IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION
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February 8, 2024

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Dear Abby:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, February 7, 2024. At this meeting, the DUR Commission members discussed updated PA criteria for Odevixibat (Bylvay), Oral Constipation Agents, Oral Immunotherapy, and Vesicular Monoamine Transporter (VMAT) 2 Inhibitors. Additionally, the DUR Commission received public comment regarding vitiligo as a chronic autoimmune skin disorder, not a cosmetic condition. The following recommendations have been made by the DUR Commission:

No comments were received from the medical/pharmacy associations in response to a November 7, 2023 letter that was sent to them detailing the updated PA criteria for Odevixibat (Bylvay), Oral Constipation Agents, Oral Immunotherapy, and Vesicular Monoamine Transporter (VMAT) 2 Inhibitors.

Odevixibat (Bylvay)

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

1. Request adheres to all FDA approved labeling including age, dosing, contraindications, warnings and precautions, and drug interactions; and
2. Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) type 1 or 2; and
3. Genetic testing does not indicate PFIC type 2 with ABCB 11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and
4. Patient has moderate to severe pruritis associated with PFIC; and
5. Patient's current weight in kg is provided; and
6. Is prescribed by or in consultation with a hepatologist or gastroenterologist.

Initial authorizations will be approved for 3 months for initial treatment or after a dose increase. Additional authorizations will be considered when the following criteria are met:

1. Patient's current weight in kg is provided; and
2. Documentation is provided the patient has responded to therapy and pruritis has improved. If there is no improvement in pruritis after 3 months of treatment with the maximum 120 mcg/kg/day dose, further approval of odevixibat will not be granted.

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted or stricken)
Prior authorization (PA) is required for odevixibat (Bylvay). Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling including age, dosing, contraindications, warnings and precautions, and drug interactions; and
2. Patient has a diagnosis of genetically confirmed progressive familial intrahepatic cholestasis (PFIC) type 1 or 2; and
    a. Genetic testing does not indicate PFIC type 2 with ABCB 11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3); and
    b. Patient has moderate to severe pruritis associated with PFIC; ~~and~~ *or*
3. *Patient has a diagnosis of Alagille Syndrome (ALGS) confirmed by genetic testing demonstrating a JAG1 or NOTCH2 mutation or deletion; and*
    a. *Patient has cholestasis with moderate to severe pruritis; and*
    b. *Documentation of previous trials and therapy failures, at a therapeutic dose, with at least two of the following agents:*
        i. *Ursodeoxycholic acid (ursodiol)*
        ii. *Cholestyramine*
        iii. *Rifampin; and*
4. Patient's current weight in kg is provided; and
5. Is prescribed by or in consultation with a hepatologist*,* ~~or~~ gastroenterologist*, or a prescriber who specializes in PFIC or ALGS*.

Initial authorizations will be approved for 3 months for initial treatment or after a dose increase. Additional authorizations will be considered when the following criteria are met:

1. Patient's current weight in kg is provided; and
2. Documentation is provided the patient has responded to therapy and pruritis has improved. If there is no improvement in pruritis after 3 months of treatment with the maximum 120 mcg/kg/day dose, further approval of odevixibat will not be granted.

Oral Constipation Agents

Current Clinical Prior Authorization
Prior authorization (PA) is required for oral constipation agents subject to clinical criteria. Payment for non-preferred oral constipation agents will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred oral constipation agent. Payment will be considered under the following conditions:

1. Patient meets the FDA approved age; and
2. Patient must have documentation of adequate trials and therapy failures with both of the following:
    a. Stimulant laxative (senna) plus saline laxative (milk of magnesia); and
    b. Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose); and
3. Patient does not have a known or suspected mechanical gastrointestinal obstruction; and
4. Patient has one of the following diagnoses:
    a. A diagnosis of chronic idiopathic constipation (Amitiza, Linzess, Motegrity, Trulance)
        i. Patient has less than 3 spontaneous bowel movements (SBMs) per week; and
        ii. Patient has two or more of the following symptoms within the last 3 months:

1. Straining during at least 25% of bowel movements;
2. Lumpy or hard stools for at least 25% of bowel movements; and
3. Sensation of incomplete evacuation for at least 25% of bowel movements; and

iii. Documentation the patient is not currently taking constipation causing therapies

b. A diagnosis of irritable bowel syndrome with constipation (Amitiza, Ibsrela, Linzess, or Trulance)
   i. Patient is female (Amitiza only); and
   ii. Patient has recurrent abdominal pain on average at least 1 day per week in the last 3 months associated with two (2) or more of the following:
      1. Related to defecation;
      2. Associated with a change in stool frequency; and/or
      3. Associated with a change in stool form
c. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza, Movantik, Relistor, or Symproic)
   i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and
   ii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
      1. Hard to very hard stool consistency;
      2. Moderate to very severe straining; and/or
      3. Having a sensation of incomplete evacuation

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

<u>Proposed Clinical Prior Authorization</u> (changes highlighted, italicized and/or stricken)

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

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* ~~Patient meets the FDA approved age~~; and
2. Patient must have documentation of adequate trials and therapy failures with ~~both of~~ the following:
   a. Members 18 years of age or older:
      i. Stimulant laxative (senna) plus saline laxative (milk of magnesia); and
      ii. Stimulant laxative (senna) plus osmotic laxative (polyethylene glycol or lactulose); *or* ~~and~~
   b. Members 17 years of age or younger:
      i. *Polyethylene glycol; and*
      ii. *One other preferred generic laxative, such as lactulose or senna; and*
3. Patient does not have a known or suspected mechanical gastrointestinal obstruction; and
4. Patient has one of the following diagnoses:
   a. A diagnosis of chronic idiopathic constipation (Amitiza, Linzess, Motegrity, Trulance)
      i. Patient has less than 3 spontaneous bowel movements (SBMs) per week; and
      ii. Patient has two or more of the following symptoms within the last 3 months:
         1. Straining during at least 25% of bowel movements; ~~and~~

2. Lumpy or hard stools for at least 25% of bowel movements; ~~and~~
3. Sensation of incomplete evacuation for at least 25% of bowel movements; and

iii. Documentation the patient is not currently taking constipation causing therapies; or

b. A diagnosis of irritable bowel syndrome with constipation (Amitiza, Ibsrela, Linzess, or Trulance)
   i. Patient is female (Amitiza only); and
   ii. Patient has recurrent abdominal pain on average at least 1 day per week in the last 3 months associated with two (2) or more of the following:
      1. Related to defecation;
      2. Associated with a change in stool frequency; ~~and/or~~
      3. Associated with a change in stool form; *or*

c. A diagnosis of opioid-induced constipation with chronic, non-cancer pain (Amitiza, Movantik, Relistor, or Symproic)
   i. Patient has been receiving stable opioid therapy for at least 30 days as seen in the patient's pharmacy claims; and
   ii. Patient has less than 3 spontaneous bowel movements (SBMs) per week, with at least 25% associated with one or more of the following:
      1. Hard to very hard stool consistency;
      2. Moderate to very severe straining; ~~and/or~~
      3. Having a sensation of incomplete evacuation; *or*

d. *A diagnosis of functional constipation (Linzess)*
   i. *Patient has less than 3 SBMs per week; and 1 or more of the following criteria at least once per week for at least 2 months:*
      1. *History of stool withholding or excessive voluntary stool retention;*
      2. *History of painful or hard bowel movements;*
      3. *History of large diameter stools that may obstruct the toilet;*
      4. *Presence of a large fecal mass in the rectum;*
      5. *At least 1 episode of fecal incontinence per week.*

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

Oral Immunotherapy

Current Clinical Prior Authorization

Prior authorization is required for sublingual allergen immunotherapy. Payment will be considered under the following conditions:

1. Medication is prescribed by an allergist; and
2. Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and
3. Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines); and
4. Patient has a documented intolerance to immunotherapy injections; and
5. The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration).

6. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved.

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

- Patient is 18 through 65 years of age; and
- Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen.
- If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen season and continued throughout the season.

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

- Patient is 10 through 65 years of age (Oralair®); and
- Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, and Kentucky blue/June grass.
- If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season; or
- Patient is 5 through 65 years of age (Grastek®); and
- Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop).
- If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of each grass pollen season.

Proposed Clinical Prior Authorization (changes italicized/highlighted and/or stricken)
Prior authorization is required for sublingual allergen immunotherapy. Payment will be considered *when patient has an FDA approved or compendia indication for the requested drug* under the following conditions:

1. *Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings & precautions, drug interactions, and use in specific populations; and*
2. Medication is prescribed by *or in consultation with* an allergist *or immunologist*; and
3. ~~Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and~~
4. *Patient has documentation of an adequate trial and therapy failure with an intranasal corticosteroid and oral or nasal antihistamine used concurrently; and* ~~Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines); and~~
5. Patient has a documented intolerance to immunotherapy injections; and
6. The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration).
7. If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved.

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

~~1. Patient is 18 through 65 years of age; and~~

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

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

1. *Request is for* ~~Patient is 10 through 65 years of age (~~Oralair®~~)~~; and
    a. *Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and*
    b. Patient has a positive skin test or *in vitro* testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, and Kentucky blue/June grass.
    c. If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season; or
2. *Request is for* ~~Patient is 5 through 65 years of age (~~Grastek®~~)~~; and
    a. *Patient is diagnosed with grass pollen-induced allergic rhinitis, with or without conjunctivitis; and*
    b. Patient has a positive skin test or *in vitro* testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop).
    c. If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ~~each~~ grass pollen season *as follows:*
        - *Seasonally, through the end of the grass pollen season or*
        - *For sustained effectiveness, up to three consecutive years (including the intervals between grass pollen seasons) for one grass pollen season after cessation of treatment. Authorizations would be given in 12-month intervals up to three consecutive years with one grass pollen season.*

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

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

Vesicular Monoamine Transporter (VMAT) 2 Inhibitors

<u>Current Clinical Prior Authorization Criteria</u>
Prior authorization (PA) is required for VMAT 2 inhibitors. Payment for non-preferred agents will be considered only for cases in which there is documentation of previous trial and therapy failure with a preferred agent (when applicable, based on diagnosis). Payment will be considered under the following conditions:
<u>Tardive Dyskinesia</u> (Ingrezza or Austedo)

1. Patient meets the FDA approved age; and
2. Patient has a diagnosis of tardive dyskinesia (TD) based on the presence of ALL of the following:
    a. Involuntary athetoid or choreiform movements

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

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

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

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

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

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

1. Patient continues to meet the criteria for initial approval; and

2. Documentation of improvement in chorea symptoms is provided.

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

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

Tardive Dyskinesia (Ingrezza or Austedo)

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

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

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

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

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

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

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

Additionally, based on verbal and written public comment provided at the February 7, 2024 meeting, the DUR Commission respectfully requests the Department review and consider vitiligo a disease state, not a cosmetic condition. Information provided establishes vitiligo as a chronic autoimmune skin disorder.

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations for Odevixibat (Bylvay), Oral Constipation Agents, Oral Immunotherapy, and Vesicular Monoamine Transporter (VMAT) 2 Inhibitors, as well as reclassifying vitiligo as a disease state, not a cosmetic condition.

Sincerely,

Pamela Smith R.Ph.

Pamela Smith, R.Ph.
Drug Utilization Review Project Coordinator
Iowa Medicaid

Cc: Erin Halverson, R.Ph, Iowa Medicaid
Gina Kuebler, R.Ph, Iowa Medicaid