Iowa Medicaid Drug Utilization Review Commission
Meeting Minutes November 5, 2025

Attendees:

Commission Members Present
Melissa Klotz, Pharm.D.; Jason Kruse, D.O.; Holly Randleman, Pharm.D.; Caitlin Reinking, Pharm.D.; Chuck Wadle, D.O.; Bryon Schaeffer, MD, FAAFP; Rhea Hartley, M.D.; Jennifer Johnson, Pharm.D.; Abby Cate, Pharm.D., Iowa Department of Health and Human Services; and Jordan Thoman, Wellpoint Iowa.

Commission Members Absent
None

Staff in Attendance
Pam Smith, R.Ph.

Guests in Attendance
Erin Halverson, R.Ph., Iowa Medicaid; Gina Kuebler, R.Ph., Iowa Medicaid; Melissa Biddle, Iowa Medicaid; Darian Forcier, Iowa Department of Health and Human Services; Candace Jordan, Pharm.D., Molina Healthcare; and Emily Rogers, Pharm.D., Iowa Total Care.

Welcome & Introductions

Chairperson Melissa Klotz called the meeting to order at 9:32 a.m. The minutes from the August 6, 2025, meeting were reviewed. Holly Randleman motioned to accept them, and Rhea Hartley seconded. All members were in favor. The recommendation letter sent to DHHS after the last DUR meeting was also reviewed.

Iowa Medicaid Pharmacy Update

Michael Line, M.D. will be the new Iowa Medicaid Chief Medical Officer. He brings over 20 years of clinical leadership experience, most recently as Director of Patient Care at Hy-Vee Exemplar Care. His career has focused on pediatrics, including years as a hospitalist at Blank Children's Hospital and Chief Medical Officer in Jefferson, IA. There is also a new HHS Director, Larry Johnson, who was previously the Director of the Iowa Department of Inspections, Appeals, and Licensing (DIAL) for more than six years, and has been in state government for more than 15 years. A notice has been posted on the www.iowamedicaidpdl.com site detailing coverage of opioid reversal agents, and the medications available through the Iowa Medicaid Preferred Drug List with no requirement for prior authorization (PA).

Prevalence Report Summaries

An overview of plan statistics from June 2025 through August 2025 was provided:

- Iowa Total Care by Emily Rogers
- Molina Healthcare by Candace Jordan
- Wellpoint Iowa by Jordan Thoman

- Fee-for-Service by Pam Smith

Comparative Prevalence Report Summary

Pam Smith also created a report that compared the FFS stats with those from each MCO. Its side-by-side statistics showed that $252,223,614 was spent in total for 1,912,771 prescriptions. The complete comparative summary, as well as the four individual prevalence reports, can be found in the meeting packet posted on www.iadur.org.

Public Comment

In addition to the written public comments provided to Commission members, they heard oral public comments from the speakers shown below.

Name	Representing	Drug/Topic
Jake Engelmeier	Apellis	Empaveli
Amy Hornig	Abbvie	Rinvoq
Mae Kwong	Soleno Therapeutics	Vykat XR
Nikki Asse	Novo Nordisk	Wegovy
Christina Trout	University of Iowa Healthcare	Duvyzat

Written Provider Comments Received: Lamotrigine chewable tablet quantity limit, which was shared with the Commission. A comment regarding biologic treatment of Hidradenitis Suppurativa was submitted without a completed conflict of interest disclosure form and was not shared with the Commission.

Written Manufacturer Comments Received: Zoryve

Retrospective DUR Data Presentations

Risk of Hyperthermia with Scopolamine Patch: Letters will be sent to all prescribers identified as prescribing scopolamine patch to educate them on the recent FDA safety warning about the risk of hyperthermia to ensure that critical safety information reaches prescribers of this medication.

Utilization of SGLT2 Inhibitors in Members with CKD: Letters will be sent to prescribers identified as having members with a diagnosis of CKD without a claim for an SGLT2 inhibitor, outlining current guideline recommendations for SGLT2 inhibitors as first line therapy in eligible patients and including details on preferred agents within the class. This will also appear as a DUR Digest article, and the Medicaid staff will have an internal discussion regarding potential medical/pharmacy association listserv notification emails going forward.

Retrospective DUR Proposals

Duplicate Short-Acting Opioids: Data will be pulled to identify members with ≥ 2 chemically distinct short-acting opioids with ≥ 60 days overlap in a 90-day period. Results will also be checked for early refills, though the 90% refill allowance on controlled medications should prevent most of them. However, filling on the 27th day consistently does allow for an extra month of medication per year.

Bisphosphonate Drug Holiday: Data will be pulled to identify members with utilization of an oral bisphosphonate for ≥3 years.

Commission Recommendations for Retrospective DUR Agenda Topics

1. Revisit underutilized medications such as sacubitril/valsartan (Entresto).

The Commission took a short break and open session resumed at 10:53 a.m.

Prior Authorization

Annual Review of Prior Authorization Criteria: Changes were suggested for the following categories, to be discussed at upcoming meetings:

PA Category	Recommended Changes
Alpha$_1$-Proteinase Inhibitor Enzymes	Research and pull data on potential issues with re-authorization resulting from the criteria requirement to show a reduction in the rate of deterioration of lung function.
CNS Stimulants	Clarify language on 4e to be more inclusive, possibly rewording to say simply "provider" versus a specific listing of specialists. Pam Smith said she'd review similar wording in other PA criteria too.

Brenoscatib (Brinsupri): The Commission reviewed the proposed prior authorization criteria as follows:

Prior authorization (PA) is required for brensocatib (Brinsupri). Payment will be considered for an FDA approved or compendia indicated diagnosis 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 non-cystic fibrosis bronchiectasis (NCFB) confirmed by a chest CT scan; and*
3. *Patient is 18 years of age or older with a history of ≥ 2 pulmonary exacerbations requiring antibiotic treatment in the previous 12 months; or*
4. *Patient is 12 to 17 years of age with ≥ 1 pulmonary exacerbation requiring antibiotic treatment in the previous 12 months; and*
5. *Patient has experienced at least 2 of the following symptoms in the previous 12 months: cough, chronic sputum production, and/or chronic respiratory infections; and*
6. *Patient has been counseled on the importance of abstinence from tobacco and, if a current smoker, been encouraged to enroll in a smoking cessation program; and*
7. *Is prescribed by or in consultation with a pulmonologist or infectious disease specialist.*

Initial requests will be approved for 12 months. Additional authorizations will be considered annually with documentation of a positive clinical response to therapy, demonstrated by at least one of the following:

1. *Improvement in or stabilization of symptoms; or*
2. *Reduction in or stabilization of the frequency, severity, or duration of exacerbations; or*
3. *Reduction in the decline of FEV_1.*

Rhea Hartley motioned to accept the criteria as amended, allowing for twelve months on the initial approval rather than six, and Caitlin Reinking seconded. All members were in favor. The recommendation will be sent to the Department for consideration.

Diazoxide Choline (Vykat XR): The Commission reviewed the proposed prior authorization criteria as follows:

Prior authorization (PA) is required for diazoxide choline (Vykat XR). 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 Prader-Willi syndrome confirmed by genetic testing (attach results); and*
3. *Patient has hyperphagia with associated symptoms such as food-seeking behaviors (hoarding, foraging, stealing, and attempting to consume inedible items); and*
4. *Patient's current weight in kg is provided; and*
5. *Is prescribed by or in consultation with an endocrinologist.*

If the criteria for coverage is met, initial requests will be approved for 6 months. Additional approvals will be considered under the following conditions:

1. *Documentation showing improvement or stabilized signs and symptoms of disease such as decrease in food related behaviors, lessened food preoccupation that affects daily life, etc., and*
2. *Patient's current weight in kg is provided.*

Rhea Hartley motioned to accept the criteria as written, and Holly Randleman seconded. All members were in favor. The recommendation will be sent to the Department for consideration. Staff will also continue to monitor this to see if more information comes out about usage past 16 weeks.

Hepatitis C Treatments, Direct Acting Antivirals: The Commission reviewed a recommendation to remove prior authorization criteria. Jason Kruse motioned to remove the existing criteria and implement the proposed quantity limits outlined below, along with a 365-day treatment lookback that restricts Mavyret to 16 weeks per year and

sofosbuvir/velpatasvir to 12 weeks per year; Rhea Hartley seconded. All members were in favor. The recommendations will be sent to the Department for consideration.

Drug Product	**Quantity**	**Days' Supply**
Mavyret tablets	84	28
Mavyret pellets	140 packets (5 cartons)	28
Sofosbuvir 400 mg/velpatasvir 100 mg tablets	28	28
Sofosbuvir 200 mg/velpatasvir 50 mg tablets	56	28
Sofosbuvir 200 mg/velpatasvir 50mg pellets	56	28
Sofosbuvir 150 mg/velpatasvir 37.5mg pellets	28	28

Incretin Mimetics for Non-Diabetes Indications: The Commission reviewed proposed criteria, including the addition of criteria for MASH. Discussion also addressed considerations for the MACE indication (such as age requirements and limiting ASCVD to prior MI, prior stroke, or symptomatic PAD), the need for chart notes to confirm diagnosis, and inclusion of current A1C lab results. Following discussion, the Commission agreed on the prior authorization criteria outlined below:

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.*

Rhea Hartley motioned to accept the criteria as amended, and Holly Randleman seconded. All members were in favor. The recommendation will be sent to the Department for consideration. Dr. Kruse asked if allowance of a liver fibrosis panel, validated for fatty liver, could be added to criteria to estimate fibrosis score. Pam Smith will investigate and bring this back to the next meeting.

Janus Kinase (JAK) Inhibitors: The Commission reviewed the proposed prior authorization criteria as follows:

Prior authorization (PA) is required for Janus kinase (JAK) inhibitors. 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, excluding requests for the FDA approved indication of alopecia areata or other excluded medical use(s), as defined in Section 1927 (d)(2) of the Social Security Act, State Plan, and Rules when the following conditions are met:

1. *Patient is not using or planning to use a JAK inhibitor in combination with other JAK inhibitors, biological therapies, or potent immunosuppressants (azathioprine or cyclosporine); and*
2. *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*
3. *Patient has a diagnosis of:*
    a. *Moderate to severe rheumatoid arthritis; with*
        i. *A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate; and*
        ii. *A documented trial and inadequate response to one preferred TNF inhibitor; OR*
    b. *Psoriatic arthritis; with*
        i. *A documented trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and*
        ii. *Documented trial and therapy failure with one preferred TNF inhibitor used for psoriatic arthritis; OR*
    c. *Moderately to severely active ulcerative colitis; with*
        i. *A documented trial and inadequate response with a preferred TNF inhibitor; OR*
    d. *Moderately to severely active Crohn's disease; with*
        i. *A documented trial and inadequate response with a preferred TNF inhibitor; OR*
    e. *Polyarticular Course Juvenile Idiopathic Arthritis; with*
        i. *A documented trial and inadequate response to the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and*
        ii. *A documented trial and inadequate response with a preferred TNF inhibitor; OR*
    f. *Axial spondyloarthritis conditions (e.g., ankylosing spondylitis or nonradiographic axial spondyloarthritis); with*
        i. *A documented trial and inadequate response to at least two preferred non-steroidal anti-inflammatories (NSAIDs) at a maximally tolerated dose for a minimum of at least one month; and*
        ii. *A documented trial and inadequate response with at least one preferred TNF inhibitor; OR*
    g. *Atopic dermatitis; with*

i. *Documentation patient has failed to respond to good skin care and regular use of emollients; and*
ii. *A documented adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or*
iii. *A documented trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and*
iv. *For mild to moderate atopic dermatitis (topical treatments):*
    1. *Affected area is less than 20% of body surface area (BSA); and*
    2. *Patient has been instructed to use no more than 60 grams of topical ruxolitinib per week; or*
v. *For moderate to severe chronic hand eczema (topical treatments):*
    1. *Chronic hand eczema has persisted for more than 3 months or recurred two or more times within a 12-month time frame after the initial occurrence with complete clearances between relapses; and*
    2. *Patient has been instructed to use no more than 30 grams per 2 weeks or 60 grams per month of topical delgocitinib; or*
vi. *For moderate to severe atopic dermatitis (oral treatments):*
    1. *A documented trial and therapy failure with a systemic drug product for the treatment of moderate to severe atopic dermatitis, including biologics; and*
    2. *Requests for upadacitinib for pediatric patients 12 to less than 18 years of age must include the patient's weight in kg; or*

h. *Nonsegmental vitiligo; with*
    i. *A documented trial and inadequate response with a potent topical corticosteroid; or*
    ii. *A documented trial and inadequate response with a topical calcineurin inhibitor; and*
    iii. *The patient's body surface area (BSA) is less than or equal to the affected BSA per FDA approved label, if applicable; or*
i. *Giant Cell Arteritis; with*
    i. *Documentation patient is currently taking a glucocorticoid, with a tapering dose, or has discontinued use of glucocorticoids.*

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

Rhea Hartley motioned to accept the criteria as proposed, and Holly Randleman seconded. All members were in favor. The recommendation will be sent to the Department for consideration. This set of criteria will also be brought back to the next meeting to discuss changes due to the revised indication for Rinvoq.

Pegcetacoplan (Empaveli): The Commission reviewed the proposed prior authorization criteria as follows:

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

1. *Request adheres to all FDA approved labeling including age, dosing, contraindications, and warnings and precautions; and*
2. *Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH); and*
    a. *Flow cytometry shows detectable glycosylphosphatidylinositol (GPI)-deficient hematopoietic clones or ≥ 10% PNH cells; and*
    b. *History of at least one red blood cell transfusion in the previous 12 months; and*
    c. *Documentation of hemoglobin < 10.5 g/dL; or*
3. *Patient has a diagnosis of compliment 3 glomerulopathy (C3G) or immune-complex membranoproliferative glomerulonephritis (IC-MPGN); and*
    a. *Diagnosis is confirmed on renal biopsy; and*
    b. *Patient is on a maximally tolerated dose of an angiotensin converting enzyme inhibitor (ACEI), angiotensin receptor blocker (ARB), and/or sodium glucose cotransporter-2 (SGLT2) inhibitor for at least 3 months prior to starting pegcetacoplan; and*
    c. *Patient has a history of a trial and therapy failure with systemic oral glucocorticoids or mycophenolate mofetil; and*
    d. *Documentation of a baseline urine protein-to-creatinine ratio (UPCR) ≥ 1g/g; and*
    e. *Patient has an eGFR ≥ 30 mL/min/1.73 m_2; and*
4. *For patients under 18 years of age, current weight in kg is provided; and*
5. *Is prescribed by or in consultation with a hematologist or nephrologist; and*
6. *Medication will be administered in the member's home; and*
7. *Member or member's care giver has been properly trained in subcutaneous infusion or subcutaneous injection and prescriber has determined home administration is appropriate; and*
8. *Will not be used with another complement inhibitor or will only be considered for patients switching from one complement inhibitor to pegcetacoplan based on FDA approved labeling.*

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

Initial authorizations will be approved for the FDA approved recommended time period when switching from a different complement inhibitor to verify treatment has been discontinued, or for 6 months otherwise.

Additional authorizations will be considered when the following criteria are met:

1. *Documentation of a positive clinical response to therapy:*
    a. *PNH: e.g., increased or stabilization or hemoglobin levels or reduction in transfusions; or*

b. *C3G or IC-MPGN: e.g., reduction in UPCR from baseline and eGFR ≥ 30 mL/min/1.73 m_2; and*

2. *Is not prescribed concurrently with other complement inhibitors*

Rhea Hartley motioned to accept the proposed criteria, and Holly Randleman seconded. All members were in favor. The recommendation will be sent to the Department for consideration.

Sepiaptern (Sephience): The Commission reviewed the newly proposed prior authorization criteria as follows:

Prior authorization (PA) is required for sepiapterin (Sephience). 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 hyperphenylalaninemia (HPA) with sepiapterin-responsive phenylketonuria (PK); and*
3. *Patient is on a phenylalanine (Phe) restricted diet prior to therapy and will continue throughout therapy; and*
4. *Patient has a baseline blood Phe level ≥ 360 µmol/L while following a Phe restricted diet, obtained within 2 weeks of initiation of sepiapterin therapy (attach lab results); and*
5. *Patient's current weight in kg is provided; and*
6. *Blood Phe levels will be measured after 2 weeks of therapy and at least one more time before initial renewal; and*
7. *Is not prescribed concurrently with sapropterin (Kuvan) or pegvaliase-pqpz (Palynziq).*

Initial requests will be considered for 2 months to assess response to therapy.

Continuation of therapy will be considered when the following criteria are met:

1. *Patient's current weight in kg is provided; and*
2. *Patient continues a Phe restricted diet; and*
3. *After an initial 2-month treatment, an updated blood Phe level must be provided documenting response to therapy, defined as at least a 30% reduction in blood Phe level. If blood Phe level does not decrease at maximum dose, the patient is considered a non-responder and no further requests will be approved; and*
4. *Patient continues to respond to therapy as demonstrated by a reduction in Phe blood levels since initiation of therapy; and*
5. *Is not prescribed concurrently with sapropterin (Kuvan) or pegvaliase-pqpz (Palynziq).*

Jason Kruse motioned to accept the criteria as recommended, and Rhea Hartley seconded. All members were in favor. The recommendation will be sent to the Department for consideration.

Select Topical Agents: The Commission reviewed the proposed prior authorization criteria as follows:

Prior authorization (PA) is required for select topical agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria 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 (note, only FDA-approved indications for each drug and specific dosage form will be considered); and*
2. *Patient has a diagnosis of plaque psoriasis with total overall involvement on scalp and non-scalp areas ≤ 25% of the body surface area (BSA) at baseline. Total non-scalp BSA should not exceed 20%; and*
    a. *Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks; or*
3. *Patient has a diagnosis of seborrheic dermatitis; and*
    a. *Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred topical corticosteroid (scalp- medium to high potency or nonscalp- low potency) and a preferred topical antifungal for a minimum of 4 consecutive weeks; or*
4. *Patient has a diagnosis of mild to moderate atopic dermatitis; and*
    a. *Patient has failed to respond to good skin care and regular use of emollients; and*
    b. *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; or*
    c. *Patient has documentation of an adequate trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks.*

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

Rhea Hartley motioned to accept the criteria as recommended, and Holly Randleman seconded. All members were in favor. The recommendation will be sent to the Department for consideration.

Miscellaneous

DUR Digest: The Commission members conducted the initial review of DUR Digest Volume 38, Number 1. There were no additional changes recommended.

MedWatch: The Commission members received FDA announcements concerning new Black Box Warnings.

At 12:32, Rhea Hartley motioned to adjourn, and Jason Kruse seconded. All in attendance agreed.

The next scheduled meeting is tentatively set for February 4, 2026, and will be in a virtual format only.