior-authorization-criteria.html

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of moderate to severe COPD when all of the following are met:
   a. FEV1/FVC ratio < 0.7; and
   b. Post-bronchodilator FEV1 % predicted of 30% to 79%; and
   c. Modified Medical Research Council (mMRC) dyspnea score of ≥ 2 or a COPD Assessment Test (CAT) score ≥ 10; and
3. Patient is adherent with COPD treatments, meeting one of the following criteria:
   a. The patient has a blood eosinophil of ≥ 100 and has experienced an exacerbation while adherent to a current 60-day trial of a triple combination regimen consisting of a long-acting beta agonist (LABA), a long-acting muscarinic antagonist (LAMA), and an inhaled corticosteroid (ICS); or
   b. The patient has a blood eosinophil of < 100 and has experienced an exacerbation while adherent to a current 60-day trial of a dual combination regimen consisting of a LABA and LAMA; and
4. Dual or triple combination regimen will be continued in combination with ensifentrine (Ohtuvayre).

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

If the criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Additional authorizations will be considered upon documentation of a response to treatment (e.g., improved dyspnea, decreased exacerbations) and patient continues their dual or triple combination regimen.

- **Incretin Mimetics for Non-Diabetes Indications**
  Prior authorization (PA) is required for incretin mimetics not otherwise covered by the Anti-Diabetics Non-Insulin Agents PA criteria for covered FDA approved or compendia indications. Payment for excluded medical use(s) (e.g., weight loss), as defined in the Iowa State Plan and Iowa Administrative Code 441 – 78.2(4) will be denied. Payment will be considered under the following conditions:
  1. Request adheres to all FDA approved labeling for requested drug and indication, including dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and

2. Patient is ≥ 45 years of age; and
3. Patient has been screened for and does not have type 1 or type 2 diabetes mellitus (attach current lab results, obtained within 6 months of request, documenting an A1C < 6.5% or a fasting plasma glucose < 126 mg/dL); and
4. The requested drug will be used to reduce the risk of major adverse cardiovascular events (MACE) (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in an adult with established cardiovascular disease (CVD) and either obesity or overweight; and
    a. Patient has established CVD with history of one of the following (attach chart notes documenting diagnosis):
        i. Prior myocardial infarction (MI);
        ii. Prior stroke (ischemic or hemorrhagic);
        iii. Symptomatic peripheral arterial disease (PAD), as evidenced by intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest), peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; and
    b. Patient has a baseline body mass index (BMI) ≥ 27 kg/m^2, obtained within 6 months of request; and
    c. Patient has been evaluated for cardiovascular standard of care treatment; and
    d. For Wegovy dosing:
        i. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
        ii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment; and
5. Patient will use medication in combination with a reduced calorie diet and increased physical activity; and
6. The requested agent will not be used in combination with other incretin mimetics.

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

Requests will be considered for initiation and appropriate dosage escalation. Requests for continuation of therapy, once at an established maintenance dose will be considered at 12-month intervals when:

1. The requested drug will be used to reduce the risk of MACE; and
    a. Patient does not have type 1 or type 2 diabetes; and

b. Patient has been evaluated for cardiovascular standard of care treatment; and
c. For Wegovy, a maintenance dose of 1.7 mg or 2.4 mg once weekly is requested; and

2. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and
3. The requested agent will not be used in combination with other incretin mimetics.

- **Vonoprazan (Voquezna)**
  Prior authorization (PA) is required for vonoprazan (Voquezna), Voquezna Dual Pak, and Voquezna Triple Pak. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:
  1. Request adheres to all FDA approved labeling for requested drug and indication, including, age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
  2. Patient has a diagnosis of healing of erosive esophagitis (attach endoscopy results for initial diagnosis), maintenance of healed erosive esophagitis (attach endoscopy results for initial diagnosis), and relief of heartburn associated with non-erosive gastroesophageal reflux disease (GERD); and
     a. Documentation of an 8-week trial and therapy failure, based on ongoing symptoms, with two preferred PPIs, each twice-daily dosing; or
  3. Patient has an active Helicobacter pylori (H. pylori) infection (attach documentation); and
     a. Patient has documentation of a recent trial and therapy failure with a preferred agent(s) for the treatment of H. pylori infection; and
     b. Request is for the triple pak or dual pak.

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

If the criteria for coverage are met, requests will be evaluated for the dosage and duration of therapy according to the indications specified on the FDA approved label.

2. **Changes to Existing PA Criteria** – The below criteria have been updated effective April 1, 2025. See the complete PA criteria chart on the PDL website[2].
   - **Dupilumab (Dupixent)**
   - **Select Preventative Migraine Treatments**
   - **Select Topical Agents (renamed from Select Topical Psoriasis Agents)**

3. **Point of Sale Billing Updates:**
   - **Fifteen (15) Day Initial Prescription Supply Limit List:** Effective April 1, 2025, the following medications will be removed from the initial 15-day prescription limit list: Afinitor, Afinitor Disperz, Bosulif capsules, Cometriq, Imbruvica, Tafinlar, Tepmetko and Zejula. A comprehensive list of included medications can be found on the Fifteen Day Initial Prescription Supply Limit List.[3]

We encourage providers to go to the PDL website[4] to view all recent changes to the PDL. If you have questions, please contact the Pharmacy Prior Authorization (PA) Helpdesk at 1-877-776-1567, locally in Des Moines at 515-256-4607, or by e-mail at pba_iapdlinfo@optum.com.

If you have questions, please contact Iowa Medicaid Provider Services, the appropriate managed care organization (MCO) or dental plan:

Iowa Medicaid Provider Services:
- Phone: 1-800-338-7909
- Email: imeproviderservices@hhs.iowa.gov

Managed Care Organizations (MCOs):
Iowa Total Care:
- Phone: 1-833-404-1061
- Email: providerrelations@iowatotalcare.com
- Website: https://www.iowatotalcare.com

Molina Healthcare of Iowa:
- Phone: 1-844-236-1464
- Email: iaproviderrelations@molinahealthcare.com
- Website: https://www.molinahealthcare.com/providers/ia/medicaid/home.aspx
- Provider Portal: https://www.availity.com/molinahealthcare

[2] https://www.iowamedicaidpdl.com/pa-pdl/prior-authorization-criteria.html
[3] https://www.iowamedicaidpdl.com/pa-pdl/preferred-drug-lists.html
[4] https://www.iowamedicaidpdl.com/

Wellpoint Iowa, Inc.:

- Phone: 1-833-731-2143
- Email: ProviderSolutionsIA@wellpoint.com
- Website: https://www.provider.wellpoint.com/iowa-provider/home

Dental Plans:

Delta Dental:

- Phone: 1-888-472-1205
- Email: provrelations@deltadentalia.com
- Website: https://www.deltadentalia.com/dentists/

MCNA Dental:

- Phone: 1-855-856-6262
- Email: IA_PR_Dept@mcna.net
- Website: https://www.mcnaia.net/dentists