Iowa Medicaid Drug Utilization Review Commission
Meeting Minutes April 4, 2018

Attendees:

Commission Members
Mark Graber, M.D., FACEP; Laurie Anderson, Pharm.D.; Brett Faine, Pharm.D.; Kellen Ludvigson, Pharm.D.; Melissa Klotz, Pharm.D.; Jason Kruse, D.O.; Susan Parker, Pharm.D.; and Sandy Pranger, R.Ph. (Amerigroup).
Staff
Pam Smith, R.Ph.
Guests
Erin Halverson, R.Ph., IME; Melissa Biddle, IME; and Karrie Hansotia, United Healthcare Plan of the River Valley.

Welcome & Introductions

Brett Faine called the meeting to order at 9:30 a.m. at the Learning Resource Center in West Des Moines. The minutes from the February 7, 2018 meeting were reviewed. Mark Graber motioned to accept them, and Jason Kruse seconded. The decision was unanimous. The recommendation letter sent to DHS after the last meeting was also reviewed.

IME Pharmacy Update

Dr. Gillette has resigned from the Commission, but Dr. Wadle will be joining in June.

Fee-for-Service Prevalence Report Summary

Pam Smith provided a five-minute overview for fee-for service statistics from January through February 2018, including: total amount paid ($5,359,301), cost per user ($385.48), and number of total prescriptions dispensed (64,246). There were 13,903 unique users, which is 24.7% more than the total for November and December due to the approximately 10,000 members who were temporarily assigned FFS benefits after they lost AmeriHealth coverage November 30th. There were many large ranking changes on the top 100 pharmacies and prescribers reports, also due to the reassigned population. The top 5 therapeutics classes by paid amount were: Antihemophilic Agents; Anticonvulsants; Antipsychotics – Atypicals; Stimulants – Amphetamines – Long Acting; and Influenza Agents. The highest prescription count continues to come from the SSRI category, with Anticonvulsants in second place, followed by: Antipsychotics – Atypicals; Beta-Lactams/Clavulanate Combinations; and Antiasthmatic – Beta - Adrenergics. The top 100 drugs were also reviewed, by paid amount and prescription count. The ten most expensive medications were: Feiba, Vyvanse, Tamiflu, methylphenidate hcl er, Synagis, Invega Sustenna, Latuda, Focalin XR, Humira Pen, and Humalog. The five drugs with the highest prescription count were: hydrocodone/apap 5-325mg, cetirizine hcl tab 10mg, fluoxetine 20mg, amoxicillin suspension 400/5ml, and omeprazole cap 20mg. Pam Smith also created a report that compared the FFS stats above with those from each MCO

below. Its side-by-side statistics showed that $98,033,423 was spent in total for 252,736 unique users who had 1,283,258 prescriptions. The Commission requested that the drug strengths be combined on future prevalence reports, rather than listed individually as they have been, but felt no other changes were currently necessary.

MCO Prevalence Report Summary and Updates

United Healthcare Community Plan: Karrie Hansotia spoke for five minutes and provided written summaries that included United's statistics from January through February 2018, including: total paid amount ($58,768,814.49), unique users (161,462), and cost per user ($363.98). She noted that the significant increases to paid amount and unique users since the November/December period were the result of members previously assigned to AmeriHealth migrating to United Healthcare on December 1st. There was also a handout showing utilization by age and gender; females age 19-64 had the highest utilization. On the top 100 pharmacies by prescription count report, Broadlawns, and 4 Walgreens locations made up the top 5. Hy-Vee Pharmacy Solutions was the top pharmacy by paid amount. Lists of the top 100 prescribers by prescription count and paid amount were provided. There were some large jumps in rank that were attributed to an error in ranking on the previous report from November/December. The top 5 therapeutic classes by paid amount were: Insulins; Antipsychotic, Atypical, Dopamine, Serotonin Antagonist; Tx for Attention Deficit-Hyperact (ADHD)/Narcolepsy; Adrenergics, Aromatic, Non-Catecholamine; and Anti-Inflammatory Tumor Necrosis Factor Inhibitor. The top 5 classes by prescription count were: SSRIs; Anticonvulsants; Penicillins; Proton-Pump Inhibitors; and Analgesics, Narcotics. The most expensive drugs were Tamiflu, Vyvanse, Latuda, methylphenidate er, and Humira Pen, while amoxicillin, omeprazole, lisinopril, levothyroxine sodium, and hydrocodone/apap had the top 5 prescription counts.

Amerigroup: Sandy Pranger provided a three-minute overview for Amerigroup's statistics from January through February 2018, including: a breakdown of utilization by age and gender, top 100 pharmacies by prescription count, top 100 pharmacies by paid amount, top 100 prescribing providers by prescription count, and top 100 prescribing providers by paid amount. The Bi-Monthly Statistics report reflected that expenditures totaled $33,905,308, a 5.8% increase from November and December. Similar to previous reports, the top 5 therapeutics classes by paid amount were: ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants; Antidiabetics; Antiasthmatic and Bronchodilator Agents; Antivirals; and Antipsychotics/Antimanic Agents. These were the top five classes by prescription count: Antidepressants, Antiasthmatic and Bronchodilator Agents, Anticonvulsants, Antihypertensives, and Ulcer Drugs. Vyvanse was the most expensive medication, followed by Tamiflu, Humira Pen, methylphenidate er, and Latuda. Hydrocodone-acetaminophen has been the drug with the highest prescription count, followed by: amoxicillin suspension 400/5ml, fluoxetine cap 20mg, omeprazole 40mg, and Ventolin HFA.

Public Comment

In addition to the written public comments provided to Commission members, they heard oral public comments from the speakers listed below.

Name	Representing	Drug/Topic
Maggie Murphy	Teva	Austedo
Mark Veerman	Janssen	Invokana
Jim Baumann	Pfizer	Chronic Pain Syndromes
Donald Hillebrand	Unity Point	Hepatitis C PA Criteria

ProDUR Edits

Age Edit – Smoking Cessation Therapy, Oral & Nicotine Replacement Therapy: Current PA criteria includes an age limit that was not discussed or recommended at the previous DUR meetings. Smoking Cessation Therapy and Nicotine Replacement Therapy PA criteria limit consideration of coverage of these agents to patients 18 years of age and older, consistent with their label. With the recommendation to remove PA criteria and implement a quantity limit, the Commission unanimously agreed that an FDA approved age edit also be recommended (motion by Jason Kruse, second by Melissa Klotz).

Point of Sale Drug Utilization Review (DUR) Edits – Therapeutics Duplication: Currently, soft edits are provided to the pharmacy via the point of sale (POS) alerting them of the TD. If the ProDUR edits requested by the MCOs are implemented, therapeutic duplication (TD) would be targeted initially, with other edits being implemented over time. The edit would stop/reject all TD claims at POS, requiring the pharmacist to review and make a determination as to whether therapy is appropriate with the ability to override the edit if so. Extensive programming will be required if certain medications and/or drug categories are targeted, rather than applying the edit to everything across the board. Erin Halverson clarified that the DUR modules would apply TD edits to all categories, and that these edits would override prior authorization criteria for the Fee-for-Service program. Susan Parker added that everything would need to be programmed the same across Fee-for-Service and both MCOs, which does not currently work with the systems each has. Instead, PAs could be put in place for problem categories. Karrie Hansotia said that United Healthcare had already run the numbers for how many adult members would be affected for duplicate antipsychotics, and that they would need to hire additional staff to process PAs if the edit was implemented for that category, as thousands of members would need prior authorization. Erin Halverson also added that there was a lot of off-label usage and not maxing dosage before adding second agent in the pediatric population based on prior authorizations received by the Fee-for-Service program. The Commission will review antipsychotics in adults at a future meeting when Dr. Wadle will be present to provide psychiatrist input. Pam Smith will gather more information and bring it back in preparation for this future discussion.

Prior Authorization

Deutetrabenazine (Austedo) & Valbenazine (Ingrezza): The Commission reviewed the prior authorization criteria as follows:

Prior authorization 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 former 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 is not suicidal, or does not have untreated/inadequately treated depression;*
    b. *Patient does not have hepatic impairment;*
    c. *Will not be used concurrently with MAO inhibitors, reserpine, or other VMAT2 inhibitors; and*
    d. *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*
    e. *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).*

Chorea associated with Huntington's disease (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.*

Mark Graber motioned to accept the criteria as amended, and Jason Kruse seconded. All members were in favor. The recommendation will be sent to the medical/pharmacy groups for comment and brought back to the next meeting for further discussion.

Hepatitis C Treatments: 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 has a diagnosis of chronic hepatitis C and*
2. *Patient's age and/or weight is within the FDA labeled age and/or weight; and*
3. *Patient has had testing for hepatitis C virus (HCV) genotype; and*
4. *Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and*
5. *Patient has been tested for hepatitis B (HBV) prior to initiating treatment of HCV*

and individuals with active HBV infection are treated (either at same time as HCV therapy or before HCV therapy is started); and

6. *Viral load will be submitted by prescriber 12 weeks after completion of therapy; and*
7. *Patient's prior treatment history is provided (treatment naïve or treatment experienced); and*
8. *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*
9. *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*
10. *For regimens containing sofosbuvir, patient does not have severe renal impairment (creatinine clearance < 30ml/min) or end stage renal disease requiring hemodialysis; and*
11. *HCV treatment is prescribed by or in consultation with a digestive disease, liver disease, or infectious disease provider practice; and*
12. *For patients on a regimen containing ribavirin, the following must be documented on the PA form:*
    a) *Patient is not a pregnant female or 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*
13. *Prescriber has reviewed the patient's current medication list and acknowledged that there are no significant drug interactions with the HCV medication.*
14. *Documentation is provided for patients who are ineligible to receive ribavirin.*
15. *Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved.*
16. *Patient does not have limited life expectancy (less than 12 months) due to non-liver-related comorbid conditions.*
17. *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 length of therapy for the particular treatment.*
18. *Lost or stolen medication replacement requests will not be authorized.*
19. *The 72-hour emergency supply rule does not apply to oral hepatitis C antiviral agents.*

Jason Kruse motioned to accept the criteria as amended, and Kellen Ludvigson seconded. All members were in favor. The recommendation will be sent to the

medical/pharmacy groups for comment and brought back to the next meeting for further discussion.

Janus Kinase Inhibitors: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for Janus kinase (JAK) inhibitors. Payment will be considered when the following conditions are met:

1. *Patient meets the FDA approved age and*
2. *Patient is not using or planning to use tofacitinib in combination with biologic DMARDs or potent immunosuppressants (azathioprine or cyclosporine); and*
3. *Has been tested for latent tuberculosis prior to initiating therapy and will be monitored for active tuberculosis during treatment; and*
4. *Recommended laboratory monitoring of lymphocytes, neutrophils, hemoglobin, liver enzymes and lipids are being conducted according to the manufacturer labeling; and*
5. *Patient does not have a history of malignancy, except for those successfully treated for non-melanoma skin cancer (NMSC); and*
6. *Patient is not at an increased risk of gastrointestinal perforation; and*
7. *Patient does not have an active, serious infection, including localized infections; and*
8. *Medication will not be given concurrently with live vaccines; and*
9. *Follows FDA approved dosing based on indication; and*
10. *Patient has a diagnosis of:*
    a. *Moderate to severe rheumatoid arthritis with*
        i. *A documented trial and inadequate response to two preferred oral disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, or leflunomide; and*
        ii. *A documented trial and inadequate response to two preferred biological DMARDs; OR*
    b. *Psoriatic arthritis with*
        i. *A documented trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and*
        ii. *Documented trial and therapy failure with two preferred biological agents used for psoriatic arthritis.*

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

Mark Graber motioned to accept the criteria as amended, and Jason Kruse seconded. All members were in favor. The recommendation will be sent to the medical/pharmacy groups for comment and brought back to the next meeting for further discussion.

Biologicals for Arthritis: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for biologicals used for arthritis. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological agents. Payment will be considered under the following conditions:

- *Patient has been screened for hepatitis B and C. Patients with evidence of active hepatitis B infection (hepatitis surface antigen positive > 6 months) must have documentation they are receiving or have received effective antiviral treatment; and*
- *Patient has been screened for latent TB infection, patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB treatment; and*
- *Patient has a diagnosis of rheumatoid arthritis (RA):*
  A trial and inadequate response to two preferred disease modifying antirheumatic drugs (DMARD) used concurrently. The combination must include methotrexate plus another preferred oral DMARD (hydroxycholoroquine, sulfasalazine, or leflunomide.
  Upon an unsuccessful methotrexate trial in patients with established RA, the combination trial with a second DMARD may be overridden if there is evidence of severe disease documented by radiographic erosions; or
- *Patient has a diagnosis of moderate to severe psoriatic arthritis:*
  A trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); or
- *Patient has a diagnosis of moderate to severe juvenile idiopathic arthritis:*
  A trial and inadequate response to intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and

In addition to the above:
Requests for TNF Inhibitors:

- *Patient has not been treated for solid malignancies, nonmelanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent; and*
- *Patient does not have a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less.*

Requests for Interleukins:

- *Medication will not be given concurrently with live vaccines.*

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

Jason Kruse motioned to accept the criteria as amended, and Mark Graber seconded. All members were in favor. The recommendation will be sent to the medical/pharmacy groups for comment and brought back to the next meeting for further discussion.

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. *Patient does not have severe renal impairment (CrCl < 30 mL/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 indicated for psoriatic arthritis.*

<u>Plaque Psoriasis</u>

- *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 indicated for plaque psoriasis.*

Mark Graber motioned to accept the criteria as amended, and Jason Kruse seconded. All members were in favor. The recommendation will be sent to the medical/pharmacy groups for comment and brought back to the next meeting for further discussion.

Methotrexate Injection: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for non-preferred methotrexate injection. Payment will be considered under the following conditions:

1. *Diagnosis of severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (pJIA) and ALL of the following:*
   a. *Prescribed by a rheumatologist; and*
   b. *Patient has a documented trial and intolerance with oral methotrexate; and*
   c. *Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD (hydroxychloroquine, leflunomide, or sulfasalazine); and*
   d. *Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and*
   e. *Patient does not reside in a long-term care facility.*
2. *Diagnosis of severe, recalcitrant, disabling psoriasis and ALL of the following:*
   a. *Patient is 18 years of age or older; and*
   b. *Prescribed by a dermatologist; and*
   c. *Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D*

analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy).

d. *Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and*
e. *Patient does not reside in a long-term care facility.*

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

Kellen Ludvigson motioned to accept the criteria as amended, and Mark Graber seconded. All members were in favor. The recommendation will be sent to the medical/pharmacy groups for comment and brought back to the next meeting for further discussion.

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 indications(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. Requests for non-preferred brand name drugs, when there is a preferred A-rated bioequivalent generic product available, are also subject to the Selected Brand Name prior authorization criteria and must be included with this request. 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 or SNRI* ***WITH***
   b. *documented non-pharmacologic therapies (cognitive behavior therapies, exercise, etc.)*
2. *A diagnosis of post-herpetic 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 (duloxetine and 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®)*
5. *A diagnosis of neuropathic pain associated with spinal cord injury (Lyrica®)*

The Commission believes a continued or updated plan to reduce opioids should be provided every 3 months. Erin Halverson suggested adding a renewal section, which could include a requirement for evidence of improved quality of life. Mark Graber said that lidocaine isn't indicated for diabetic peripheral neuropathy, so it should probably be removed from bullet #3. Pam Smith will amend the criteria and bring it back to the next meeting.

CNS Stimulants and Atomoxetine: This was tabled until the June 6, 2018 meeting when Dr. Wadle would be in attendance to provide psychiatrist input.

Anti-Diabetic Non-Insulin Agents: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for preferred anti-diabetic, non-insulin agents subject to clinical criteria. Payment will be considered under the following conditions:

1. *A diagnosis of Type 2 Diabetes Mellitus, and*
2. *Patient is 18 years of age or older, and*
3. *The patient has not achieved HgbA1C goals after a minimum three month trial with metformin at maximally tolerated dose.*

Payment for a non-preferred anti-diabetic, non-insulin agent subject to clinical criteria will be authorized only for cases in which there is documentation of previous trials and therapy failures with metformin, a preferred DPP-4 Inhibitor or DPP-4 Inhibitor Combination, a preferred Incretin Mimetic, and a preferred SGLT2 Inhibitor at maximally tolerated doses.

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

Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented continued improvement in HgbA1C.

No further changes were recommended. 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 conducted the initial review of the draft DUR Digest Volume 30, Number 3.

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

Articles of Interest: The Commission members were provided a link to an article recently published regarding nonpharmacologic treatment of chronic pain in disadvantaged patients.

At 11:31, Kellen Ludvigson motioned to adjourn the meeting and Jason Kruse seconded. (No closed session was needed due to lack of profile review post MCO transition.)

The next meeting will be held at 9:30 a.m. on Wednesday, June 6, 2018, at the Learning Resource Center in West Des Moines.