



IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION

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Date: June 29, 2010

To: Iowa Medical/Pharmacy Associations

From: Pam Smith, R.Ph., DUR Project Coordinator

RE: **DUR Recommendation to the Department of Human Services**

The members of the Iowa Medicaid Drug Utilization Review Commission met on June 2, 2010 and voted in favor of making the following recommendations to the Department of Human Services regarding clinical prior authorization criterion and ProDUR edits. You are receiving this letter because the DUR Commission is interested in the opinions of the members of your organization on these issues.

Guanfacine Extended-Release (Intuniv™)

Newly Proposed Clinical Prior Authorization Criteria

Prior authorization is required for Intuniv. 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 immediate release guanfacine 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 two of the following: a preferred amphetamine stimulant, a preferred non-amphetamine stimulant, or Strattera*
- The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.*

Extended Release Formulations

Current Clinical Prior Authorization Criteria

Payment for a non-preferred extended release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the preferred immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

Proposed Clinical Prior Authorization Criteria

Payment for a non-preferred extended release formulation will be considered when the following is met:

- Previous trial with the preferred immediate release product at a therapeutic dose that resulted in a partial response with a documented intolerance to the preferred immediate release product of the same chemical entity and a

- Previous trial and therapy failure at a therapeutic dose with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis.

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

Biologicals for Ankylosing Spondylitis

Current Clinical Prior Authorization Criteria

Prior authorization is required for biologicals used for ankylosing spondylitis. Payment will be considered following inadequate responses 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 months in duration. 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 the following: hydroxychloroquine, sulfasalazine, methotrexate, leflunomide, d-penicillamine, azathioprine, oral gold and/or intramuscular gold.

Payment for non-preferred biologicals for ankylosing spondylitis will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

Proposed Clinical Prior Authorization Criteria

Prior authorization is required for biologicals used for ankylosing spondylitis. Payment will be considered following inadequate responses 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 months in duration. 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: the following hydroxychloroquine, sulfasalazine and methotrexate, leflunomide, d-penicillamine, azathioprine, oral gold and/or intramuscular gold.

Payment for non-preferred biologicals for ankylosing spondylitis will be considered only for cases in which there is documentation of a previous trials and therapy failures with a two preferred biological agents.

Biologicals for Inflammatory Bowel Disease

Current Clinical Prior Authorization Criteria

Prior authorization is required for biologicals used for inflammatory bowel disease. Prior authorization is required for all non-preferred biologicals for inflammatory bowel disease as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

- Crohn's Disease – Payment will be considered following an inadequate response to a preferred conventional therapy such as aminosalicylates (mesalamine, sulfasalazine), corticosteroids, azathioprine/6-mercaptopurine, and/or methotrexate.
- Ulcerative colitis (moderate to severe) – Payment will be considered following an inadequate response to a preferred conventional therapy such as aminosalicylates, corticosteroids, and/or azathioprine/6-mercaptopurine.

Proposed Clinical Prior Authorization Criteria

Prior authorization is required for biologicals used for inflammatory bowel disease. ~~Prior authorization is required for all non-preferred biologicals for inflammatory bowel disease as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy.~~

- Crohn's Disease – Payment will be considered following an inadequate response to a **two** preferred conventional therapies ~~such as~~ **including** aminosalicylates (mesalamine, sulfasalazine), ~~corticosteroids~~, azathioprine/6-mercaptopurine, and/or methotrexate. Payment for non-preferred biologicals for **Crohn's disease** inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial~~s~~ and therapy failure~~s~~ with a **two** preferred **biological** agents.
- Ulcerative colitis (moderate to severe) – Payment will be considered following an inadequate response to a **two** preferred conventional therapies ~~such as~~ **including** aminosalicylates, ~~corticosteroids~~, and/or azathioprine/6-mercaptopurine.

Biologicals for Plaque Psoriasis

Current Clinical Prior Authorization Criteria

Prior authorization is required for biologicals used for plaque psoriasis. Payment will be considered following an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine. Prior authorization is required for all non-preferred biologicals for plaque psoriasis as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

Proposed Clinical Prior Authorization Criteria

Prior authorization is required for biologicals used for plaque psoriasis. Payment will be considered following an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine. ~~Prior authorization is required for all non-preferred biologicals for plaque psoriasis as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy.~~ Payment for non-preferred biologicals for plaque psoriasis will be considered only for cases in which there is documentation of a previous trial~~s~~ and therapy failure~~s~~ with a **two** preferred **biological** agents.

Lidocaine Patch (Lidoderm®)

Current Clinical Prior Authorization Criteria

Prior authorization is required for topical lidocaine patches (Lidoderm®). Payment will be considered for a diagnosis of pain associated with post-herpetic neuralgia following a previous treatment failure with a preferred agent at therapeutic dose from one of the following: tricyclic

antidepressant, opioid, or gabapentin. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.

Proposed Clinical Prior Authorization Criteria

Prior authorization is required for topical lidocaine patches (Lidoderm®). Payment will be considered for a diagnosis of pain associated with post-herpetic neuralgia following a previous treatment failure with a preferred agent at therapeutic dose from ~~one~~ **two** of the following: tricyclic antidepressant, opioid, **carbamazepine, valproic acid** or gabapentin. A maximum of 30 patches may be dispensed with the initial prescription to determine efficacy.

ProDUR Quantity Limits – Quetiapine (Seroquel®)

The following was recommended for new ProDUR quantity limits. Any prescription for a quantity outside of these limits would require the prescriber to complete the Quantity Limit Override Prior Authorization form.

Seroquel 25mg	90
Seroquel 50mg	90
Seroquel 100mg	90
Seroquel 200mg	90
Seroquel 300mg	60
Seroquel 400mg	60

Prior to the formal recommendation of this clinical prior authorization criterion and ProDUR edit going to the Department of Human Services, the DUR Commission is interested in the opinions of the members of your organization. Any comments regarding the proposed changes may be forwarded to me and will be shared with the DUR Commission Members. My contact information is listed below. Please have comments/feedback submitted to me on or before July 30, 2010.

Sincerely,



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