IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION
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Susan L. Parker, R.Ph, Pharm.D.
Pharmacy Director
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Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, May 5, 2021. At this meeting, the DUR Commission members discussed the proposed prior authorization (PA) criteria for Risdiplam (Evrysdi); Binge Eating Disorder; IL-5 Antagonists; Isotretinoin (Oral); Multiple Sclerosis Agents - Oral; Nonsteroidal Anti-Inflammatory Drugs (NSAIDs); and removal of PA criteria for Alpha$_2$ Agonists, Extended Release. In addition, the DUR Commission discussed a ProDUR age edit for the extended release Alpha$_2$ Agonists. The following recommendations have been made by the DUR Commission:

Comments were received and reviewed from the medical/pharmacy associations in response to a March 9, 2021 letter that was sent to them detailing the proposed criteria for Risdiplam (Evrysdi); Binge Eating Disorder; IL-5 Antagonists; Isotretinoin (Oral); Multiple Sclerosis Agents - Oral; Nonsteroidal Anti-Inflammatory Drugs (NSAIDs); removal of PA criteria for Alpha$_2$ Agonists, Extended Release; and the ProDUR age edit on extended release Alpha$_2$ Agonists.

Risdiplam (Evrysdi)

Newly Proposed Clinical Prior Authorization Criteria

Prior authorization (PA) is required for risdiplam (Evrysdi). Payment will be considered under the following conditions:

1. Patient has a diagnosis of spinal muscular atrophy (SMA); and
2. Patient meets the FDA approved age for diagnosis; and
3. Dosing follows FDA approved dose for age and weight; and
4. A negative pregnancy test for females of reproductive potential prior to initiating treatment; and
5. Female patients of reproductive potential have been advised to use effective contraception during treatment and for at least 1 month after last dose and male

patients of reproductive potential have been counseled on the potential effects on fertility; and
6. Patient does not have impaired liver function; and
7. Will not be prescribed concomitantly with other SMA treatments, such as Spinraza (nusinersen), Zolgensma (onasemnogene abeparvovec), or any other new products that are approved by the FDA and released; and
8. Documentation of previous SMA therapies and response to therapy is provided; and
    a. For patients currently on Spinraza, documentation Spinraza will be discontinued is provided, including date of last dose, and the appropriate interval based on the dosing frequency of the other drug has been met (i.e. 4 months from the last dose when on maintenance therapy); or
    b. For patients treated with Zolgensma, requests will not be considered; and
9. Is prescribed by or in consultation with a neurologist; and
10. Pharmacy will educate the member, or member's caregiver, on the storage and administration of Evrysdi, as replacements for improper storage or use will not be authorized.

If the criteria for coverage are met, requests will be approved for 1 year. Requests for continuation of therapy will require documentation of a positive response to therapy including stabilization or improved function unless intercurrent event (fracture, illness, other) affects functional testing.

Binge Eating Disorder

Current Clinical Prior Authorization Criteria
Binge Eating Disorder (Vyvanse only)

a. Patient is 18 to 55 years of age; and
b. Patient meets DSM-5 criteria for Binge Eating Disorder (BED); and
c. 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
d. 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
e. Prescription is written by a psychiatrist or psychiatric nurse practitioner; and
f. Patient has a BMI of 25 to 45; and
g. Patient does not have a history of cardiovascular disease; and
h. Patient has no history of substance abuse; and
i. Is not being prescribed for the treatment of obesity or weight loss; and
j. Doses above 70mg per day will not be considered.
k. 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.

DSM-5 Criteria

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

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted or stricken)

Binge Eating Disorder (Vyvanse only)

a. Patient is 18 to 55 years of age; and
b. Patient meets DSM-5 criteria for Binge Eating Disorder (BED); and
c. 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
d. 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
e. Prescription is written by a psychiatrist*,* ~~or~~ psychiatric nurse practitioner*, or psychiatric physician assistant*; and
f. Patient has a BMI of 25 to 45; and
g. Patient does not have a history of cardiovascular disease; and
h. Patient has no history of substance abuse; and
i. Is not being prescribed for the treatment of obesity or weight loss; and
j. Doses above 70mg per day will not be considered.
k. 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.

DSM-5 Criteria

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

IL-5 Antagonists

Current Clinical Prior Authorization Criteria

Prior authorization is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. Payment will be considered under the following conditions:

1. Patient meets the FDA approved age for submitted diagnosis; and
2. Is dosed within FDA approved dosing for submitted diagnosis and age; and
3. Patient has a diagnosis of severe asthma with an eosinophilic phenotype, and
    a. Patient has a pretreatment blood eosinophil count of ≥ 150 cells per mcL within the previous 6 weeks or blood eosinophils ≥ 300 cells per mcL within 12 months prior to initiation of therapy; and
    b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and
    c. Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and
    d. A pretreatment forced expiratory volume in 1 second (FEV_1) < 80% predicted in adults and < 90% in adolescents; or
4. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis, and
    a. Patient has documentation of an adequate trial and therapy failure with systemic glucocorticoids; and
    b. One of the following:
        i. Eosinophil count greater than 1000 cells/mcL; or
        ii. Eosinophil count greater than 10% of the total leukocyte count; and
5. Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist.

If criteria for coverage are met, an initial authorization will be given for 3 months to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered when the following criteria are met:

Severe Asthma with an Eosinophilic Phenotype:

1. Patient continues to receive therapy with an ICS, LABA and LTRA; and

2. Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or
3. Patient has experienced a decrease in administration of rescue medication (albuterol); or
4. Patient has experienced a decrease in exacerbation frequency; or
5. Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline.

Eosinophilic Granulomatosis with Polyangiitis:

1. Patient has demonstrated a positive clinical response to therapy (increase in remission time).

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 (changes italicized/highlighted or stricken)
Prior authorization is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. *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.* Payment will be considered under the following conditions:

1. *Is requested for an FDA approved or compendia indicated diagnosis; and*
2. Patient meets the FDA approved *or compendia indicated* age *and dose* for submitted diagnosis; and
3. ~~Is dosed within FDA approved dosing for submitted diagnosis and age; and~~
4. Patient has a diagnosis of severe asthma with an eosinophilic phenotype, and
    a. Patient has a pretreatment blood eosinophil count of ≥ 150 cells*/mcL* ~~per mcL~~ within the previous 6 weeks or blood eosinophils ≥ 300 cells*/mcL* ~~per mcL~~ within 12 months prior to initiation of therapy; and
    b. Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and
    c. Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and
    d. A pretreatment forced expiratory volume in 1 second (FEV_1) < 80% predicted in adults and < 90% in adolescents; or
5. Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis, and
    a. Patient has documentation of an adequate trial and therapy failure with systemic glucocorticoids; and
    b. One of the following:
        i. Eosinophil count ~~greater than~~ >1000 cells/mcL; or
        ii. Eosinophil count ~~greater than~~ > 10% of the total leukocyte count; *or* ~~and~~
6. *Patient has a diagnosis of hypereosinophilic syndrome (HES); and*
    a. *Patient has been diagnosed with HES for ≥ 6 months prior to starting treatment; and*
    b. *Documentation that non-hematologic secondary causes of HES have been ruled out; and*
    c. *Documentation patient does not have FIP1L1-PDGFRα kinase-positive HES; and*

d. *Documentation of ≥ 2 HES flares within the previous 12 months while on stable HES therapy (e.g., chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy); and*
e. *Patient has a blood eosinophil count ≥ 1,000 cells/mcL; and*
f. *Medication will be used in combination with stable doses of at least one other HES therapy; and*

7. Prescribed by or in consultation with an allergist, *hematologist,* immunologist, pulmonologist, or rheumatologist.

If criteria for coverage are met, an initial authorization will be given for 3 months *for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis or 6 months for a diagnosis of hypereosinophilic syndrome* to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered when the following criteria are met:

Severe Asthma with an Eosinophilic Phenotype:

1. Patient continues to receive therapy with an ICS, LABA and LTRA; and
2. Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or
3. Patient has experienced a decrease in administration of rescue medication (albuterol); or
4. Patient has experienced a decrease in exacerbation frequency; or
5. Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline.

Eosinophilic Granulomatosis with Polyangiitis:

1. Patient has demonstrated a positive clinical response to therapy (increase in remission time).

Hypereosinophilic Syndrome:

1. Patient has demonstrated a positive clinical response to therapy (improvement of symptoms and/or reduction in the number of flares); and
2. Medication continues to be used in combination with stable doses of at least one other HES therapy.

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

Isotretinoin (Oral)

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne under the following conditions:

1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata.
2. Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (www.ipledgeprogram.com) risk management program.

Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted or stricken)
Prior authorization (PA) is required for oral isotretinoin therapy. Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Payment will be ~~approved~~ *considered* for preferred oral isotretinoin products for *moderate to severe* acne under the following conditions:

1. There are documented trials and therapy failures of systemic antibiotic therapy and topical *vitamin A derivative (*tretinoin *or adapalene)* therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical *vitamin A derivative* ~~tretinoin~~ therapy are not required for approval for treatment of acne *conglobata; and*~~.~~
2. *Prescriber attests patient has enrolled in and meets all requirements of the iPLEDGE program.* ~~Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (www.ipledgeprogram.com) risk management program.~~

Initial authorization will be granted for up to ~~20~~ *24* weeks. A minimum of *8 weeks* ~~two months~~ without therapy is required to consider subsequent authorizations.

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

Multiple Sclerosis Agents – Oral

Current Clinical Prior Authorization Criteria
For patients initiating therapy with a preferred oral medication, a manual prior authorization (PA) is not required if a preferred injectable interferon or non-interferon agent is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided:

1. A diagnosis of relapsing forms of multiple sclerosis; and
2. Patient meets the FDA approved age; and
3. Request is for FDA approved dosing; and
4. A previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis.
5. Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent.

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

For patients initiating therapy with fingolimod (Gilenya):

1. Patient does not have a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization or Class lll/lV heart failure; and
2. Patient does not have a history or presence of Mobitz Type ll 2nd degree or 3rd degree AV block or sick sinus syndrome, unless the patient has a pacemaker; and
3. Patient does not have a baseline QTc interval ≥ 500ms; and

4. Patient is not being treated with Class Ia or Class lll anti-arrhythmic drugs.

For patients initiating therapy with teriflunomide (Aubagio):
1. Patient does not have severe hepatic impairment; and
2. A negative pregnancy test for females of childbearing age; and
3. Use of a reliable form of contraception for females of childbearing age; and
4. Patient is not taking leflunomide.

For patients initiating therapy with dimethyl fumarate (Tecfidera & Vumerity):
1. Patient does not have a low lymphocyte count as documented by a recent (within 6 months) CBC prior to initiating therapy; and
2. Upon renewal, documentation of an updated CBC.

For patients initiating therapy with cladribine (Mavenclad):
1. Patient's current weight is provided; and
2. Patient does not have a current malignancy and patient is up to date on all age appropriate malignancy screening; and
3. Pregnancy has been excluded in females of reproductive potential; and
4. Women and men of reproductive potential must use effective contraception during treatment and for 6 months after the last dose in each treatment course; and
5. Women must not intend to breastfeed while being treated and for 10 days after the last dose; and
6. Patient does not have HIV infection; and
7. Patient does not have active chronic infection (e.g. hepatitis or tuberculosis); and
8. No more than two yearly treatment courses (i.e. two treatment courses consisting of two treatment cycles) will be considered.

For patients initiating therapy with siponimod (Mayzent):
1. Patient does not have a CYP2C9*3/*3 genotype; and
2. Patient does not have a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III/IV heart failure; and
3. Patient does not have a presence of Mobitz Type II 2nd degree, 3rd degree AV block or sick sinus syndrome, unless the patient has a functioning pacemaker.

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted or stricken)
For patients initiating therapy with a preferred oral *multiple sclerosis agent* ~~medication~~, a manual prior authorization (PA) is not required if a preferred injectable interferon or non-interferon agent is found in the member's pharmacy claims history in the previous 12 months. If a preferred injectable agent is not found in the member's pharmacy claims, documentation of the following must be provided:
1. A diagnosis of relapsing forms of multiple sclerosis; and
2. *Request must adhere to all FDA approved labeling, including indication, age, dosing, contraindications, and warnings and precautions* ~~Patient meets the FDA approved age~~; and
3. ~~Request is for FDA approved dosing; and~~
4. *Documentation of a* previous trial and therapy failure with a preferred interferon or non-interferon used to treat multiple sclerosis.

Requests for a non-preferred oral multiple sclerosis agent must document a previous trial and therapy failure with a preferred oral multiple sclerosis agent.

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

~~For patients initiating therapy with fingolimod (Gilenya):~~

1. ~~Patient does not have a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization or Class lll/lV heart failure; and~~
2. ~~Patient does not have a history or presence of Mobitz Type ll 2nd degree or 3rd degree AV block or sick sinus syndrome, unless the patient has a pacemaker; and~~
3. ~~Patient does not have a baseline QTc interval ≥ 500ms; and~~
4. ~~Patient is not being treated with Class Ia or Class lll anti-arrhythmic drugs.~~

~~For patients initiating therapy with teriflunomide (Aubagio):~~

1. ~~Patient does not have severe hepatic impairment; and~~
2. ~~A negative pregnancy test for females of childbearing age; and~~
3. ~~Use of a reliable form of contraception for females of childbearing age; and~~
4. ~~Patient is not taking leflunomide.~~

~~For patients initiating therapy with dimethyl fumarate (Tecfidera & Vumerity):~~

1. ~~Patient does not have a low lymphocyte count as documented by a recent (within6 months) CBC prior to initiating therapy; and~~
2. ~~Upon renewal, documentation of an updated CBC.~~

~~For patients initiating therapy with cladribine (Mavenclad):~~

1. ~~Patient's current weight is provided; and~~
2. ~~Patient does not have a current malignancy and patient is up to date on all age appropriate malignancy screening; and~~
3. ~~Pregnancy has been excluded in females of reproductive potential; and~~
4. ~~Women and men of reproductive potential must use effective contraception during treatment and for 6 months after the last dose in each treatment course; and~~
5. ~~Women must not intend to breastfeed while being treated and for 10 days after the last dose; and~~
6. ~~Patient does not have HIV infection; and~~
7. ~~Patient does not have active chronic infection (e.g. hepatitis or tuberculosis); and~~
8. ~~No more than two yearly treatment courses (i.e. two treatment courses consisting of two treatment cycles) will be considered.~~

~~For patients initiating therapy with siponimod (Mayzent):~~

1. ~~Patient does not have a CYP2C9*3/*3 genotype; and~~
2. ~~Patient does not have a recent (within past 6 months) occurrence of myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, or Class III/IV heart failure; and~~
3. ~~Patient does not have a presence of Mobitz Type II 2nd degree, 3rd degree AV block or sick sinus syndrome, unless the patient has a functioning pacemaker.~~

Nonsteroidal Anti-Inflammatory Drugs

Current Clinical Prior Authorization

Prior authorization (PA) is required for all non-preferred nonsteroidal anti-inflammatory drugs

(nsaids) and COX-2 inhibitors. PA is not required for preferred nonsteroidal anti-inflammatory drugs or COX-2 inhibitors.

1. Requests for a non-preferred nsaid must document previous trials and therapy failures with at least three preferred nsaids.
2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with three preferred nsaids, two of which must be a preferred COX-2 preferentially selective nsaid.
3. Requests for a non-preferred extended release nsaid must document previous trials and therapy failures with three preferred nsaids, one of which must be the preferred immediate release nsaid of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance.

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 (changes italicized/highlighted or stricken)
Prior authorization (PA) is required for all non-preferred nonsteroidal anti-inflammatory drugs (*NSAID*s) ~~and COX-2 inhibitors~~. ~~PA is not required for preferred nonsteroidal anti-inflammatory drugs or COX-2 inhibitors.~~ *Payment for a non-preferred NSAID will be considered under the following conditions:*

1. ~~Requests for a non-preferred nsaid must document~~ *Documentation of* previous trials and therapy failures with at least three preferred *NSAID*s*; and*~~.~~
2. ~~Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with three preferred nsaids, two of which must be a preferred COX-2 preferentially selective nsaid.~~
3. Requests for a non-preferred extended release *NSAID* must document previous trials and therapy failures with three preferred *NSAID*s, one of which must be the preferred immediate release *NSAID* of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance.

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

Alpha$_2$ Agonists, Extended Release

Current Clinical Prior Authorization – ***Recommendation to Remove Criteria***
Prior authorization (PA) is required for extended-release alpha$_2$ agonists. Payment will be considered for patients when the following is met:

1. The patient has a diagnosis of ADHD and is between 6 and 17 years of age; and
2. Previous trial with the preferred immediate release product of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance; and
3. Previous trial and therapy failure at a therapeutic dose with one preferred amphetamine and one preferred non-amphetamine stimulant.

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

ProDUR Edit(s)

The DUR Commission recommends implementing a ProDUR age edit on Alpha$_2$ Agonists for ADHD, allowing claims for members 6 through 17 years of age, with the removal of PA criteria.

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations for clinical prior authorization criteria for Risdiplam (Evrysdi); Binge Eating Disorder; IL-5 Antagonists; Isotretinoin (Oral); Multiple Sclerosis Agents (Oral); Nonsteroidal Anti-Inflammatory Drugs (NSAIDs); removal of PA criteria for Alpha$_2$ Agonists, Extended Release; and the ProDUR age edit for extended release Alpha$_2$ Agonists.

Sincerely,

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

Cc: Erin Halverson, R.Ph, IME
Gina Kuebler, R.Ph, IME