IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION

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Dear Abby:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, August 5, 2026. At this meeting, Commission members reviewed and discussed prior authorization (PA) criteria for Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products; Cardiac Myosin Inhibitors; Incretin Mimetics for Non-Diabetes Indications; and Setmelanotide (Imcivree). In addition, they discussed removal of prior authorization for topical clindamycin products with implementation of ProDUR quantity limits and removal of quantity limits for lamotrigine chewable tablets. The following recommendations have been made by the DUR Commission:

Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the established dosage limits per month. Payment for Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation.

PA will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trials and therapy failure with a preferred agent in this class. Note Aprepitant (Emend) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized and/or stricken)
~~Prior authorization (PA) is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the established dosage limits per month. Payment for Antiemetic-5HT3 Receptor Antagonists/Substance P~~

~~Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation.~~

~~PA will be required for all non-preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trials and therapy failure with a preferred agent in this class. Note Aprepitant (Emend) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.~~

Prior authorization (PA) is required for Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin agents under the following conditions:

1. *Request adheres to all FDA approved labeling for requested drug and indication(s), including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations.*
2. *Requests for a non-preferred Antiemetic-5HT3 Receptor Antagonist/Substance P Neurokinin agent must document a previous trial and therapy failure with a preferred agent in this class, unless otherwise stated in criteria.*
3. *Requests for aprepitant (Emend) will only be considered when used in combination with other antiemetic agents (5HT3 agent and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.*
4. *Requests for tradipitant (Nereus) will be considered under the following conditions:*
    a. *Is prescribed for the prevention of motion-induced vomiting; and*
    b. *Member has a planned event expected to cause vomiting induced by motion; and*
    c. *Documentation of a previous trial and therapy failure with transdermal scopolamine; and*
    d. *Documentation of previous trials and therapy failures with 2 antihistamines used for motion sickness (e.g., diphenhydramine, meclizine, promethazine); and*
    e. *Request is for the maximum number of days of the planned event expected to cause vomiting induced by motion.*
    f. *Requests for more than 90 doses per 365-day period will not be considered.*

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

Cardiac Myosin Inhibitors
(formerly Mavacamten [Camzyos])

Current Clinical Prior Authorization Criteria
Prior authorization (PA) is required for mavacamten (Camzyos). Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and
3. Patient exhibits symptoms of New York Heart Association (NYHA) class II or III symptoms; and
4. Is prescribed by or in consultation with a cardiologist; and
5. Patient has a left ventricular ejection fraction (LVEF) ≥ 55%; and
6. Patient has a peak left ventricular outflow tract (LVOT) gradient ≥ 50 mmHg at rest or with provocation; and
7. Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following:
    a. Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and
    b. Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and
    c. Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker.

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

Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by improvement in obstructive HCM symptoms.

Proposed Clinical Prior Authorization Criteria (changes highlighted/italicized and/or stricken)
Prior authorization (PA) is required for *cardiac myocin inhibitors* ~~mavacamten (Camzyos)~~. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agent(s) would be medically contraindicated. Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and
3. Patient exhibits symptoms of New York Heart Association (NYHA) class II or III symptoms; and
4. Is prescribed by or in consultation with a cardiologist; and
5. Patient has a left ventricular ejection fraction (LVEF) ≥ 55%; and
6. Patient has a peak left ventricular outflow tract (LVOT) gradient ≥ 50 mmHg at rest or with provocation; and
7. Documentation of a previous trial and therapy failure, at a maximally tolerated dose, with all of the following:
    a. Non-vasodilating beta-blocker (atenolol, metoprolol, bisoprolol, propranolol); and
    b. Non-dihydropyridine calcium channel blocker (verapamil, diltiazem); and
    c. Combination therapy with disopyramide plus beta-blocker or disopyramide plus a non-dihydropyridine calcium channel blocker*; and*
8. *Will not be used in combination with another cardiac myosin inhibitor*.

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

Request for continuation of therapy will be considered with documentation of a positive response to therapy as evidenced by improvement in obstructive HCM symptoms.

Incretin Mimetics for Non-Diabetes Indications

Current Clinical Prior Authorization Criteria

Prior authorization (PA) is required for incretin mimetics not otherwise covered by the Anti-Diabetics Non-Insulin Agents PA criteria for covered FDA approved or compendia indications. Payment for excluded medical use(s) (e.g. weight loss), as defined in the Iowa State Plan and Iowa Administrative Code 441 – 78.2(4) will be denied. Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has been screened for and does not have type 1 or type 2 diabetes mellitus; and
3. The requested drug will be used to reduce the risk of major adverse cardiovascular events (MACE) (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in an adult with established cardiovascular disease (CVD) and either obesity or overweight; and
    a. Patient has established CVD, i.e. coronary artery disease (angina, MI), cerebrovascular disease (stroke, transient ischemic attack), peripheral arterial disease, heart failure, atrial fibrillation and other arrhythmias, valvular heart disease, congenital heart disease, cardiomyopathies, aortic disease (aneurysm, dissection), DVT or PE; and
    b. Patient has a baseline body mass index (BMI) ≥ 27 kg/m^2 (attach documentation), obtained within 6 months of request; and
    c. Patient has been evaluated for cardiovascular standard of care treatment; and
    d. For Wegovy:
        i. Patient is ≥ 18 years of age; and
        ii. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
        iii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment; or
4. Patient has a diagnosis of moderate to severe obstructive sleep apnea (OSA); and
    a. Patient has a baseline BMI ≥ 30 kg/m^2; and
    b. Prescriber attests patient has a recent (within prior three years) apnea/hypopnea index (AHI) ≥ 15 events per hour, as documented by a polysomnography (PSG) or at-home sleep study (document AHI); and
    c. For Zepbound:
        i. Patient meets the FDA approved age for OSA; and
        ii. Initiation and escalation dosages will be permitted up to a maximum of 20 weeks prior to reaching the recommended maintenance dosage of 10 mg to 15 mg once weekly; and
        iii. Maintenance dosages other than 10 mg to 15 mg once weekly will not be approved for maintenance treatment; or

5. Patient has a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH); and
    a. Patient has moderate to advanced liver fibrosis (stages F2 to F3 fibrosis) as confirmed by one of the following (attach results from testing documenting fibrosis stage);
        i. Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g. FibroScan), with a LSM of 8 kPa to 15 kPa; or
        ii. LSM by magnetic resonance elastography (MRE) with a LSM of 3.1 kPa to 4.4 kPa; or
        iii. Liver biopsy with a non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) ≥4 with a score of 1 or more in steatosis, lobular inflammation, and hepatocyte ballooning; and
    b. Patient has been evaluated for cardiometabolic standard of care treatment; and
    c. Concurrent use of an incretin mimetic with resmetirom (Rezdiffra) for the treatment of MASH will only be considered after documented trials of each agent individually at therapeutic doses, with evidence of inadequate response; and
    d. Patient has not had significant alcohol consumption within the past year (> 20 g per day in women or > 30 g per day in men); and
    e. For Wegovy:
        i. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
        ii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment (see requests for continuation of therapy below for maintenance dose requirement); and
6. Patient will use medication in combination with a reduced calorie diet and increased physical activity; and
7. The requested agent will not be used in combination with other incretin mimetics.

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

Requests will be considered for initiation and appropriate dosage escalation. Requests for continuation of therapy, once at an established maintenance dose will be considered at 12-month intervals when:

1. The requested drug will be used to reduce the risk of MACE; and
    a. Patient has been evaluated for cardiovascular standard of care treatment; and
    b. For Wegovy, a maintenance dose of 1.7 mg or 2.4 mg once weekly is requested; or
2. The requested drug will be used to treat moderate to severe OSA; and
    a. Documentation of a positive response to therapy is provided; and
    b. The maintenance dose is requested and maintained (Zepbound 10 mg to 15 mg once weekly); or
3. The requested drug will be used for noncirrhotic MASH; and
    a. Documentation of a positive response to therapy (e.g., improvement in or stabilization of fibrosis, improvement in liver function such as reduction in alanine aminotransferase [ALT], improvement in LSM by VCTE, MRE, or biopsy); and
    b. Patient has not progressed to cirrhosis; and

c. For Wegovy, a maintenance dose of 2.4 mg once weekly is requested, or 1.7 mg weekly with documentation of an adequate trial and intolerance to the maintenance dose of 2.4 mg once weekly. Patient must have a retrial of the recommended maintenance dose of 2.4 mg once weekly at least annually before a maintenance dose of 1.7 mg will be reauthorized; and

4. Patient does not have type 1 or type 2 diabetes; and
5. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and
6. The requested agent will not be used in combination with other incretin mimetics.

Proposed Clinical Prior Authorization Criteria (changes italicized/highlighted, and/or stricken)
Prior authorization (PA) is required for incretin mimetics not otherwise covered by the Anti-Diabetics Non-Insulin Agents PA criteria for covered FDA approved or compendia indications. Payment for excluded medical use(s) (e.g. weight loss), as defined in the Iowa State Plan and Iowa Administrative Code 441 – 78.2(4) will be denied. Payment will be considered under the following conditions:

1. Request adheres to all FDA approved labeling for requested drug and indication, including dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. ~~Patient has been screened for and does not have type 1 or type 2 diabetes mellitus; and~~
3. The requested drug will be used to reduce the risk of major adverse cardiovascular events (MACE) (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in an adult with established cardiovascular disease (CVD) and either obesity or overweight; and
    a. Patient has established CVD, i.e. coronary artery disease (angina, MI), cerebrovascular disease (stroke, transient ischemic attack), peripheral arterial disease, heart failure, atrial fibrillation and other arrhythmias, valvular heart disease, congenital heart disease, cardiomyopathies, aortic disease (aneurysm, dissection), DVT or PE; and
    b. Patient has a baseline body mass index (BMI) ≥ 27 kg/m^2 (attach documentation), obtained within 6 months of request; and
    c. Patient has been evaluated for cardiovascular standard of care treatment; and
    d. For Wegovy *(injection or tablet)*:
        i. Patient is ≥ 18 years of age; and
        ii. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
        iii. *For Wegovy injection:* Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment; or
        iv. *For Wegovy tablets: Maintenance dosages other than 25 mg once daily will not be approved for maintenance treatment (if patient does not tolerate the 25 mg once daily maintenance dosage, consider switching to Wegovy injection 1.7 mg once weekly); or*
4. Patient has a diagnosis of moderate to severe obstructive sleep apnea (OSA); and
    a. Patient has a baseline BMI ≥ 30 kg/m^2; and
    b. Prescriber attests patient has a recent (within prior three years) apnea/hypopnea index (AHI) ≥ 15 events per hour, as documented by a polysomnography (PSG) or at-home sleep study (document AHI); and
    c. For Zepbound:
        i. Patient meets the FDA approved age for OSA; and

ii. Initiation and escalation dosages will be permitted up to a maximum of 20 weeks prior to reaching the recommended maintenance dosage of 10 mg to 15 mg once weekly; and
iii. Maintenance dosages other than 10 mg to 15 mg once weekly will not be approved for maintenance treatment; or

5. Patient has a diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH); and
    a. Patient has moderate to advanced liver fibrosis (stages F2 to F3 fibrosis) as confirmed by one of the following (attach results from testing documenting fibrosis stage);
        i. Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g. FibroScan), with a LSM of 8 kPa to 15 kPa; or
        ii. LSM by magnetic resonance elastography (MRE) with a LSM of 3.1 kPa to 4.4 kPa; or
        iii. Liver biopsy with a non-alcoholic fatty liver disease (NAFLD) Activity Score (NAS) ≥4 with a score of 1 or more in steatosis, lobular inflammation, and hepatocyte ballooning; and
    b. Patient has been evaluated for cardiometabolic standard of care treatment; and
    c. Concurrent use of an incretin mimetic with resmetirom (Rezdiffra) for the treatment of MASH will only be considered after documented trials of each agent individually at therapeutic doses, with evidence of inadequate response; and
    d. Patient has not had significant alcohol consumption within the past year (> 20 g per day in women or > 30 g per day in men); and
    e. For Wegovy *injection*:
        i. Initiation and escalation dosages will be permitted for a maximum of 8 weeks for each dosage; and
        ii. Maintenance dosages other than 1.7 mg or 2.4 mg once weekly will not be approved for maintenance treatment (see requests for continuation of therapy below for maintenance dose requirement); and
6. Patient will use medication in combination with a reduced calorie diet and increased physical activity; and
7. The requested agent will not be used in combination with other incretin mimetics.

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

Requests will be considered for initiation and appropriate dosage escalation. Requests for continuation of therapy, once at an established maintenance dose will be considered at 12-month intervals when:

1. The requested drug will be used to reduce the risk of MACE; and
    a. Patient has been evaluated for cardiovascular standard of care treatment; and
    b. For Wegovy *injection*, a maintenance dose of 1.7 mg or 2.4 mg once weekly is requested; or
    c. *For Wegovy tablets, a maintenance dose of 25 mg once daily is requested; or*
2. The requested drug will be used to treat moderate to severe OSA; and
    a. Documentation of a positive response to therapy is provided; and
    b. The maintenance dose is requested and maintained (Zepbound 10 mg to 15 mg once weekly); or

3. The requested drug will be used for noncirrhotic MASH; and
    a. Documentation of a positive response to therapy (e.g., improvement in or stabilization of fibrosis, improvement in liver function such as reduction in alanine aminotransferase [ALT], improvement in LSM by VCTE, MRE, or biopsy); and
    b. Patient has not progressed to cirrhosis; and
    c. For Wegovy *injection*, a maintenance dose of 2.4 mg once weekly is requested, or 1.7 mg weekly with documentation of an adequate trial and intolerance to the maintenance dose of 2.4 mg once weekly. Patient must have a retrial of the recommended maintenance dose of 2.4 mg once weekly at least annually before a maintenance dose of 1.7 mg will be reauthorized; and
4. ~~Patient does not have type 1 or type 2 diabetes; and~~
5. Patient continues to use medication in combination with a reduced calorie diet and increased physical activity; and
6. The requested agent will not be used in combination with other incretin mimetics.

Setmelanotide (Imcivree)

Newly Proposed Clinical Prior Authorization Criteria

Prior authorization (PA) is required for setmelanotide (Imcivree). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Documentation of the patient's baseline weight (kg) and body mass index (BMI) obtained within the past 60 days is provided; and
3. Patient must have a diagnosis of obesity (BMI > 30 kg/m^2 for adults or 95th percentile using growth chart assessments for pediatric patients) (attach growth chart assessments for pediatric patients); and
4. Patient has a diagnosis of obesity due to one of the following:
    a. Proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, and
        i. Genetic testing demonstrates that variants in POMC, PCSK1, or LEPR genes are interpreted as pathogenic, likely pathogenic, or of uncertain significance (attach results); or
    b. Bardet-Biedl syndrome (BBS) as evidenced by documentation in the patient's chart notes (attach documentation); or
    c. Acquired hypothalamic obesity (HO) as evidenced by documentation in the patient's chart notes (attach documentation) of having or had a hypothalamic tumor, hypothalamic lesion, or hypothalamic damage or injury; and
5. Is prescribed by or in consultation with an endocrinologist, a geneticist, or an expert in rare genetic disorders of obesity.

If criteria for coverage is met, initial requests will be approved for 1 year. Additional approvals will be considered under the following conditions:

1. Patient's current weight (kg) and BMI document a decrease of at least 5% of baseline body weight (or at least 5% baseline BMI for patients with continued growth potential, attach growth chart assessment) since initiating treatment.

Topical Acne and Rosacea Products – Removal of Topical Clindamycin from PA

The Commission reviewed topical clindamycin products and recommended removing the prior authorization requirement and implementing quantity limits. The recommendation is expected to reduce administrative burden on providers, as the majority of prior authorization requests for these products are approved. Implementation of quantity limits will support appropriate utilization while maintaining access to therapy.

Recommended Quantity Limits

Drug Product	Package Size	Maximum Quantity Per 30 Days
Clindamycin 1% gel (generic to Cleocin T gel)	30 g tube	60 g (2 tubes)
	60 g tube	120 g (2 tubes)
Clindamycin 1% gel (generic to Clindagel)	75 mL bottle	150 mL (2 bottles)
Clindamycin 1% lotion (generic to Cleocin T lotion)	60 mL bottle	120 mL (2 bottles)
Clindamycin 1% solution (generic to Cleocin T solution)	30 mL bottle	60 mL (2 bottles)
	60 mL bottle	120 mL (2 bottles)
Clindamycin 1% foam (generic to Evoclin)	50 g aerosol can	100 grams (2 cans)
	100 g aerosol can	200 grams (2 cans)
Clindamycin 1% pledget (generic to Cleocin T pledget)	60 applicators	120 applicators (2 packages)

Note: Availability of branded products may vary; they are included as reference points.

Lamotrigine Chewable Tablets – Removal of Quantity Limits

The Commission reviewed the existing quantity limits for lamotrigine 5 mg and 25 mg chewable tablets and recommended removal of the quantity limits. The proposed change is expected to decrease provider administrative burden and facilitate appropriate dosing for patients who are unable to swallow tablets and rely on the chewable formulation to meet their prescribed dose requirements.

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendations regarding prior authorization for Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products; Cardiac Myosin Inhibitors; Incretin Mimetics for Non-Diabetes Indications; and Setmelanotide (Imcivree); as well as removal of prior authorization for topical clindamycin products with the implementation of ProDUR quantity limits and removal of quantity limits for lamotrigine 5 mg and 25 mg chewable tablets.

Sincerely,

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

Cc: Erin Halverson, R.Ph, Iowa Medicaid
Gina Kuebler, R.Ph, Iowa Medicaid