IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION

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February 6, 2025

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Dear Abby:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, February 5, 2025. At this meeting, the DUR Commission members discussed prior authorization (PA) criteria for Dupilumab (Dupixent); Ensifentrine (Ohtuvayre); Incretin Mimetics for Non-Diabetes Indications; Select Preventative Migraine Treatments; Select Topical Agents; and Vonoprazan (Voquenza). The following recommendations have been made by the DUR Commission:

No comments were received from the medical/pharmacy associations in response to a November 13, 2024 letter that was sent to them detailing PA criteria for Dupilumab (Dupixent); Ensifentrine (Ohtuvayre); Incretin Mimetics for Non-Diabetes Indications; Select Preventative Migraine Treatments; Select Topical Agents; and Vonoprazan (Voquenza).

Dupilumab (Dupixent)

Current Clinical Prior Authorization Criteria

Prior authorization (PA) 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 will continue with skin care regimen and regular use of emollients; and
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 in adults; < 90% predicted in adolescents 12 to 17 years of age; and < 95% predicted in children 6 to 11 years of age; 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. One (1) 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; 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 pruritits, 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.

Proposed Clinical Prior Authorization Criteria (changed italicized/highlighted and/or stricken)
Prior authorization (PA) 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 will continue with skin care regimen and regular use of emollients; ~~and~~ *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 in adults; < 90% predicted in adolescents 12 to 17 years of age; and < 95% predicted in children 6 to 11 years of age; 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. One (1) 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; 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 pruritits, 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~~ *or*
8. *Patient has a diagnosis of chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype; and*
    a. Patient has moderate to severe airflow limitation, measured within the past 12 months, as evidenced by both of the following:
        i. FEV1/FVC ratio < 0.7, and
        ii. FEV1 % predicted between 30% to 79%; and
    b. Patient has a minimum blood eosinophil count of 300 cells/mcL, measured within the past 12 months; and
    c. Patient has documentation of maximal inhaled therapy for 3 or more months and an inadequate response to:
        i. Triple therapy with all of the following treatments:
            1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and
            2. Long-acting beta agonist (LABA); and
            3. Inhaled corticosteroid (ICS); or
        ii. Double therapy with all of the following if ICS is contraindicated
            1. LABA; and
            2. LAMA; and
    d. Patient has history of at least 2 moderate or 1 severe exacerbation(s) in the previous 12 months despite receiving maximal triple therapy or double therapy (defined above). Moderate exacerbation is defined as patient required treatment with systemic corticosteroids and/or antibiotics and severe

exacerbation is defined as hospitalization or observation for over 24 hours in an emergency department or urgent care facility; and

e. Patient will continue to receive maintenance therapy (as documented above) concomitantly with dupilumab; and

9. Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorization will be given for 6 months *for all the above indications, except for COPD, which will receive an initial authorization of 12 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.

Ensifentrine (Ohtuvayre)

Newly Proposed Clinical Prior Authorization Criteria

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 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 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

Newly Proposed Clinical Prior Authorization Criteria

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.

Select Preventative Migraine Treatments

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for select preventative migraine agents. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred, select preventative migraine agent. Payment will be considered 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 headaches 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 ≥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. Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and
3. The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and
4. Patient has been evaluated for and does not have medication overuse headache; and
5. For Episodic and Chronic Migraine, patient has documentation of three trials and therapy failures, of at least 3 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
6. 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.

7. Lost, stolen, or destroyed medication replacement requests will not be authorized.

Initial requests will be approved for 3 months. Additional PAs 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.

<u>Proposed Clinical Prior Authorization Criteria</u> (changes italicized/highlighted and/or stricken)
Prior authorization (PA) is required for select preventative migraine agents. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred, select preventative migraine agent. Payment will be considered 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 headaches 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 ≥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. Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and
3. The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and
4. Patient has been evaluated for and does not have medication overuse headache; and
~~5. For Episodic and Chronic Migraine, patient has documentation of three trials~~

~~and therapy failures, of at least 3 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~~

6. 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.
7. Lost, stolen, or destroyed medication replacement requests will not be authorized.

Initial requests will be approved for 3 months. Additional PAs 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.

Select Topical Agents (formerly Select Topical Psoriasis Agents)

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for select topical psoriasis agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria 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 plaque psoriasis with involvement estimated to affect ≤ 20% of the body surface area; and
3. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks.

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 italicized/highlighted and/or stricken)

Prior authorization (PA) is required for select topical ~~psoriasis~~ agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria 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 plaque psoriasis with involvement estimated to affect ≤ 20% of the body surface area; and
    a. *Request is for roflumilast 0.3% cream or tapinarof 1% cream; and*
    b. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks*; or*
3. *Patient has a diagnosis of seborrheic dermatitis; and*
    a. *Request is for roflumilast 0.3% foam; and*
    b. *Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred topical corticosteroid (scalp - medium to high potency or nonscalp – low-potency) and preferred topical antifungal for a minimum of 4 consecutive weeks; or*
4. *Patient has a diagnosis of mild to moderate atopic dermatitis; and*
    a. *Request is for roflumilast 0.15% cream or tapinarof 1% cream; 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; or*
    d. Patient has documentation of an adequate trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks;

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

Vonoprazan (Voquezna)

Newly Proposed Clinical Prior Authorization Criteria

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.

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations for Dupilumab (Dupixent); Ensifentrine (Ohtuvayre); Incretin Mimetics for Non-Diabetes Indications; Select Preventative Migraine Treatments; Select Topical Agents; and Vonoprazan (Voquenza).

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