NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

Nebraska Medicaid DUR Board Meeting
Tuesday Jan 14th, 2025
In Person & Virtual
Public Meeting 6:30pm
Best Western Plus Lincoln Inn & Suites
2201 Wildcat Circle Lincoln, Nebraska 68521

JOIN VIA WEBEX
https://sonvideo.webex.com/sonvideo/j.php?MTID=m814fb5bb9692a7bee3c9370289ae4992
MEETING NUMBER
2489 145 6921

I. Opening and Introductions
II. Declaration of any Conflict of Interest or changes
III. Agenda approval
IV. Review and Approval of Minutes from previous Board meeting
    a. November 12, 2024
V. Update on Recommendations from Previous Meeting
VI. Retrospective DUR
    a. Old Business
        i. Current Profile Review
            1. Gabapentin and Pregabalin concomitant use
    b. New Business
        i. Recommendations for Future Profile Review
            1. Stimulant use in 18 years and younger
            2. SUD treatment utilization discussion
VII. Prospective DUR
    a. Old Business-None
    b. New Business
        i. Annual Review of Self-Administered Immunomodulators PA **(See attachment)**
VIII. Special Requests from the Department
IX. Future Meeting Dates
X. Concerns and Comments from the DUR Board
XI. Concerns and Comments from the DUR Director
XII. Concerns and Comments from the State DHHS Representatives
XIII. Concerns and Comments from the MCO Representatives
XIV. Concerns and Comments from the Public Attendees
XV. Adjournment

Nebraska Medicaid Program Request for Prior Authorization of Payment
Immunomodulators: Self-Administered Injectables

If the following information is not complete, correct, or legible, the PA process can be delayed. *Please use one form per member.*

Member Information

MEMBER'S LAST NAME: | **MEMBER'S FIRST NAME:**

MEDICAID NUMBER: | **MEMBER'S DATE OF BIRTH:** – –

Prescriber Information

PRESCRIBER'S LAST NAME: | **PRESCRIBER'S FIRST NAME:**

PRESCRIBER'S NPI NUMBER: | **DEA NUMBER:**

PRESCRIBER'S PHONE NUMBER: – – | **PRESCRIBER'S FAX NUMBER:** – –

Participating Pharmacy

NAME: | **REQUEST DATE**

PHARMACY PHONE NUMBER: – – | **PHARMACY FAX NUMBER:** – –

Please indicate which medication is being requested and complete the information below:
Non-preferred agents require a trial of a preferred agent within this drug class with the same indication

DRUG REQUESTED (Adbry, Dupixent, Ebglyss, Fasenra, Nucala, Tezspire, Xolair)

- ☐ Adbry™ (tralokinumab-ldrm)
- ☐ Dupixent® (dupilumab)
- ☐ Fasenra® (benralizumab)
- ☐ Nucala® (mepolizumab)
- ☐ Xolair® (omalizumab) syringe
- ☐ Xolair® (omalizumab) autoinjector
- ☐ Tezspire ® (tezepelumab-ekko)
- ☐ Ebglyss ® (lebrikizumab-lbkz)

DRUG NAME: | **DRUG STRENGTH:**

DOSING SCHEDULE: | **QUANTITY PER MONTH:**

Diagnosis for use:

- ☐ Allergic Asthma (*see Section G*)
- ☐ Chronic Obstructive Pulmonary Disease and an Eosinophilic Phenotype (see Section M)
- ☐ Chronic Spontaneous Urticaria (*see Section H*)
- ☐ Chronic Rhinosinusitis with Nasal Polyposis (*see Section F*)
- ☐ Eosinophilic Asthma (*see Section A*)
- ☐ Eosinophilic Esophagitis (*see Section I*)
- ☐ IgE-Mediated Food Allergy (*see Section L*)
- ☐ Eosinophilic Granulomatosis with Polyangiitis (*see Section C*)
- ☐ Hypereosinophilic Syndrome (*see Section D*)
- ☐ Moderate to Severe Atopic Dermatitis (*see Section E*)
- ☐ Oral Corticosteroid-Dependent Asthma (*see Section B*)
- ☐ Prurigo Nodularis (*see Section J*)
- ☐ Severe Persistent Asthma (*see Section K*)

FOR INITIAL REQUESTS, SEE SECTIONS A THROUGH ~~L~~ M. FOR REAUTHORIZATION REQUESTS, SEE SECTION ~~M~~ N.

For current PDL status, please visit: https://nebraska.fhsc.com/downloads/PDL/NE_PDL-20240501.pdf

- Medication will not be approved in combination with any other interleukin IL-4, IL-5, or IL-13 antagonists, nor any anti-immunoglobulin E (IgE) antibody.
- Future FDA-approved changes not currently listed on this form will be reviewed based upon the package insert information and any pre-requisite treatment requirements for that indication.

Fax this form to: 866-759-4115
or **mail to**:
Prime Therapeutics State Government Solutions LLC MAP Dept.
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Tel: 1-800-241-8335

Adbry™ (tralokinumab-ldrm)

Treatment of moderate to severe atopic dermatitis in patients ≥ 12 years of age whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable

Dupixent® (dupilumab)

Add-on maintenance treatment for moderate to severe eosinophilic asthma or with oral corticosteroid-dependent asthma in patients ≥ 6 years of age

Treatment of uncontrolled moderate to severe atopic dermatitis in patients ≥ 6 months of age whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable

Add-on maintenance treatment for inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) in ~~adults~~ patients ≥ 12 years of age

Treatment of eosinophilic esophagitis (EoE) in patients ≥ 1 year of age and weighing ≥ 15 kg

Treatment of prurigo nodularis in adults

Add-on maintenance treatment for inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype in adults

Ebglyss® (lebrikizumab-lbkz)

Treatment of moderate to severe atopic dermatitis in patients ≥ 12 years of age whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable

Fasenra® (benralizumab)

Add-on maintenance treatment for severe eosinophilic asthma in patients ≥ 6 years of age

Treatment of eosinophilic granulomatosis with polyangiitis (EGPA) in adults

Nucala® (mepolizumab)

Add-on maintenance treatment for severe eosinophilic asthma in patients ≥ 6 years of age

Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients ~~18 years of age and older~~ with inadequate response to nasal corticosteroids

Treatment of eosinophilic granulomatosis with polyangiitis (EGPA) in adults

Treatment of patients ≥ 12 years of age with hypereosinophilic syndrome (HES) for ≥ 6 months without an identifiable non-hematologic secondary cause

Xolair® (omalizumab) syringe and autoinjector

Treatment of moderate to severe persistent asthma with a positive skin test or *in vitro* reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids in patients ≥ 6 years of age

Add-on maintenance treatment for chronic rhinosinusitis with nasal polyps (CRSwNP) in adults with inadequate response to nasal corticosteroids

Treatment of chronic spontaneous urticaria (CSU) in patients ≥ 12 years of age who remain symptomatic despite H1 antihistamine treatment

Treatment for the reduction of allergic reactions to food in patients ≥ 1 year of age with IgE-mediated food allergy to be used in conjunction with food allergen avoidance

Tezspire (tezepelumab-ekko)

Add-on maintenance treatment of severe asthma in patients ≥ 12 years of age

Initial approval (6 months) will be based on documentation of the following:

SECTION A: EOSINOPHILIC ASTHMA

1. Prescriber attestation of (please check one):

   ☐ Moderate to severe eosinophilic asthma (Dupixent) ☐ Severe eosinophilic asthma (Fasenra, Nucala)

2. Has patient had ≥ 1 exacerbation (oral corticosteroid burst, ER visit, hospital, office visit) in the past 12 months while on, and adherent to, a medium- to high-dose or max-tolerated inhaled corticosteroid plus a controller therapy, OR a max-tolerated inhaled corticosteroid/long-acting beta agonist combo? ☐ Yes ☐ No

   If no, please explain: _____

3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist

4. Submit current labs/documentation of the following:
   Baseline blood eosinophil count ≥ 150 cells/µl within the past 6 weeks.

SECTION B: ORAL CORTICOSTEROID-DEPENDENT ASTHMA

1. Does prescriber attest that patient has oral corticosteroid dependency? ☐ Yes ☐ No
2. Does prescriber attest that asthma symptoms are not adequately controlled by prior drug therapy of either medium- to high-dose or max-tolerated inhaled corticosteroid plus a controller, OR a max-tolerated inhaled corticosteroid/long-acting beta agonist combo? ☐ Yes ☐ No

   If no, please explain: _____
3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist

SECTION C: EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)

1. Patient has a diagnosis of relapsing or refractory disease with **TWO** of the following (check all that apply):

   ☐ History or presence of asthma
   ☐ Eosinophilia (> 10% of total WBCs)
   ☐ Evidence of 2 or more features of EGPA (biopsy showing histopathological evidence, non-fixed pulmonary infiltrates, cardiomyopathy, alveolar hemorrhage, or other standard characteristics)

Please attach current lab work for baseline blood eosinophil count dated within the past 6 weeks.

2. Is patient currently on a stable dose of oral prednisone or prednisolone and has been for at least 4 weeks? ☐ Yes ☐ No

   If no, please explain: _____
3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist ☐ Rheumatologist

SECTION D: HYPEREOSINOPHILIC SYNDROME (HES)

1. Has patient had a diagnosis of HES for ≥ 6 months without an identifiable non-hematologic secondary cause? ☐ Yes ☐ No
2. Has patient had two or more HES flares within the past 12 months? ☐ Yes ☐ No

   Please check ONE of the following criteria:

   ☐ Worsening of clinical signs/symptoms
   ☐ Increased eosinophils on ≥ 2 occasions
   ☐ An increase/addition of oral corticosteroids or cytotoxic or immunosuppressive therapy
3. Does patient have a blood eosinophil count ≥ 1000 cells/µl? ☐ Yes ☐ No

   If no, please explain: _____

Please attach current lab work for blood eosinophil count dated within the past 6 weeks.

4. Medication is being prescribed by **OR** in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist ☐ Hematologist ☐ Cardiologist ☐ Oncologist

SECTION E: MODERATE TO SEVERE ATOPIC DERMATITIS

1. Has patient completed a ≥ 14-day trial of a medium- to high-potency topical corticosteroid to achieve and maintain remission of low or mild disease? ☐ Yes ☐ No

   Dates of trial: _____

   If no, please explain: _____

2. Has patient completed a 6-week trial of a topical calcineurin inhibitor? ☐ Yes ☐ No

   Dates of trial: _____

   If no, please explain:

SECTION F: CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP)

1. Does patient have a confirmed diagnosis by evidence of the presence of bilateral nasal polyps by physical examination, rhinoscopy, nasal endoscopy, or diagnostic testing? ☐ Yes ☐ No

***For Xolair syringe: Please attach current lab work for serum IgE levels measured before the start of treatment.*

2. Has patient had an inadequate response or a contraindication to a trial of 1 maintenance intranasal corticosteroid used for at least 8 weeks or a systemic corticosteroid, or has had prior nasal surgery? ☐ Yes ☐ No

   If no, please explain: _____

3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Otolaryngologist ☐ Pulmonologist ☐ Allergist/Immunologist

SECTION G: ALLERGIC ASTHMA

1. Has patient had moderate to severe persistent asthma with ≥ 1 exacerbation (oral corticosteroid burst, ER visit, hospital, office visit) in the past 12 months while on, and adherent to, a medium- to high-dose or max-tolerated inhaled corticosteroid plus a controller therapy, OR a max-tolerated inhaled corticosteroid/long-acting beta agonist combo? ☐ Yes ☐ No

   If no, please explain: _____

2. Did patient test positive to a perennial aeroallergen? ☐ Yes ☐ No

Please attach lab work for serum IgE levels measured before the start of treatment.

3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist

SECTION H: CHRONIC SPONTANEOUS URTICARIA (CSU)

1. Has patient had chronic spontaneous urticaria for at least 3 months? ☐ Yes ☐ No
2. Does patient have a treatment failure, or a contraindication to a four-week trial of a second-generation H_1 antihistamine? ☐ Yes ☐ No
3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Dermatologist ☐ Allergist ☐ Immunologist

SECTION I: EOSINOPHILIC ESOPHAGITIS (EoE)

1. Does patient have a confirmed diagnosis of eosinophilic esophagitis with ≥ 15 eosinophils/high-power field? ☐ Yes ☐ No
2. Does patient have a treatment failure, contraindication, or technique difficulty to a swallowed topical corticosteroid or a proton pump inhibitor? ☐ Yes ☐ No
3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Allergist ☐ Gastroenterologist ☐ Immunologist

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Tel: 1-800-241-8335

SECTION J: PRURIGO NODULARIS

1. Does patient have a confirmed diagnosis of Prurigo Nodularis with provider attestation of ≥ 20 nodular lesions? ☐ Yes ☐ No
2. Does patient have a contraindication or a treatment failure of a medium- to super-potent topical corticosteroid? ☐ Yes ☐ No
3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Dermatologist ☐ Allergist ☐ Immunologist

SECTION K: SEVERE PERSISTENT ASTHMA

1. Has patient had severe persistent asthma with ≥ 1 exacerbation (oral corticosteroid burst, ER visit, hospital, office visit) in the past 12 months while on and adherent to one of the following? ☐ Yes ☐ No
   - A medium- to high-dose or max-tolerated inhaled corticosteroid plus a controller therapy; OR
   - A max-tolerated inhaled corticosteroid/long-acting beta agonist combo

   If no, please explain: _____
2. Medication is being prescribed by **OR** in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist

SECTION L: IgE-MEDIATED FOOD ALLERGY

Please attach lab work for serum IgE levels measured before the start of treatment.

1. Did the patient test positive for IgE **OR** a positive skin prick test **OR** an oral food challenge to allergenic foods? ☐ Yes ☐ No
2. The patient has a history of IgE-mediated allergic reaction to (Select all that apply):

   ☐ Peanuts ☐ Milk products ☐ Eggs ☐ Seafood ☐ Other: _____
3. Medication is being prescribed by **OR** in consultation with an:

   ☐ Allergist ☐ Immunologist

SECTION M: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) AND EOSINOPHILIC TYPE

1. Has patient had COPD with ≥ 2 moderate exacerbations (use of a systemic glucocorticoid, an antibiotic agent, ER visit, or office visit) in the past 12 months while on and adherent to ≥ 90-day triple therapy [a long-acting muscarinic agent (LAMA) plus a long-acting beta agonist (LABA) plus an inhaled corticosteroid (ICS) or double therapy if ICS is contraindicated] **OR** ≥ 1 exacerbation that led to hospitalization while on and adherent to ≥ 90-day triple therapy? ☐ Yes ☐ No

If no, please explain: _____

2. Medication is being prescribed by **OR** in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist
3. Submit current labs/documentation of the following: Baseline blood eosinophil (EOS) levels ≥ 300 cells/uL

SECTION ~~M~~ N: REAUTHORIZATION (12 MONTHS) WILL BE BASED ON THE FOLLOWING:

See section below for patient's specific diagnosis.

ALLERGIC ASTHMA:

1. The patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (select all that apply):
   - ☐ Decreased frequency of exacerbations
   - ☐ Decreased use of rescue medication
   - ☐ Increase in percent predicted FEV_1 from pre-treatment baseline
   - ☐ Decrease in severity of frequency of asthmatic symptoms (wheezing, shortness of breath, coughing)
2. Has the patient been compliant with therapy? ☐ Yes ☐ No

ATOPIC DERMATITIS:

1. Has the patient had a positive clinical response to therapy as confirmed by a decrease in severity of symptoms? ☐ Yes ☐ No
2. Has the patient been compliant with therapy? ☐ Yes ☐ No

CHRONIC SPONTANEOUS URTICARIA (CSU):

1. Has the patient had a positive response to therapy as confirmed by a decrease in severity of symptoms? ☐ Yes ☐ No
2. Has the patient been compliant with therapy? ☐ Yes ☐ No

EOSINOPHILIC ASTHMA AND CORTICOSTEROID-DEPENDENT ASTHMA AND SEVERE PERSISTENT ASTHMA:

1. The patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (select all that apply):
   - ☐ Decreased frequency of exacerbations
   - ☐ Increase in percent predicted FEV_1 from pre-treatment baseline
   - ☐ Decreased use of rescue medication
   - ☐ Decrease in severity or frequency of asthmatic symptoms (wheezing, shortness of breath, coughing)
2. Has the patient been compliant with therapy? ☐ Yes ☐ No

EOSINOPHILIC ESOPHAGITIS:

1. Has the patient had a positive response to therapy as confirmed by a decrease in severity of symptoms? ☐ Yes ☐ No
2. Has the patient been compliant with therapy? ☐ Yes ☐ No

EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA):

1. The patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (check all that apply):
   - ☐ Reduction in relapses
   - ☐ Reduction in glucocorticoid dose
2. Has the patient been compliant with therapy? ☐ Yes ☐ No

HYPEREOSINOPHILIC SYNDROME (HES):

1. The patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (check all that apply):
   - ☐ Reduction in number of flares
   - ☐ Decreased blood eosinophil count from baseline
2. Has the patient been compliant with therapy? ☐ Yes ☐ No

CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP):

1. Has the patient had a positive response to therapy as confirmed by a decrease in severity of symptoms? ☐ Yes ☐ No
2. Has the patient been compliant with therapy? ☐ Yes ☐ No

PRURIGO NODULARIS:

1. Has the patient had a positive response to therapy as confirmed by a decrease in itch intensity or a decrease in number of nodules? ☐ Yes ☐ No
2. Has the patient been compliant with therapy? ☐ Yes ☐ No

IgE-MEDIATED FOOD ALLERGY:

1. Has the patient been compliant with therapy? ☐ Yes ☐ No

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) AND EOSINOPHILIC TYPE:

1. The patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (select all that apply):

☐ Decreased frequency of exacerbations ☐ Dyspnea Improvement

2. Has the patient been compliant with therapy? ☐ Yes ☐ No

_____ _____

Prescriber Signature (Required) ***Date***

(By signing, the prescriber confirms that the above information is accurate and verifiable by patient records.)

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