IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION
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Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, March 4, 2020. At this meeting, the DUR Commission members discussed the proposed prior authorization (PA) criteria for Linezolid; Dupilumab (Dupixent); Biologicals for Axial Spondyloarthritis; Ivabradine (Corlanor); Anti-Diabetic Non-Insulin Agents; and removal of Chronic Pain Syndromes clinical PA criteria. The DUR Commission members also discussed ProDUR quantity limits for opioid agents. The following recommendations have been made by the DUR Commission:

No comments were received from the medical/pharmacy associations in response to a November 19, 2019 letter that was sent to them detailing the proposed criteria for Linezolid; Dupilumab (Dupixent); Biologicals for Axial Spondyloarthritis; Ivabradine (Corlanor); Anti-Diabetic Non-Insulin Agents; removal of Chronic Pain Syndromes clinical PA criteria; and the proposed ProDUR quantity limits for opioid agents.

Linezolid

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized or stricken)
Prior authorization (PA) is required for linezolid ~~(Zyvox).~~ Payment for linezolid ~~(Zyvox)~~ will be authorized when there is documentation that:

1. ~~Prescriber is an infectious disease (ID) physician or has consulted~~ *an* ~~ID physician (telephone consultation is acceptable.~~
2. *The* ~~*P*~~*patient* has ~~an active infection and meets~~ one of the following diagnostic criteria:
    a. Vancomycin-resistant Enterococcus (VRE) ~~and no alternative regimens with documented efficacy are available and VRE is not in lower urinary tract**.~~*; or*
    b. Methicillin-resistant Staph aureus (MRSA) ~~and patient is intolerant to vancomycin*~~*; or*
    c. Methicillin-resistant Staph epidermis (MRSE) ~~and patient is intolerant to vancomycin*~~*; or*

d. *Other multiply resistant gram positive infection (e.g. penicillin resistant Streptococcus spp); and*

3. *Patient meets ONE of the following criteria:*
    a. *Patient is severely intolerant to vancomycin with no alternative regimens with documented efficacy available*, or*
    b. *VRE in a part of body other than lower urinary tract**, or*
    c. *Patient discharged on linezolid and requires additional quantity (up to 10 days oral therapy will be allowed).*
4. *A current culture and sensitivity report is provided documenting sensitivity to linezolid.*

*Severe intolerance to vancomycin is defined as:

1. Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration
2. Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine)

**VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.

Dupilumab (Dupixent)

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized or stricken)
Prior authorization is required for Dupixent (dupilumab). Payment will be considered under the following conditions:

1. Patient is within the FDA labeled age for indication; and
2. Patient has a diagnosis of moderate-to-severe atopic dermatitis; and
    a. Is prescribed by or in consultation with a dermatologist, allergist, or immunologist; and
    b. Patient has failed to respond to good skin care and regular use of emollients; and
    c. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and
    d. Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and
    e. Patient has documentation of a previous trial and therapy failure with cyclosporine or azathioprine; and
    f. Patient will continue with skin care regimen and regular use of emollients; or
3. Patient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype (with a pretreatment eosinophil count ≥ 150 cells/mcL within the previous 6 weeks) OR with oral corticosteroid dependent asthma; and
    a. Is prescribed by or in consultation with an allergist, immunologist, or pulmonologist; and
    b. Has a pretreatment forced expiratory volume in 1 second (FEV_1) ≤ 80% predicted; and
    c. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (e.g. long acting $beta_2$ agonist [LABA], leukotriene receptor antagonist [LTRA], oral theophylline) for a minimum of 3 consecutive months. Patient must be compliant with therapy, based on pharmacy claims; and
    d. Patient must have one of the following, in addition to the regular maintenance

medications defined above:
   i. Two (2) or more exacerbations in the previous year or
   ii. Require daily oral corticosteroids for at least 3 days; ~~and~~ *or*
4. *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; and
5. Dose does not exceed the FDA approved dosing for indication.

If criteria for coverage are met, initial authorization will be given for 16 weeks 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.

Biologicals for Axial Spondyloarthritis

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized or stricken)
Prior authorization (PA) is required for biologicals used for *axial spondyloarthritis conditions* ~~ankylosing spondylitis. Request must adhere to all FDA approved labeling. Payment for non-preferred biologicals for ankylosing spondylitis 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:

1. *Patient has a diagnosis of:*
   a. ankylosing spondylitis *(AS) or*
   b. *nonradiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation; and*
2. *The requested dose does not exceed the maximum FDA labeled or compendia recommended dose for the submitted diagnosis; and*
3. Patient has been screened for hepatitis B and C, patients with active hepatitis B will not be considered for coverage; and
4. 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
5. Patient has documentation of an inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses, unless there are documented adverse responses or contraindications to NSAID use. These trials should be at least ~~three~~ *one* month~~s~~ in duration; and
6. Patients with symptoms of peripheral arthritis must also have failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD), unless there is a documented adverse response or contraindication to DMARD use. DMARDs include sulfasalazine and methotrexate*; and*~~.~~
7. ~~Payment~~ *Requests* for non-preferred biologicals for *axial spondyloarthritis conditions* ~~ankylosing spondylitis~~ will be considered only for cases in which there is documentation of previous trials and therapy failures with two preferred biological

agents *that are FDA approved or compendia indicated for the submitted diagnosis, when applicable.*

In addition to the above:
Requests for TNF Inhibitors:

1. 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
2. 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:

1. 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.

Ivabradine (Corlanor)

Proposed Clinical Prior Authorization Criteria *(changes highlighted/italicized or stricken)*
Prior authorization (PA) is required for ivabradine. Only FDA approved dosing will be considered. Payment will be considered under the following conditions:

1. Patient has a diagnosis of stable, symptomatic heart failure (NYHA Class II, III, or IV); and
   a. Patient is 18 years of age or older; and
   b. Patient has documentation of a left ventricular ejection fraction ≤35%; and
   c. Patient is in sinus rhythm with a resting heart rate of ≥70 beats per minute; and
   d. Patient has documentation of blood pressure ≥90/50 mmHg; ~~and~~ *or*
2. *Patient has a diagnosis of stable symptomatic heart failure (NYHA/Ross class II to IV) due to dilated cardiomyopathy, and*
   a. *Pediatric patient age 6 months and less than 18 years old; and*
   b. *Patient has documentation of a left ventricular ejection fraction ≤45%; and*
   c. *Patient is in sinus rhythm with a resting heart rate (HR) defined below;*
      i. 6 to 12 months - HR ≥ 105 bpm
      ii. 1 to 3 years - HR ≥ 95 bpm
      iii. 3 to 5 years - HR ≥ 75 bpm
      iv. *5 to 18 years - HR ≥ 70 bpm; and*
3. Heart failure symptoms persist with maximally tolerated doses of at least one beta-blocker with proven mortality benefit in a heart failure clinical trial (e.g. carvedilol 50mg daily, metoprolol succinate 200mg daily, or bisoprolol 10mg daily) *or weight appropriate dosing for pediatric patients*, or patient has a documented intolerance or FDA labeled contraindication to beta-blockers; and
4. Patient has documentation of a trial and continued use with a preferred *angiotensin system blocker* ~~ACE inhibitor or preferred ARB~~ at a maximally tolerated dose.

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

Anti-Diabetic Non-Insulin Agents

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted or stricken)
Prior authorization (PA) is required for preferred anti-diabetic, non-insulin agents subject to

clinical criteria. Payment will be considered under the following conditions:

1. *Patient has an FDA approved or compendia indicated diagnosis* ~~A diagnosis of Type 2 Diabetes Mellitus~~, and
2. Patient *meets the FDA approved or compendia indicated age* ~~is 18 years of age or older~~, and
3. *For the treatment of Type 2 Diabetes Mellitus,* ~~T~~*the* patient has not achieved HgbA1C goals after a minimum three month trial with metformin at maximally tolerated dose.
4. ~~Payment~~ *Requests* for ~~a~~ non-preferred anti-diabetic, non-insulin agent*s,* subject to clinical criteria*,* will be authorized only for cases in which there is documentation of previous trials and therapy failures with *a preferred drug in the same class. Requests for a non-preferred agent for the treatment of Type 2 Diabetes Mellitus must document 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 PAs will be considered on an individual basis after review of medical necessity and documented continued improvement in *symptoms (such as* HgbA1C *for Type 2 Diabetes)*.

Chronic Pain Syndromes

Recommendation to remove clinical prior authorization criteria

Current Clinical Prior Authorization Criteria

A prior authorization (PA) 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. Requests for renewal must include an updated opioid treatment plan and documentation of improvement in symptoms and quality of life. 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 or duloxetine.
4. A diagnosis of partial onset seizures, as adjunct therapy (Lyrica)
5. A diagnosis of neuropathic pain associated with spinal cord injury (Lyrica)

ProDUR Edit Recommendations

The DUR Commission recommends the following ProDUR quantity limits on opioids:

- Remove opioids from the current Iowa Medicaid Quantity Limit list that total ≥ 90 morphine milligram eqivalents (MME) per day, leaving current quantity limits in place for liquid agents. See Current Opioid Quantity Limits table below, drug product stricken.
- Current short-acting opioid quantity limits – six (6) units per day on all solid oral dosage forms where the quantity exceeds 6 units per day on the current Iowa Medicaid Quantity Limit list. See Current Opioid Quantity Limits table below, quantities stricken and updated.
- Establish quantity limits for opioids that fall below 90 MME per day, that do not have current quantity limits, including a maximum limit of six (6) units per day on all short-acting solid oral doage forms. See Proposed New Opioid Quantity Limits table below.

Current Opioid Quantity Limits – Proposed Changes (changes stricken)

Drug Product	Quantity	Days Supply	Comments
AVINZA 30MG (morphine er)	30	30	
AVINZA 45MG (morphine er)	30	30	
AVINZA 60MG (morphine er)	30	30	
AVINZA 75MG (morphine er)	30	30	
~~AVINZA 90MG (morphine er)~~	~~30~~	~~30~~	Exceeds 90 MME/day; Remove
~~AVINZA 120MG (morphine er)~~	~~150~~	~~30~~	Exceeds 90 MME/day; Remove
CODEINE SULFATE 15MG	180	30	6 tablets per day
CODEINE SULFATE 30MG	180	30	6 tablets per day
CODEINE SULFATE 60MG	180	30	6 tablets per day
COMBUNOX (oxycodone/ibuprofen)	28	30	
DURAGESIC 25MCG (fentanyl)	10	30	
~~DURAGESIC 50MCG (fentanyl)~~	~~10~~	~~30~~	Exceeds 90 MME/day; Remove
~~DURAGESIC 75MCG (fentanyl)~~	~~10~~	~~30~~	Exceeds 90 MME/day; Remove
~~DURAGESIC 100MCG (fentanyl)~~	~~10~~	~~30~~	Exceeds 90 MME/day; Remove
~~EMBEDA 20-0.8MG (morphine/naltrexone)~~	~~60~~	~~30~~	Removed from market
~~EMBEDA 30-1.2MG (morphine/naltrexone)~~	~~60~~	~~30~~	Removed from market
~~EMBEDA 50-2MG (morphine/naltrexone)~~	~~60~~	~~30~~	Removed from market
~~EMBEDA 60-2.4MG (morphine/naltrexone)~~	~~60~~	~~30~~	Removed from market
~~EMBEDA 80-3.2MG (morphine/naltrexone)~~	~~60~~	~~30~~	Removed from market
~~EMBEDA 100-4MG (morphine/naltrexone)~~	~~60~~	~~30~~	Removed from market
FIORICET/CODEINE 50-300-40-30MG (butalbital-apap-caffeine w/ codeine)	60	30	
FIORICET/CODEINE 50-325-40-30MG (butalbital-apap-caffeine w/ codeine)	60	30	
FIORINAL/CODEINE 50-325-40-30MG(butalbital-asa-caffeine-codeine)	60	30	
HYCET SOL (hydrocodone/apap)	3600ML	30	120ML per day
KADIAN 10MG (morphine sulfate er capsule)	60	30	
KADIAN 20MG (morphine sulfate er capsule)	60	30	
KADIAN 30MG (morphine sulfate er capsule)	60	30	
KADIAN 40MG (morphine sulfate er capsule)	60	30	
~~KADIAN 50MG (morphine sulfate er capsule)~~	~~60~~	~~30~~	Exceeds 90 MME/day; Remove

~~KADIAN 60MG (morphine sulfate er capsule)~~	~~60~~	~~30~~	Exceeds 90 MME/day; Remove
~~KADIAN 80MG (morphine sulfate er capsule)~~	~~60~~	~~30~~	Exceeds 90 MME/day; Remove
~~KADIAN 100MG (morphine sulfate er capsule)~~	~~60~~	~~30~~	Exceeds 90 MME/day; Remove
MSCONTIN 15MG (morphine sulfate sa)	90	30	
~~MSCONTIN 30MG (morphine sulfate sa)~~	~~90~~	~~30~~	Exceeds 90 MME/day; Remove
~~MSCONTIN 60MG (morphine sulfate sa)~~	~~90~~	~~30~~	Exceeds 90 MME/day; Remove
~~MSCONTIN 100MG (morphine sulfate sa)~~	~~300~~	~~30~~	Exceeds 90 MME/day; Remove
NORCO 5-325MG (hydrocodone/apap)	180 (~~360~~)	30	6 tablets per day
NORCO 7.5-325MG (hydrocodone/apap)	180 (~~240~~)	30	6 tablets per day
NORCO 10-325MG (hydrocodone/apap)	180	30	6 tablets per day
~~NUCYNTA 50MG (tapentadol)~~	~~180~~	~~30~~	Exceeds 90 MME/day; Remove
~~NUCYNTA 75MG (tapentadol)~~	~~180~~	~~30~~	Exceeds 90 MME/day; Remove
~~NUCYNTA 100MG (tapentadol)~~	~~180~~	~~30~~	Exceeds 90 MME/day; Remove
OPANA ER 5MG (oxymorphone)	60	30	
OPANA ER 7.5MG (oxymorphone)	60	30	
OPANA ER 10MG (oxymorphone)	60	30	
~~OPANA ER 15MG (oxymorphone)~~	~~60~~	~~30~~	Exceeds 90 MME/day; Remove
~~OPANA ER 20MG (oxymorphone)~~	~~60~~	~~30~~	Exceeds 90 MME/day; Remove
~~OPANA ER 30MG (oxymorphone)~~	~~60~~	~~30~~	Exceeds 90 MME/day; Remove
PERCOCET 5-325MG (oxycodone w/ apap)	180 (~~360~~)	30	6 tablets per day
PERCOCET 7.5-325MG (oxycodone w/ apap)	180 (~~240~~)	30	6 tablets per day
~~PERCOCET 10-325MG (oxycodone w/ apap)~~	~~180~~	~~30~~	Exceeds 90 MME/day; Remove
TYLENOL W/ CODEINE ELIXIR (apap w/ codeine)	2700ML	30	90ML per day
TYLENOL W/ CODEINE NO. 2 (apap w/ codeine)	180 (~~390~~)	30	6 tablets per day
TYLENOL W/ CODEINE NO. 3 (apap w/ codeine)	180 (~~390~~)	30	6 tablets per day
TYLENOL W/ CODEINE NO. 4 (apap w/ codeine)	180 (~~390~~)	30	6 tablets per day
ULTRACET (tramadol/apap)	180 (~~240~~)	30	6 tablets per day
ULTRAM 50MG (tramadol)	180 (~~240~~)	30	6 tablets per day
ULTRAM ER 100MG (tramadol er)	30	30	
ULTRAM ER 200MG (tramadol er)	30	30	
ULTRAM ER 300MG (tramadol er)	30	30	
VICODIN ES 7.5-300MG(hydrocodone/apap)	150	30	5 tablets per day
VICODIN HP 10-300MG (hydrocodone/apap)	180	30	6 tablets per day
XODOL 5-300MG (hydrocodone/apap)	180 (~~360~~)	30	6 tablets per day
XODOL 7.5-300MG (hydrocodone/apap)	180	30	6 tablets per day
XODOL 10-300MG (hydrocodone/apap)	180	30	6 tablets per day
ZAMICET (hydrocodone/apap)	2700ML	30	90ML per day

Proposed New Opioid Quantity Limits

Drug Product	Quantity	Days Supply	Comments
ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE CAP 320.5-30-16 MG	180	30	6 capsules per day
ACETAMINOPHEN-CAFFEINE-DIHYDROCODEINE TAB 325-30-16 MG	180	30	6 tablets per day
BENZHYDROCODONE HCL-ACETAMINOPHEN TAB 4.08-325 MG (APADAZ)	180	30	6 tablets per day
BUPRENORPHINE TD PATCH WEEKLY 5 MCG/HR (BUTRANS)	4	28	1 patch per week

HYDROCODONE BITARTRATE CAP ER 12HR ABUSE-DETERRENT 10 MG (ZOHYDRO ER)	60	30	2 capsules per day
HYDROCODONE BITARTRATE CAP ER 12HR ABUSE-DETERRENT 15 MG	60	30	2 capsules per day
HYDROCODONE BITARTRATE CAP ER 12HR ABUSE-DETERRENT 20 MG	60	30	2 capsules per day
HYDROCODONE BITARTRATE CAP ER 12HR ABUSE-DETERRENT 30 MG	60	30	2 capsules per day
HYDROCODONE BITARTRATE CAP ER 12HR ABUSE-DETERRENT 40 MG	60	30	2 capsules per day
HYDROCODONE BITARTRATE CAP ER 12HR ABUSE-DETERRENT 50 MG	60	30	2 capsules per day
HYDROCODONE BITARTRATE TAB ER 24HR DETER 100 MG (HYSLINGA)	30	30	
HYDROCODONE BITARTRATE TAB ER 24HR DETER 120 MG	30	30	
HYDROCODONE BITARTRATE TAB ER 24HR DETER 20 MG	30	30	
HYDROCODONE BITARTRATE TAB ER 24HR DETER 30 MG	30	30	
HYDROCODONE BITARTRATE TAB ER 24HR DETER 40 MG	30	30	
HYDROCODONE BITARTRATE TAB ER 24HR DETER 60 MG	30	30	
HYDROCODONE BITARTRATE TAB ER 24HR DETER 80 MG	30	30	
HYDROCODONE-ACETAMINOPHEN SOLN 10-300 MG/15ML (LORTAB ELIXIR)	2700	30	90 ml per day
HYDROCODONE-ACETAMINOPHEN TAB 10-300 MG (VICODIN HP)	180	30	6 tablets per day
HYDROCODONE-ACETAMINOPHEN TAB 2.5-325 MG	180	30	6 tablets per day
HYDROCODONE-ACETAMINOPHEN TAB 5-300 MG (VICODIN)	180	30	6 tablets per day
HYDROCODONE-IBUPROFEN TAB 10-200 MG	150	30	5 tablets per day
HYDROCODONE-IBUPROFEN TAB 5-200 MG	150	30	5 tablets per day
HYDROCODONE-IBUPROFEN TAB 7.5-200 MG	150	30	5 tablets per day
HYDROMORPHONE HCL SUPPOS 3 MG	120	30	4 supp. per day
HYDROMORPHONE HCL TAB ER 24HR DETER 12 MG (EXALGO)	30	30	
HYDROMORPHONE HCL TAB ER 24HR DETER 16 MG	30	30	
HYDROMORPHONE HCL TAB ER 24HR DETER 8 MG	30	30	
LEVORPHANOL TARTRATE TAB 2 MG	120	30	4 tablets per day
MEPERIDINE HCL TAB 100 MG	180	30	6 tablets per day
MEPERIDINE HCL TAB 50 MG	180	30	6 tablets per day
MORPHINE SULFATE SUPPOS 10 MG	180	30	6 supp. per day
MORPHINE SULFATE SUPPOS 5 MG	180	30	6 supp. per day
MORPHINE SULFATE TAB ER 12HR DETER 15 MG (MORPHABOND)	90	30	3 tablets per day
MORPHINE SULFATE TAB ER ABUSE-DETERRENT 15 MG (ARYMO ER)	90	30	3 tablets per day
OXYCODONE CAP ER 12HR ABUSE-DETERRENT 13.5 MG (XTAMPZA ER)	60	30	2 capsules per day
OXYCODONE CAP ER 12HR ABUSE-DETERRENT 18 MG	60	30	2 capsules per day
OXYCODONE CAP ER 12HR ABUSE-DETERRENT 27 MG	60	30	2 capsules per day
OXYCODONE CAP ER 12HR ABUSE-DETERRENT 9 MG	60	30	2 capsules per day
OXYCODONE HCL CAP 5 MG	180	30	6 capsules per day
OXYCODONE HCL CONC 100 MG/5ML (20 MG/ML)	87	30	2.9 ml per day
OXYCODONE HCL SOLN 5 MG/5ML	1770	30	59 ml per day
OXYCODONE HCL TAB 5 MG	180	30	6 tablets per day
OXYCODONE HCL TAB ABUSE DETER 5 MG (ROXYBOND OR OXAYDO)	180	30	6 tablets per day
OXYCODONE HCL TAB ABUSE DETER 7.5 MG (OXAYDO)	180	30	6 tablets per day

OXYCODONE HCL TAB ER 12HR DETER 10 MG (OXYCONTIN)	60	30	2 tablets per day
OXYCODONE HCL TAB ER 12HR DETER 15 MG	60	30	2 tablets per day
OXYCODONE HCL TAB ER 12HR DETER 20 MG	60	30	2 tablets per day
OXYCODONE W/ ACETAMINOPHEN TAB 2.5-300 MG	180	30	6 tablets per day
OXYCODONE W/ ACETAMINOPHEN TAB 2.5-325 MG	180	30	6 tablets per day
OXYCODONE-ASPIRIN TAB 4.8355-325 MG	180	30	6 tablets per day
OXYCODONE-IBUPROFEN TAB 5-400 MG	120	30	4 tablets per day
TAPENTADOL HCL TAB ER 12HR 50 MG (NUCYNTA ER)	60	30	2 tablets per day

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations for clinical prior authorization criteria for Linezolid; Dupilumab (Dupixent); Biologicals for Axial Spondyloarthritis; Ivabradine (Corlanor); Anti-Diabetic Non-Insulin Agents; removal of Chronic Pain Syndromes clinical PA criteria; and the ProDUR quantity limits for opioid agents.

Sincerely,

Pamela 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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