IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION
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April 4, 2014

Susan L. Parker, R.Ph., Pharm.D.
Pharmacy Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, April 2, 2014. At this meeting, the DUR Commission members discussed the proposed prior authorization criteria for Anti-Diabetics, Non-Insulin Agents and Trametinib (Mekinist™); the medical necessity of brimonidine (Mirvaso®) and ospemifene (Osphena®);and quantity limits for butalbital containing products and transdermal scopolamine (Transderm Scōp®). The following recommendations have been made by the DUR Commission:

The DUR Commission reviewed comments received from the medical/pharmacy associations in response to a February 6, 2014 letter that was sent to them detailing the proposed criteria for Trametinib (Mekinist™). Comments received from the medical/pharmacy associations regarding the criteria for Anti-Diabetics, Non-Insulin Agents were reviewed at the February 5, 2014 DUR meeting.

Anti-Diabetics, Non-Insulin Agents (replacing DPP-4 Inhibitors and Incretin Mimetics)

Changes are italicized:
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 a maximally tolerated dose, unless evidence is provided that use of this agent would be medically contraindicated.*

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 ***and*** *a preferred Incretin*

Mimetic at maximally tolerated doses, unless 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.

Trametinib (Mekinist™)

Newly Proposed Prior Authorization Criteria

Prior authorization is required for trametinib (Mekinist™). Payment will be considered for patients when the following criteria are met:

1. Patient is 18 years of age or older; and
2. Patient has a documented diagnosis of unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutation as detected by an FDA-approved test; and
3. Patient has not received prior therapy with a BRAF-inhibitor; and
4. Prescriber is an oncologist.

If the criteria for coverage are met, authorizations will be given at three (3) month intervals. Updates on disease progression must be provided with each renewal request. If disease progression is noted, therapy will not be continued.

The DUR Commission members reviewed information on brimonidine (Mirvaso®) and ospemifene (Osphena®). Section 1927(d)(2) of the Social Security Act states Medicaid programs may exclude from coverage agents when used for the treatment of sexual or erectile dysfunction and agents when used for cosmetic use. Iowa Medicaid rules currently exclude coverage of drugs used for sexual or erectile dysfunction, as well as drugs used for cosmetic purposes. Based on the indications for both medications, the DUR Commission determined they are not medically necessary and voted in favor of excluding brimonidine (Mirvaso®) and ospemifene (Osphena®) from coverage.

The DUR Commission members also reviewed utilization of butalbital containing products and transdermal scopolamine (Transderm Scōp®) and made the recommendation to implement the following quantity limits:

Butalbital containing products – 60 units per 30 days
Transdermal scopolamine (Transderm Scōp®) – 8 patches per 30 days

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations for clinical prior authorization criteria for Anti-Diabetics, Non-Insulin Agents and Trametinib (Mekinist™); excluding brimonidine (Mirvaso®) and ospemifene (Osphena®) from coverage; and implementing quantity limits on butalbital containing products and transdermal scopolamine (Transderm Scōp®).

Sincerely,

Paula Smith R.Ph.

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

Cc: Erin Halverson, R.Ph., IME
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