IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION
1305 East Walnut – Des Moines, IA 50309 ☐ (515) 974-3131 ☐ Fax 1-866-626-0216

Holly Randleman, Pharm.D.
Melissa Klotz, Pharm.D.
Jason Kruse, D.O
Rhea Hartley, M.D.
Susan Parker, R.Ph., Pharm.D.
Jason Wilbur, M.D.
Charles Wadle, D.O.
John Ellis, Pharm.D.
Emily Rogers, Pharm.D.

Professional Staff: Pam Smith, R.Ph.
DUR Project Coordinator

May 3, 2023

Susan L. Parker, R.Ph, Pharm.D.
Pharmacy Director
Iowa Medicaid
1305 East Walnut
Des Moines, Iowa 50309

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, May 3, 2023. At this meeting, the DUR Commission members discussed implementation of a 90-day drug supply allowance for select medications in addition to new or updated prior authorization (PA) criteria for Viloxazine (Qelbree); Dupilumab (Dupixent); Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral; and Janus Kinase Inhibitors. The following recommendations have been made by the DUR Commission:

No comments were received from the medical/pharmacy associations in response to a February 8, 2023 letter that was sent to them detailing the proposed 90-day drug supply allowance for select medications in addition to new or updated PA criteria for Viloxazine (Qelbree); Dupilumab (Dupixent); Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral; and Janus Kinase Inhibitors.

90-Day Drug Supply Allowance

The DUR Commisison discussed and proposed implementation of a 90-day drug supply allowance of select, cost-effective generic maintenance medications. Details of the proposed policy are as follows:

- Dispensing fee - pharmacy gets one dispensing fee per 90-day supply billed.
- Copayment - member gets charged one copay (if applicable) per 90-day supply billed.
- Member exclusions - none
- Initial fill – quantity would be at the discretion of prescriber, but consideration should be given to dispensing less than a 90-day supply with the initial fill when starting members on new medications or with dose adustments to minimize waste.
- 90-day drug selection process – will include select generic products from MediSpan maintenance drug categories.
- Exclusion criteria -
    - Safety – e.g., risks associated with a particular class
    - Controlled substances

    - Narrow therapeutic index (NTI) drugs
    - Drugs subject to frequent dose adjustments
    - OTC drugs
    - Brand drugs
    - PA drug categories (Clinical PA)
    - Nopreferred or nonrecommended drugs
    - Other therapeutic categories – antibiotics, ophthalmic, otic, and topical products
- Initial categories (select, generic drugs) – blood pressure; cholesterol lowering agents; antidepressants; diabetes mellitus
- Review list annually

Viloxazine (Qelbree)

Current Clinical Prior Authorization Criteria

Prior authorization is required for viloxazine (Qelbree). Payment will be considered under the following conditions:

1. Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV); and
2. Patient is between 6 and 17 years of age; and
3. 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) and
4. Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred amphetamine stimulant; and
5. Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred methylphenidate stimulant; and
6. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine; and
7. Is dosed based on FDA approved dosing, and dose does not exceed 400 mg per day; and
8. 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.

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

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted/stricken)

Prior authorization is required for viloxazine (Qelbree). 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 and precautions, drug interactions, and use in specific populations; and*
2. Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV); and
3. ~~Patient is between 6 and 17 years of age; and~~
4. 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) and

5. ~~Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred amphetamine stimulant; and~~
6. ~~Documentation of a previous trial and therapy failure at a therapeutic dose with at least one preferred methylphenidate stimulant; and~~
7. Documentation of a previous trial and therapy failure at a therapeutic dose with atomoxetine *or a preferred stimulant*; and
8. ~~Is dosed based on FDA approved dosing, and~~ ~~d~~*D*ose does not exceed 400 mg per day *for pediatric patients (< 18 years of age) and 600 mg per day for adult patients*; and
9. 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.

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

Dupilumab (Dupixent)

Current Clinical Prior Authorization Criteria

Prior authorization is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. 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 and precautions, drug interactions, and use in specific populations; and
2. Patient's current weight in kilograms (kg) is provided; and
3. 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
4. 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
5. 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
        ii. Oral corticosteroid; or
6. Patient has a diagnosis of eosinophilic esophagitis (EoE); and
    a. Is prescribed by, or in consultation with, an allergist, gastroenterologist, or immunologist; and
    b. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and
    c. Patient has signs and symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain, heartburn regurgitation, chest pain and/or, odynophagia); and
    d. Documentation of previous trials and therapy failures with all of the following:
        i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and
        ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension); and
        iii. Dietary therapy; and
7. Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request 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.

<u>Proposed Clinical Prior Authorization Criteria</u> (changes highlighted/italicized/stricken)
Prior authorization is required for Dupixent (dupilumab). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. 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 and precautions, drug interactions, and use in specific populations; and
2. Patient's current weight in kilograms (kg) is provided; and
3. 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
4. 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
5. 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
      ii. Oral corticosteroid; or
6. Patient has a diagnosis of eosinophilic esophagitis (EoE); and
   a. Is prescribed by, or in consultation with, an allergist, gastroenterologist, or immunologist; and
   b. Patient has ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) as confirmed by endoscopic esophageal biopsy (attach results); and
   c. Patient has signs and symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain, heartburn regurgitation, chest pain and/or, odynophagia); and
   d. Documentation of previous trials and therapy failures with all of the following:
      i. High dose proton pump inhibitor (PPI) for at least 8 weeks; and
      ii. Swallowed topical corticosteroid (e.g., fluticasone propionate, oral budesonide suspension); and
      iii. Dietary therapy; ~~and~~ *or*
7. *Patient has a diagnosis of moderate to severe prurigo nodularis (PN); and*
   a. *Is prescribed by, or in consultation with an allergist, immunologist, or dermatologist; and*
   b. *Patient has experienced severe to very severe pruritus, as demonstrated by a current* Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7*; and*
   c. *Patient has ≥ 20 nodular lesions (attach documentation); and*
   d. *Documentation of a previous trial and therapy failure with a high or super high potency topical corticosteroid for at least 14 consecutive days; and*
8. Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorization will be given for 6 months to assess the response to treatment. Request 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.

Gonadotropin-Releasing Hormone (GnRH Receptor Antagonist, Oral

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for oral gonadotropin-releasing hormone (GnRH) antagonists. Payment for non-preferred oral GnRH antagonists may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent. Payment will be considered for patients when the following is met:

1. Pregnancy has been ruled out; and
2. Patient does not have osteoporosis; and
3. Request adheres to all FDA approved labeling for requested drug, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
4. Requests for elagolix (Orilissa) will be considered under the following conditions:
    a. Patient has a diagnosis of moderate to severe pain associated with endometriosis; and
    b. Patient has documentation of a previous trial and therapy failure with at least one preferred oral NSAID and at least one preferred 3-month course of a continuous hormonal contraceptive taken concurrently; and
    c. Patient has documentation of a previous trial and therapy failure with a preferred GnRH agonist.
    d. Initial requests will be considered for 3 months. Additional requests will be considered upon documentation of improvement of symptoms
    e. Requests will be considered for a maximum of 24 months for the 150mg dose and six (6) months for the 200mg dose; or
5. Requests for elagolix, estradiol, and norethindrone acetate; elagolix (Oriahnn) or relugolix, estradiol, norethindrone acetate (Myfembree) will be considered under the following conditions:
    a. Patient is premenopausal; and
    b. Patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids); and
    c. Patient has documentation of a previous trial and therapy failure with at least one preferred 3-month course of a continuous hormonal contraceptive; and
    d. Patient has documentation of a previous trial and therapy failure with tranexamic acid.
    e. Initial requests will be considered for 6 months. Additional requests will be considered upon documentation of improvement of symptoms.
    f. Requests will be considered for a maximum of 24 months of treatment.

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

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized/stricken)
Prior authorization (PA) is required for oral gonadotropin-releasing hormone (GnRH) antagonists. Payment for non-preferred oral GnRH antagonists may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent. Payment will be considered for patients when the following is met:

1. Pregnancy has been ruled out; and
2. Patient does not have osteoporosis; and
3. Request adheres to all FDA approved labeling for requested drug, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
4. Requests for elagolix (Orilissa) *or relugolix, estradiol, norethindrone acetate (Myfembree)* will be considered under the following conditions:
    a. Patient has a diagnosis of moderate to severe pain associated with endometriosis; and
    b. Patient has documentation of a previous trial and therapy failure with at least one preferred oral NSAID and at least one preferred 3-month course of a continuous hormonal contraceptive taken concurrently; and
    c. Patient has documentation of a previous trial and therapy failure with a preferred GnRH agonist.
    d. Initial requests will be considered for 3 months. Additional requests will be considered upon documentation of improvement of symptoms*; and*
    e. Requests will be considered *based on drug, dose, and length of therapy:*
        i. *Orilissa* - ~~for a~~ maximum *duration* of *therapy of* 24 months for the 150mg dose and six (6) months for the 200mg dose*; or*
        ii. *Myfembree - maximum duration of therapy of 24 months; or*
5. Requests for elagolix, estradiol, and norethindrone acetate; elagolix (Oriahnn) or relugolix, estradiol, norethindrone acetate (Myfembree) will be considered under the following conditions:
    a. Patient is premenopausal; and
    b. Patient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids); and
    c. Patient has documentation of a previous trial and therapy failure with at least one preferred 3-month course of a continuous hormonal contraceptive; and
    d. Patient has documentation of a previous trial and therapy failure with tranexamic acid.
    e. Initial requests will be considered for 6 months. Additional requests will be considered upon documentation of improvement of symptoms.
    f. Requests will be considered for a maximum *duration of therapy* of 24 months ~~of treatment~~.

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

Janus Kinase Inhibitors

Current Prior Authorization Criteria

Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. 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 an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and
2. 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
3. Patient has a diagnosis of:

a. Moderate to severe rheumatoid arthritis (baricitinib, tofacitinib, upadacitinib); with
    i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and
    ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR
b. Psoriatic arthritis (tofacitinib, upadacitinib); with
    i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
    ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR
c. Moderately to severely active ulcerative colitis (tofacitinib, upadacitinib); with
    i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and
    ii. A documented trial and inadequate response with a preferred TNF inhibitor; and
    iii. If requested dose is for tofacitinib 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit; OR
d. Polyarticular Course Juvenile Idiopathic Arthritis (tofacitinib); with
    i. A documented trial and inadequate response to intraarticular glucocorticoid injections; and
    ii. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
    iii. A documented trial and inadequate response with a preferred TNF inhibitor; OR
e. Ankylosing spondylitis (tofacitinib); with
    i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and
    ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR
f. Atopic dermatitis; with
    i. Documentation patient has failed to respond to good skin care and regular use of emollients; and
    ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
    iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
    iv. For mild to moderate atopic dermatitis (ruxolitinib)
        a. A documented trial and therapy failure with crisaborole; and
        b. Affected area is less than 20% of body surface area (BSA); and
        c. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or
    v. For moderate to severe atopic dermatitis (abrocitinib, upadacitinib):
        a. A documented trial and therapy failure with cyclosporine or azathioprine; and

b. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg.

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

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized/stricken)
Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. 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 an FDA approved or compendia indicated diagnosis for the requested drug*, excluding requests for the FDA approved indication of alopecia areata, vitiligo, or other excluded medical use(s), as defined in Section 1927(d)(2) of the Social Security Act, State Plan, and Rules* when the following conditions are met:

1. Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and
2. 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
3. Patient has a diagnosis of:
    a. Moderate to severe rheumatoid arthritis (baricitinib, tofacitinib, upadacitinib); with
        i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and
        ii. A documented trial and inadequate response to one preferred TNF inhibitor; OR
    b. Psoriatic arthritis (tofacitinib, upadacitinib); with
        i. A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
        ii. Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR
    c. Moderately to severely active ulcerative colitis (tofacitinib, upadacitinib); with
        i. A documented trial and inadequate response to two preferred conventional therapies including amino salicylates and azathioprine/6-mercaptopurine; and
        ii. A documented trial and inadequate response with a preferred TNF inhibitor; and
        iii. If requested dose is for tofacitinib 10mg twice daily, an initial 16 weeks of therapy will be allowed. Continued requests at this dose will need to document an adequate therapeutic benefit; OR
    d. Polyarticular Course Juvenile Idiopathic Arthritis (tofacitinib); with
        i. A documented trial and inadequate response to intraarticular glucocorticoid injections; and
        ii. A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and
        iii. A documented trial and inadequate response with a preferred TNF inhibitor; OR
    g. *Axial spondyloarthritis conditions (e.g., a*nkylosing spondylitis *or nonradiographic axial spondyloarthritis)* (tofacitinib*, upadacitinib*); with

i. A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and
ii. A documented trial and inadequate response with at least one preferred TNF inhibitor; OR

h. Atopic dermatitis; with
   i. Documentation patient has failed to respond to good skin care and regular use of emollients; and
   ii. A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
   iii. A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
   iv. For mild to moderate atopic dermatitis (ruxolitinib)
      a. A documented trial and therapy failure with crisaborole; and
      b. Affected area is less than 20% of body surface area (BSA); and
      c. Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or
   v. For moderate to severe atopic dermatitis (abrocitinib, upadacitinib):
      a. A documented trial and therapy failure with cyclosporine or azathioprine; and
      b. Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg.

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

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations for implementation of a 90-day drug supply allowance for select medications in addition to new or updated PA criteria for Viloxazine (Qelbree); Dupilumab (Dupixent); Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Oral; and Janus Kinase Inhibitors.

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