Iowa Medicaid Drug Utilization Review Commission
Meeting Minutes April 1, 2015

Attendees:

Commission Members
Mark Graber, M.D., FACEP; Laurie Pestel, Pharm.D.; Gregory Barclay, M.D.; Kellen Ludvigson, Pharm.D.; Larry Ambroson, R.Ph.; Brett Faine, Pharm.D.; Brian Couse, M.D.; and Susan Parker, Pharm.D.

Staff
Pam Smith, R.Ph.

Guests
Chuck Wadle, D.O., Magellan; Jason Kessler, M.D., IME; Erin Halverson, R.Ph., IME; Megan Smith, Pharm.D., IME; Tina Valentino, Pharm.D., IME; Andria Seip, IME; Elizabeth Matney, IME: and Melissa Biddle, IME.

Welcome & Introductions

Mark Graber called the meeting to order at 9:37 a.m. at the Fred Maytag II Scout Center in Des Moines. The minutes from the February 4, 2015 meeting were reviewed. Kellen Ludvigson motioned to accept them, and Brian Couse seconded. All members were in favor. Andria Seip and Elizabeth Matney gave a presentation regarding Medicaid Modernization and its projected impact to providers and members. This initiative aims to improve the coordination and quality of care while providing predictability and sustainability for taxpayers in Medicaid spending. There will still be a preferred drug list (PDL) that all of the chosen managed care organizations will have to follow. Questions and comments may be emailed to MedicaidModernization@dhs.state.ia.us, and a new site has been created focusing on Iowa Medicaid's change to managed care organizations effective January 1, 2016: https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization. The full presentation can be accessed at the following link: https://dhs.iowa.gov/sites/default/files/IME_ModernizationPresentation_031815.pdf. Tina Valentino spoke about the new Complex Pharmaceutical Oversight Program (CPOP) started in January 2015, which focuses on complex high-cost medications, and reaches out to patients and prescribers to review medical records and maintain outcomes, as well as finding problem patterns for certain medications. The goal of the program is to reduce waste and improve clinical outcomes. There have been 270 members processed through CPOP since January. The resulting cost avoidance savings will be reported in quarterly reports. The DUR recommendation letter sent to DHS after the last meeting was also reviewed.

IME Updates

There was nothing additional to those listed above.

Prevalence Report Summary

Statistics from January though February 2015 were discussed, including: cost per user ($310.79), number of total prescriptions dispensed (an increase of 2.2% compared to the previous reporting period), average cost per prescription ($65.61), and generic utilization (84.4%). The total paid amount increased by 4.5% from the previous reporting period. There were 204,409 unique users, which is 3.0% more than the total for November and December. Lists of the top 20 therapeutic classes were provided. SSRIs had the highest prescription count, and Anticonvulsants came in second. The top 100 drugs were also reviewed. The ten most expensive medications were: Abilify, Vyvanse, methylphenidate hcl er, Lantus, Focalin XR, Advate, Synagis, Strattera, Cymbalta, and Tamiflu.

Case Studies

Pam Smith presented 4 case studies. Recommendations by commissioners from these four examples resulted in annualized total savings of $1,552.85 pre-rebate (state and federal).

Public Comment

Name	Representing	Drug/Topic
Alan Koslow	Heartland Vascular	apixiban
Elizabeth Potente	Avanir	Nuedexta
Nancy Bell	Pfizer	Apixiban and Lyrica
Karen Loihl	Iowa Psychiatric Society	ProDUR edit on stimulants
Andrew Ko	Shire	Vyvanse
Tami Sova	UCB	Vimpat
Deepak Patel	Novo Nordisk	Victoza
Diane Hanna	Celgene	Otezla
Randy Maigaard	Broadlawns	Hepatitis C PA criteria
Doug Hanson	Broadlawns	Hepatitis C PA criteria
Gary Riley	Abbvie	Viekira Pak

ProDUR Edits

Impact of Select CNS Stimulant Quantity Limits: The DUR Commission discussed implementing quantity limits on multiple stimulant medications at the February meeting. The members had requested data be brought back to the next meeting to determine the impact to prescribers and the prior authorization department of implementing these quantity limits and to seek input from the medical and pharmacy associations regarding the proposed quantity limits. Blocking multiple strengths was also suggested, and IME staff will look into this possibility. After further discussion and feedback from the Iowa Psychiatric Society, the Commission decided to refer this to the Mental Health Advisory Group (MHAG) again prior to implementation. Current recommendations are as follows:

Drug	Proposed Quantity Limit Per 30 Days	Current Quantity Limit Per 30 Days
Adderall 12.5mg tablet	90	120
Adderall 20mg tablet	90	120
Concerta 18mg tablet	30	60
Concerta 27mg tablet	30	60
Concerta 54mg tablet	30	60
Focalin IR tablet (all strengths)	60	None
Focalin XR 5mg	30	60
Focalin XR 10mg	30	60
Focalin XR 15mg	30	90
Focalin XR 20mg	30	60
Focalin XR 25mg	30	60
Focalin XR 30mg	30	60
Ritalin IR (all strengths)	90	None

Focus Studies

Naltrexone Utilization in the Pediatric Population: This was a follow-up discussion. Five (5) of the 12 members identified changed therapy, for an annualized cost savings of $2,161.96 (state and federal, pre-rebate) as a result of the 26 surveys sent out to prescribers and pharmacies. Fourteen (53.85%) of those surveys were returned.

Adalimumab Use without Methotrexate: This was a follow-up discussion. Two of the 10 members identified changed therapy, increasing annual costs by $934.40 (state and federal, pre-rebate) as a result of the 20 surveys sent out to prescribers and pharmacies with 11 (55.00%) of those surveys returned.

Duplicate Beta-Blockers: Letters will be sent to the providers of the members identified as using more than one beta-blocker concurrently in January 2015 to ask if the patient could be adequately controlled with one beta-blocker.

Vimpat Dosing: Letters will be sent to the providers of the members exceeding 400mg per day of Vimpat to ask if the dose could be slowly decreased to 400mg per day. Depending on the responses received, a ProDUR edit limiting the maximum dose to 400mg daily across all strengths and dosage forms might also be implemented in the future.

Public Comment

Name	Representing	Drug/Topic
Kevin Nelson	Merck	Belsomra

Prior Authorization

Hepatitis C Agents: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for hepatitis C treatments. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions:

1. *Patient is 18 years of age or older and has a diagnosis of chronic hepatitis C; and*
2. *Patient has had testing for hepatitis C virus (HCV) genotype; and*
3. *Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and*
4. *Viral load will be submitted by prescriber 12 weeks after completion of therapy; and*
5. *Patient has advanced liver disease corresponding to a Metavir score of 3 or greater fibrosis as confirmed by one of the following:*
    - *Liver biopsy confirming a Metavir score ≥ F3; or*
    - *Transient elastography (FibroScan) score ≥ 9.5kPa; or*
    - *FibroSURE (FibroTest) score ≥ 0.58; or*
    - *APRI score > 1.5; or*
    - *Radiological imaging consistent with cirrhosis (i.e. evidence of portal hypertension); or*
    - *Physical findings or clinical evidence consistent with cirrhosis; or*
    - *Patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), proteinuria, nephrotic syndrome, or membranoproliferative glomerulonephritis.*
6. *Patient's prior treatment history is provided (treatment naïve or treatment experienced); and*
7. *If patient has a history of non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and*
8. *Patient has abstained from the use of illicit drugs and alcohol for a minimum of three (3) months as evidenced by a negative urine confirmation test; and*
9. *Patient does not have severe renal impairment (creatinine clearance <30ml/min) or end stage renal disease requiring hemodialysis; and*
10. *HCV treatment is prescribed by a digestive disease, liver disease, or infectious disease provider practice; and*
11. *For patients on a regimen containing ribavirin, the following must be documented on the PA form:*
    a) *Patient is not a pregnant female or a male with a pregnant female partner; and*
    b) *Women of childbearing potential and their male partners must use two forms of effective contraception during treatment and for at least 6 months after treatment has concluded; and*

c) Monthly pregnancy tests will be performed during treatment; and

12. *Prescriber has reviewed the patient's current medication list and acknowledged that there are no significant drug interactions with the HCV medication.*
13. *Documentation is provided for patients who are ineligible to receive interferon or ribavirin.*
14. *Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved.*
15. *If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on established length of therapy for the particular treatment (defined below).*
16. *Lost or stolen medication replacement requests will not be authorized.*
17. *The 72-hour emergency supply rule does not apply to oral hepatitis C antiviral agents.*

Brett Faine motioned to accept the criteria as amended, and Larry Ambroson seconded. All members were in favor. The recommended PA criteria will be sent to the medical/pharmacy associations for comment and brought back to the next DUR meeting.

CNS Stimulants and Atomoxetine: The Commission reviewed the prior authorization criteria as follows:

Prior authorization (PA) is required for CNS stimulants and Atomoxetine for patients 21 years of age or older. Prior to requesting prior authorization for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at https://pmp.iowa.gov/IAPMPWebCenter/. Payment for CNS stimulants and Atomoxetine will be considered under the following conditions:

1. *Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, SNAP-IV). Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms the patient continues to require medication to treat the symptoms of ADD/ADHD will be required for renewals or patients newly eligible that are established on medication to treat ADD/ADHD.*
2. *Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG).*
3. *Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at*

maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist.

4. *Binge Eating Disorder (Vyvanse only)*
   - *Patient is 18 to 55 years of age; and*
   - *Patient meets the DSM-5 criteria for Binge Eating Disorder; and*
   - *Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number of episodes must be reported); and*
   - *Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent 3 month period, that did not significantly reduce the number of binge eating episodes; and*
   - *Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with topiramate and fluvoxamine*
   - *Prescription is written by a psychiatrist or psychiatric nurse practitioner; and*
   - *Patient has a BMI of 25 to 45; and*
   - *Patient does not have personal or family history of cardiovascular disease; and*
   - *Patient has no history of substance abuse; and*
   - *Is not being prescribed for the treatment of obesity or weight loss; and*
   - *Doses above 70mg per day will not be considered.*
   - *Initial requests will be approved for 12 weeks.*
   - *Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week.*

   <u>DSM-5 Criteria</u>

   i. *Recurrent episodes of binge eating, including eating an abnormally large amount of food in a discrete period of time and has a feeling of lack of control over eating; and*
   ii. *The binge eating episodes are marked by at least three of the following:*
      1. *Eating more rapidly than normal*
      2. *Eating until feeling uncomfortably full*
      3. *Eating large amounts of food when not feeling physically hungry*
      4. *Eating alone because of embarrassment by the amount of food consumed*
      5. *Feeling disgusted with oneself, depressed, or guilty after overeating; and*
   iii. *Episodes occur at least 1 day a week for at least 3 months; and*
   iv. *No regular use of inappropriate compensatory behaviors (e.g. purging, fasting, or excessive exercise) as are seen in bulimia nervosa; and*
   v. *Does not occur solely during the course of bulimia nervosa or anorexia nervosa.*

Moderate to Severe BED
Based on the number of binge eating episodes per week:
Moderate - 4 to 7
Severe – 8 to 13
Extreme – 14 or more

*Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. *If a non-preferred long-acting medication is requested, a trial with the preferred immediate release and extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required.*

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

Larry Ambroson motioned to accept the criteria, and Brian Couse seconded. All members were in favor. The recommended PA criteria will be sent to the medical/pharmacy associations for comment and brought back to the next DUR meeting.

Dextromethorphan/Quinidine (Nuedexta): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for Nuedexta®. Payment will be considered under the following conditions:

1. *Patients must have a diagnosis of pseudobulbar affect (PBA) secondary to a neurological condition.*
2. *A trial and therapy failure at a therapeutic dose with amitriptyline or an SSRI; and*
3. *Patient has documentation of a current EKG (within the past 3 months) without QT prolongation.*
4. *Initial authorizations will be approved for 12 weeks with a baseline Center for Neurologic Studies Lability Scale (CNS-LS) questionnaire.*
5. *Subsequent prior authorizations will be considered at 6 month intervals with documented efficacy as seen in an improvement in the CNS-LS questionnaire.*

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

Brett Faine motioned to accept the criteria, and Kellen Ludvigson seconded. All members were in favor. The recommended PA criteria will be sent to the medical/pharmacy associations for comment and brought back to the next DUR meeting.

Chronic Pain Syndromes: The Commission reviewed the prior authorization criteria as follows:

A prior authorization is required for pregabalin (Lyrica®) and milnacipran (Savella™). These drugs will be considered for their FDA indication(s) and other conditions as listed in the compendia. Requests for doses above the manufacturer recommended dose will not be considered. For patients with a chronic pain diagnosis who are currently taking opioids, as seen in pharmacy claims, a plan to decrease and/or discontinue the opioid(s) must be provided with the initial request. Initial authorization will be given for three (3) months. There must be a significant decrease in opioid use or discontinuation of opioid(s) after the initial three (3) month authorization for further approval consideration. Additional prior authorizations will be considered with documentation of a continued decrease in opioid utilization. Payment will be considered under the following conditions:

1. *A diagnosis of **fibromyalgia** (Lyrica® and Savella™)*
    a. *A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following preferred generic agents: tricyclic antidepressant, SSRI, or SNRI, **WITH***
    b. *Documented non-pharmacologic therapies (cognitive behavior therapies, exercise, etc.).*
2. *A diagnosis of **postherpetic neuralgia** (Lyrica®)*

    A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant, topical lidocaine, or valproate.
3. *A diagnosis of **diabetic peripheral neuropathy** (Lyrica®)*

    A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant, duloxetine or topical lidocaine.
4. *A diagnosis of **partial onset seizures**, as adjunct therapy (Lyrica®)*

Kellen Ludvigson motioned to accept the criteria, and Brett Faine seconded. All members were in favor. The recommended PA criteria will be sent to the medical/pharmacy associations for comment and brought back to the next DUR meeting.

Sedative/Hypnotics – Non-Benzodiazepines: The Commission reviewed the prior authorization criteria as follows:

Preferred agents are available without prior authorization (PA). Requests for doses above the manufacturer recommended dose will not be considered. Prior authorization is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of previous trials and therapy failures with, at a minimum, three (3) preferred agents. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be considered when the following criteria are met:

1. *A diagnosis of insomnia; and*
2. *Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued; and*
3. *Enforcement of good sleep hygiene is documented; and*
4. *All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses.*
5. *In addition to the above criteria, requests for suvorexant (Belsomra) will require documentation of a trial and therapy failure with at least one non-preferred agent, other than suvorexant, prior to consideration of coverage.*
6. *Non-preferred alternative delivery systems will only be considered for cases in which the use of the alternative delivery system is medically necessary and there is a previous trial and therapy failure with a preferred alternative delivery system if available.*

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

Brett Faine motioned to accept the criteria, and Larry Ambroson seconded. All members were in favor. The recommended PA criteria will be sent to the medical/pharmacy associations for comment and brought back to the next DUR meeting.

Apixaban (Eliquis): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for apixaban (Eliquis®). Payment will be considered under the following conditions:

1. *Patient does not have a mechanical prosthetic heart valve; and*
2. *Patient does not have active pathological bleeding.*

<u>Atrial Fibrillation</u>

- *Patient has a diagnosis of non-valvular atrial fibrillation; with*
- *Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial); and*
- *Presence of at least one additional risk factor for stroke, with a CHADS2 score ≥ 1.*
- *Requests will be considered for the following dosing:*
  - *5mg twice daily; or*
  - *2.5mg twice daily in patients with any two (2) of the following:*
    - *Age ≥80 years*
    - *Body weight ≤60 kg*
    - *Serum creatinine ≥1.5 mg/dL.*

<u>Treatment and Prevention of DVT or PE</u>

- *Patient has documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial).*
- *Requests will be considered for the following dosing:*
  - *Initial Treatment of DVT or PE: 10mg twice daily for 7 days, followed by 5mg twice daily up to 12 months of treatment.*
  - *Prevention of DVT or PE following initial therapy with standard anticoagulation therapy for 6 to 12 months of treatment for DVT or PE: 2.5mg twice daily*

<u>Prophylaxis of DVT following hip or knee replacement surgery</u>

- *Requests will be considered when the patient has contraindications to use of the preferred agent(s).*
- *Requests will be considered for the following dosing:*
  - *Hip replacement: 2.5mg twice daily for up to 35 days following hip replacement; or*
  - *Knee replacement: 2.5mg twice daily for up to 12 days after knee replacement.*

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

As this was the second review of these criteria, no motion was necessary. The recommendation will be sent to the Department for consideration.

In February, the DUR Commission also made a recommendation that the P&T Committee conduct an overall cost comparison of the Novel Oral Anticoagulants (NOACs) versus warfarin to determine if one or more of these agents could be available to members without requiring a warfarin trial. When looking at costs for warfarin, the DUR Commission would like the following factors to be taken into account: the costs for INR monitoring, frequent office visits to stabilize INR, and bridging therapy while the patient is being stabilized on warfarin. Erin Halverson said the P&T Committee will review this issue at their August meeting.

Thrombopoietin Receptor Agonists: The Commission reviewed the prior authorization criteria as follows:

Payment for a preferred thrombopoietin receptor agonist will only be considered for cases in which there is a diagnosis of chronic immune thrombocytopenic purpura (ITP) including documentation of an insufficient response to a corticosteroid, an immunoglobulin, or the patient has undergone a splenectomy.

Payment for eltrombopag (Promacta®) for the treatment of chronic hepatitis C associated thrombocytopenia will only be considered to allow for initiation and/or maintenance of interferon-based therapy with ribavirin when the patient has a baseline platelet count less then 75 x 10^9/L. Requests will not be considered under the following conditions:

1. *Patients taking direct acting antiviral agents for the treatment of chronic hepatitis C infection in addition to interferon based therapy with ribavirin.*
2. *Patients taking direct acting antiviral agents used without interferon for treatment of chronic hepatitis C infection.*
3. *Patients with decompensated liver disease with a Child-Pugh score > 6 (Class B & C).*
4. *Patients with a history of ascites.*
5. *Patients with hepatic encephalopathy.*

Payment for eltrombopag (Promacta®) for the treatment of severe aplastic anemia will only be considered under the following conditions:

1. *Patient has documentation of an insufficient response or intolerance to at least one prior immunosuppressive therapy; and*
2. *Patient has a platelet count less than or equal 30 X 10^9/L.*
3. *If criteria for coverage are met, initial authorization will be given for 16 weeks. Documentation of hematologic response after 16 weeks of therapy will be required for further consideration.*

Payment for a non-preferred thrombopoietin receptor agonist will be considered following documentation of a recent trial and therapy failure with a preferred thrombopoietin receptor agonist unless such a trial would be medically contraindicated.

As this was the second review of these criteria, no motion was necessary. The recommendation will be sent to the Department for consideration.

Testosterone Products: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for testosterone products. Payment will be considered with documentation of a specific testicular or hypothalamic/pituitary disease (primary hypogonadism or hypogonadotropic hypogonadism) that results in classic hypogonadism. Requests for FDA approved indications other than hypogonadism will not be subject to prior authorization criteria with adequate documentation of diagnosis. Payment for non-preferred testosterone products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. Requests for erectile dysfunction, infertility, and age-related hypogonadism will not be considered. Payment will be considered under the following conditions:

1. *Patient is male and 18 years of age or older (or 12 years of age and older for testosterone cypionate); and*
2. *Patient has two (2) morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (Please attach lab results); and*
3. *Patient has primary hypogonadism or hypogonadotropic hypogonadism (further defined below):*

- *Primary hypogonadism (congenital or acquired) caused by testicular failure due to one of the following:*
  - *Cryptorchidism*
  - *Bilateral torsion*
  - *Orchitis*
  - *Vanishing testes syndrome,*
  - *Orchiectomy*
  - *Klinefelter's syndrome,*
  - *Chemotherapy*
  - *Toxic damage from alcohol or heavy metals*
- *Hypogonadotropic hypogonadism*
  - *Idiopathic gonadotropin or lutenizing hormone-releasing (LHRH) deficiency*
  - *Pituitary-hypothalamic injury from tumors, trauma, or radiation*

4. *Patient does not have:*
   - *Breast or prostate cancer*
   - *Palpable prostate nodule or prostate-specific antigen (PSA) > 4ng/mL*
   - *Hematocrit > 50%*
   - *Untreated severe obstructive sleep apnea*
   - *Severe lower urinary tract symptoms*
   - *Uncontrolled or poorly controlled heart failure*

Requests for continuation of therapy will require the following:

1. *An updated testosterone level (Please attach lab result); and*
2. *Documentation the patient has not experienced a hematocrit > 54% or an increase in PSA > 1.4ng/mL in the past 12 months.*

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

As this was the second review of these criteria, no motion was necessary. The recommendation will be sent to the Department for consideration.

Apremilast (Otezla): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for apremilast (Otezla®). Payment will be considered under the following conditions:

1. *Patient is 18 years of age or older; and*
2. *Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints) or*
3. *Patient has a diagnosis of moderate to severe plaque psoriasis; and*
4. *Prescribed by a rheumatologist or a dermatologist; and*
5. *Patient does not have severe renal impairment (CrCl < 30mL/min).*

<u>Psoriatic Arthritis</u>

- *Patient has documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and*
- *Patient has documentation of trials and therapy failures with two preferred biological agents used for psoriatic arthritis.*

Plaque Psoriasis

- *Patient has documentation of a trial and inadequate response to phototherapy, systemic retinoids, methotrexate, or cyclosporine; and*
- *Patient has documentation of trials and therapy failures with two preferred biological agents.*

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

As this was the second review of these criteria, no motion was necessary. The recommendation will be sent to the Department for consideration.

Miscellaneous

DUR Digest: The Commission members reviewed the draft for DUR Digest Volume 27, Number 3.

MedWatch: The Commission members received FDA announcements concerning new Black Box Warnings.

A unanimous roll call vote was made at 12:46 to adjourn the meeting and move to closed session (motion by Kellen Ludvigson, second by Brian Couse and Larry Ambroson simultaneously).

The next meeting will be held at 9:30 a.m. on Wednesday, June 3, 2015, at the Learning Resource Center in West Des Moines.