P&T Committee Meeting Minutes
Commercial/Marketplace/CHIP
July 18th, 2023

Present (via Teams):	**Absent:**
Bret Yarczower, MD, MBA – Chair	Jeremy Bennett, MD
Amir Antonius, Pharm.D.	Holly Bones, Pharm.D.
Emily Antosh, Pharm.D.	Kim Castelnovo, RPh
Kristen Bender, Pharm.D.	Kimberly Clark, Pharm.D.
Alyssa Cilia, RPh	Bhargavi Degapudi, MD
Michael Dubartell, MD	Michael Evans, RPh
Rajneel Farley, Pharm.D.	Nichole Hossler, MD
Kelly Faust, Pharm.D.	Jason Howay, Pharm.D.
Tricia Heitzman, Pharm.D.	Keith Hunsicker, Pharm.D.
Emily Hughes, Pharm.D.	Kelli Hunsicker, Pharm.D.
Derek Hunt, Pharm.D.	Perry Meadows, MD
Kerry Ann Kilkenny, MD	Jonas Pearson, RPh
Philip Krebs, R.EEG T	William Seavey, Pharm.D.
Briana LeBeau, Pharm.D.	Michael Shepherd, MD
Ted Marines, Pharm.D.	Todd Sponenberg, Pharm.D.
Lisa Mazonkey, RPh	Jill Stone, Pharm.D.
Tyreese McCrea, Pharm.D.	Robert Strony, MD MBA
Jamie Miller, RPh	Luke Sullivan, DO
Mark Mowery, Pharm.D.	
Austin Paisley, Pharm.D.	
Kimberly Reichard, Pharm.D.	
Melissa Sartori, Pharm.D.	
Angela Scarantino	
Kristen Scheib, Pharm.D.	
Leslie Shumlas, Pharm.D.	
Aubrielle Smith Pharm.D.	
Kirsten Smith, Pharm.D.	
Michael Spishock, RPh	
Kevin Szczecina, RPh	
Amanda Taylor, MD	
Ariana Wendoloski, Pharm.D.	
Brandon Whiteash, Pharm.D.	
Margaret Whiteash, Pharm.D.	
Morgan Casciole (pharmacy resident)	
Daniele Francisko (pharmacy resident)	
Kirsten Mascaritola (pharmacy resident)	
Benjamin Andrick, Pharm.D. (non-voting participant)	
Birju Bhatt, MD (non-voting participant)	
Abigail Chua, DO (non-voting participant)	
Alfred Denio, MD (non-voting participant)	
Jeremy Garris, Pharm.D. (non-voting participant)	

Call to Order:
Dr. Bret Yarczower called the meeting to order at 1:03 p.m., Tuesday, July 18th, 2023.

Review and Approval of Minutes:
Dr. Bret Yarczower asked for a motion or approval to accept the May 16th, 2023 and June 2023 e-vote minutes as written. Minutes approved unanimously. None were opposed.

DRUG REVIEWS

QALSODY (tofersen)

Review: Qalsody is an antisense oligonucleotide indicated for the treatment of amyotrophic lateral sclerosis (ALS) in adults who have a mutation in the superoxide dismutase 1 (SOD1) gene. Qalsody is thought to cause degradation of SOD1 mRNA through binding to SOD1 mRNA, which results in a reduction of SOD1 synthesis. Qalsody is the first medication manufactured that targets this mutation. The clinical trial, however, did not meet the primary endpoint. This indication is approved under accelerated approval based on reduction in plasma neurofilament light chain observed in patients treated with Qalsody. Continued approval for this indication may be contingent upon verification of clinical benefit in confirmatory trial(s).

Qalsody is supplied as a 100mg/15ml solution in a single-dose vial. Qalsody is initiated with three loading doses of 100 mg (15 ml) administered at 14-day intervals. A maintenance dose of 100 mg (15 ml) should be administered once every 28 days. Qalsody is administered intrathecally. Prior to administration, approximately 10 ml of cerebrospinal fluid should be removed. Qalsody is then administered as an intrathecal bolus injection over 1 to 3 minutes.

The efficacy of Qalsody was assessed in a 28-week randomized, double-blind, placebo-controlled clinical study in patients 23 to 78 years of age with weakness attributable to ALS and SOD1 mutation confirmed by a central laboratory. 108 patients were randomized 2:1 to receive treatment with either Qalsody 100 mg (n=72) or placebo (n=36) for 24 weeks (3 loading doses followed by 5 maintenance doses). The primary efficacy endpoint was the change from baseline to Week 28 in the ALSFRS-R total score in the mITT population, analyzed using the joint rank test to account for mortality in conjunction with multiple imputation (MI) to account for missing data for withdrawals other than death. After the completion of the 28-week VALOR study, participants had the option to enroll in an open-label extension (OLE) study (NCT03070119). At the 52-week interim analysis, patients previously receiving placebo who initiated Qalsody in the OLE had similar reductions in NfL as those patients treated with Qalsody in the placebo-controlled period. Earlier initiation of Qalsody was associated with trends for reduction in decline on ALSFRS-R, percent-predicted SVC, and handheld dynamometry megascore, compared to placebo and delayed initiation of Qalsody, although not statistically significant. In addition, earlier initiation of Qalsody was associated with a trend toward a reduction in the risk of death or permanent ventilation, also not statistically significant.

The most common adverse reactions (≥ 10% of patients treated with Qalsody and greater than placebo) were pain, fatigue, arthralgia, increase in CSF white blood cells, and myalgia. A total of 13.5% of patients were 65 years of age and older and 1.2% of patients were 75 years of age and older at initiation of treatment in the clinical trial. No overall differences in safety or effectiveness were observed between these patients and younger patients, but a greater sensitivity of some older individuals cannot be ruled out.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: Dr. Bret Yarczower asked if most ALS cases are wild-type or are they mutated. Mark Mowery, Pharm.D., responded that most are wild-type and not mutated. Dr. Mike Dubartell asked if we are getting feedback from neurologists regarding efficacy. Mark Mowery, Pharm.D., received feedback

from Geisinger neurologist, Dr. Avila, that was positive and Dr. Avila stated he would not hesitate to start his patients on this medication if they met the criteria. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee voted by majority to accept the recommendations as presented.

Outcome: Qalsody will be a medical benefit and will be added to the medical benefit cost share list. If processed at a specialty pharmacy, Qalsody will process at the Specialty tier or the Brand Non-preferred tier for members with a three-tier benefit. The following prior authorization criteria will apply:

- Documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of a consultation with a neurologist, neuromuscular specialist, or physician specializing in the treatment of amyotrophic lateral sclerosis (ALS) **AND**
- Diagnosis of amyotrophic lateral sclerosis (ALS) with a confirmed mutation in the superoxide dismutase 1 (SOD1) gene **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

AUTHORIZATION DURATION: Initial approval will be for 12 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for 12 months or less if the reviewing provider feels it is medically appropriate and will require the following criteria:

- Medical record documentation that member is tolerating and compliant with prescribed Qalsody regimen **AND**
- Medical record documentation of regular physician follow-up

QUANTITY LIMIT:

- Initial authorization: 12-month duration with quantity limit of 13 doses
- Re-authorization: 12-month duration with quantity limit of 12 doses

GPI LEVEL: GPI-12

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

EPKINLY (epcoritamab)

Review: Epkinly is a T-cell engaging bispecific antibody indicated for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from indolent lymphoma, and high-grade B-cell lymphoma after two or more lines of systemic therapy. Epkinly binds the CD3 receptor expressed on the surface of T-cells and CD20 expressed on the surface of lymphoma cells and healthy B-lineage cells. In vitro, Epkinly-activated T-cells cause the release of proinflammatory cytokines and induced lysis of B-cells.

Epkinly is administered through a subcutaneous injection by a healthcare professional. The recommended dosage is slowly titrated up (Table 4) to reduce the incidence and severity of cytokine release syndrome (CRS). Due to the risk of CRS and immune effector cell-associated neurotoxicity syndrome (ICANS), patients should be hospitalized for 24 hours after administration of Cycle 1 Day 15 dosage of 48 mg. Treatment of Epkinly is continued for 28-day cycles until disease progression or unacceptable toxicity. To reduce the risk of CRS, for Cycle 1, all patients should be premedicated with diphenhydramine, acetaminophen, and prednisolone or dexamethasone. For Cycle 2 and beyond, patients who experienced Grade 2 or 3 CRS with a previous dose of Epkinly should receive premedication with prednisolone or dexamethasone. Prior to the initiation of Epkinly, patients should

receive prophylaxis for Pneumocystis jirovecii pneumonia (PJP). Patients should also consider initiating prophylaxis against herpes virus prior to starting Epkinly to prevent herpes zoster reactivation.

The efficacy of Epkinly was evaluated in the in EPCORE NHL-1 trial, an open-label multi-cohort, single arm trial in 157 patients with relapsed or refractory large B-cell lymphoma (LBCL) after two or more lines of systemic therapy. Patients excluded patients with CNS involvement of lymphoma, allogeneic HSCT, or solid organ transplant, ongoing active infection, or any patients with known T-cell immunity. Patients received Epkinly monotherapy as a subcutaneous injection according to the recommended dosage. The diagnosis was DLBCL NOS in 86% of patients, including 27% with DLBCL transformed from indolent lymphoma, and high-grade B-cell lymphoma in 14%. The median number of therapies was 3, with 30% receiving 2 prior therapies, 30% receiving 3 prior therapies, and 40% receiving 4 or more prior therapies. Efficacy was assessed as overall response rate (ORR) determined by Lugano 2014 criteria as assessed by Independent Review Committee (IRC) and duration of response. Efficacy is shown in Table 6. The median time to response was 1.4 months. Among responders, median follow-up for DOR was 9.8 months.

Warnings and Precautions include serious or life-threatening CRS reactions and/or ICANS reactions. CRS occurred in 51% of patients receiving EPKINLY at the recommended dosage in clinical trials, with Grade 1 reactions occurring in 27%, Grade 2 reactions in 17%, and Grade 3 reactions in 2.5% of patients. Recurrent CRS occurred in 16% of patients. Of all CRS events, most occurred during Cycle 1, with a majority of reactions occurring on Cycle 1 Day 15 when the dose is increased to 48 mg. CRS resolved in 98% of patients and the median duration of CRS events was 2 days. The most common symptoms included pyrexia, hypotension, hypoxia, dyspnea, chills, and tachycardia. Concurrent neurological adverse reactions associated with CRS occurred in 2.5% of patients and included headache, confusional state, tremors, dizziness, and ataxia. ICANS reactions occurred in 6% of patients treated with EPKINLY during the clinical trial, with a majority of reactions occurring within Cycle 1 of treatment. There was one fatal ICANS occurrence. The median duration of ICANS was 4 days with ICANS resolving in 90% of patients with supportive care. The clinical manifestations included, but were not limited to confusional state, lethargy, tremor, dysgraphia, aphasia, and non-convulsive status epilepticus. The onset of ICANS can be concurrent with CRS, following the resolution of CRS, or in absence of CRS. Other warnings and precautions include serious and fatal infections, including opportunistic infections, and serious or severe cytopenias, including neutropenia, anemia, and thrombocytopenia, and embryo-fetal toxicity.

In patients with relapsed or refractory LBCL who received Epkinly in the clinical trial, 49% were 65 years of age or older, and 19% were 75 years of age or older. No clinically meaningful difference in safety or efficacy were observed between patients 65 years of age or older compared with younger patients.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: Dr. Bret Yarczower asked if cytokine release syndrome would respond well to Actemra. Kim Reichard, Pharm.D., responded that it would be expected to respond well since most patients were resolved. Dr. Alfred Denio asked why we are making Part D recommendations for drugs that are administered by a healthcare provider. Tricia Heitzman, Pharm.D., responded that whoever is incurring the cost is what benefit the drug is billed to. Dr. Denio is asking if the medication is picked up at the pharmacy, will the member then take it to the provider office. Tricia Heitzman, Pharm.D., responded that there is also white-bagging where the pharmacy will ship directly to the provider office. Dr. Denio asked if there was a policy explaining the P&T committee stance on white-bagging. Kim Reichard, Pharm.D., and Tricia Heitzman, Pharm.D., responded they would have to get back to him. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Epkinly is a medical benefit drug and will be added to the medical benefit cost share list. When processed at a Specialty Pharmacy, Epkinly will process on the Specialty tier or Brand NP tier for members with a three-tier benefit. The following prior authorization criteria will apply:

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Epkinly is written by a hematologist or oncologist **AND**
- Medical record documentation of a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from indolent lymphoma **AND**
- Medical record documentation of prior therapy with at least two lines of systemic therapy

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

RPH SIGNOFF REQUIRED: Yes

GPI LEVEL: GPI-12

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

DAYBUE (trofinetide)

Review: Daybue is a synthetic analog of glycine-proline-glutamate, the N-terminal tripeptide of insulin-like growth factor indicated for Rett syndrome (RTT) for patients 2 years of age and older. The mechanism is unknown but actions such as anti-inflammatory, anti-oxidant, and trophic effects that stabilize dendritic morphology, synaptic protein synthesis, and neuronal signaling are observed. Daybue is administered orally or through gastrostomy tube twice daily according to weight-based dosing. Daybue is provided in a 450 mL bottle.

Safety and efficacy of Daybue was evaluated in a Phase 3 LAVENDER study, a 12-week, double-blind, randomized, placebo-controlled study that enrolled 187 female participants ranging from 5-20 years of age. The co-primary endpoints included the Rett Syndrome Behaviour Questionnaire (RSBQ) and Clinical Global Impression-Improvement (CGI-I) assessment. RSBQ is a 45-item rating scale completed by a caregiver assessing symptoms such as breathing, repetitive behaviors, nighttime behaviors, vocalizations, eye gaze, etc., with a maximum score of 90. Lower scores reflect lesser severity. CGI-I is a clinician assessment assessing improvement or worsening on a 7-point scale with 1 being very much improved and 7 being very much worse meaning a decrease in score indicates improvement. Key inclusion criteria were documented MECP2 mutation. RTT Clinical Severity Scale Rating of 10-36, CGI-S score of less than or equal to 4. Daybue was showed statistically significant improvement over placebo for both co-primary endpoints. Daybue RSBQ score had a mean of 43.7 baseline and 39.9 after twelve weeks compared to 44.5 baseline and 42.8 after 12 weeks for placebo. The CGI-I scores revealed that 61% of patients in Daybue had no change in RTT symptoms, 24.7% had minimal improvement and 13% were much improved. In the placebo group, 81.4% of patients had no change, 10.5% were minimally improved, and 4.7% were much improved.

There was another study done in pediatric patients ages 2-4 where 13 patients received Daybue for 12 weeks and 9 patients received it for 6 months. Adverse events were similar, and it also provided pharmacokinetic data leading to indication of patients 2 years and older. This medication is not recommended for people with severe hepatic or renal impairment. It is not recommended in pregnant patients but there were no adverse developmental effects observed with oral administration of pregnant animals. Of note, the plasma exposure was less in the animals than what is seen in humans.

Also of note, this medication can only be filled at AnovoRx, which is a specialty pharmacy. They will coordinate delivery and process prescriptions. Each patient will receive six or eight bottles of Daybue depending on dosing along with dosing syringes, as it is not recommended to use household dosing cups. Each bottle is only good for 14 days once opened while unused bottles should be refrigerated.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: Aubrielle Smith, Pharm.D., asked if we could add a note to policy about classical versus typical Rett Syndrome. Ted Marines, Pharm.D., stated there is a recommendation for the note to reviewer to be included in the policy. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Daybue is a pharmacy benefit and will not be added to Commercial, Exchange, and CHIP Formulary. The following prior authorization criteria will apply:

- Medical record documentation of 2 years or older **AND**
- Medical record documentation of the MECP2 gene **AND**
- Medical record documentation of diagnosis of classic, or typical Rett Syndrome **AND**
- Medical record documentation of a patients baseline symptoms using an appropriate rating scale (e.g., Rett syndrome behavioural questionnaire, simplified severity score, Clinical Global Impression-Improvement assessment) **AND**
- Medical record documentation that Daybue is appropriately dosed **AND**
- Medical record documentation that Daybue is prescribed by or in consultation with a neurologist

AUTHORIZATION DURATION: Initial approval will be for 3 months or less if the provider feels it is medically appropriate. For continued coverage, the following criteria is required:

- Medical record documentation of clinical improvement in Rett syndrome symptoms as measured by an appropriate rating scale (compared to previous measurement)

Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate. For continued coverage, the follow criteria is required:

- Medical record documentation of clinical improvement in Rett syndrome symptoms as measured by an appropriate rating scale (compared to previous measurement)

RPH SIGNOFF REQUIRED: Yes

GPI LEVEL: GPI-12

QUANTITY LIMIT: 3,600 mL per 30 days

NOTE: Below outlines diagnosis of classic, or typical Rett Syndrome

1. A period of regression followed by recovery or stabilization AND
2. ALL of the following
    a. Partial or complete loss of acquired purposeful hand skills
    b. Partial or complete loss of acquired spoken language
    c. Gait abnormalities: Impaired (dyspraxic) or absence of ability
    d. Stereotypic hand movements such as hand wringing/squeezing, clapping/tapping, mouthing, and washing/rubbing automatisms AND
3. NONE of the following
    a. Brain injury secondary to trauma (peri- or postnatally), neurometabolic disease, or severe infection that causes neurologic problems
    b. Grossly abnormal psychomotor development in the first six months of life

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

ATORVALIQ (atorvastatin)

Review: Atorvaliq (atorvastatin suspension) is indicated to reduce the risk of myocardial infarction, stroke, revascularization procedure, and angina in adults with multiple risk factors for coronary heart disease but without clinically evident coronary heart disease. It is indicated to reduce the risk of Myocardial infarction and stroke for adults with type 2 diabetes mellitus with multiple risk factors for CHD but without clinically evident CHD. It is also indicated to reduce the risk of non-fatal MI, fatal and non-fatal stroke, revascularization procedures, hospitalization for CHF, and angina in adults with clinically evident CHD. Atorvaliq is indicated to be used as an adjunct to diet to reduce low-density lipoprotein cholesterol (LDL-C) in adults with primary hyperlipidemia, adults and pediatric patients aged 10 years and older with heterozygous familial hypercholesterolemia (HeFH). It is also used as an adjunct to other LDL-C lowering therapies, or alone if such treatments are unavailable. In addition, it can be used to reduce LDL-C in adults and pediatric patients aged 10 years and older with homozygous familial hypercholesterolemia (HoFH). Atorvaliq can be used as an adjunct to diet for the treatment of adults with primary dysbetalipoproteinemia and hypertriglyceridemia.

The recommended starting dosage of Atorvaliq in adult patients is 10 to 20 mg once daily delivered in a calibrated oral syringe or other oral dosing device. The dosing regimen for the atorvastatin oral suspension is the same as the atorvastatin tablet. Patients should take Atorvaliq once daily on an empty stomach 1 hour before or 2 hours after a meal. If patients miss a dose, they should take it as soon as possible. If a dose was missed by more than 12 hours, patients should not take the missed dose and take the next scheduled dose. Patients who have swallowing difficulties or feeding tubes and are unable to take medications in solid oral dosage forms can take Atorvaliq suspension instead of taking atorvastatin tablets.

The effectiveness of Atorvaliq has been established in clinical trials of atorvastatin calcium tablets. Atorvastatin has been shown to be clinically effective in the prevention of cardiovascular disease. In the Anglo-Scandinavian Cardiac Outcomes Trial (ASCOT), a double-blind, placebo-controlled trial, the effect of atorvastatin on fatal and non-fatal coronary heart disease was assessed in 10,305 hypertensive patients 40-80 years of age, without a previous myocardial infarction and with total cholesterol levels <251 mg/dL. All patients had at least 3 of the following risk factors: male gender, age >55, smoking, diabetes, history of CHD in a first degree relative, total cholesterol: HDL >6, peripheral vascular disease, left ventricular hypertrophy, prior cerebrovascular event, specific ECG abnormality, and proteinuria/albuminuria. Patients were given antihypertensive therapy and allocated to either atorvastatin 10 mg daily (n=5168) or placebo (n=5137) using a covariate adaptive method and followed for a median of 3.3 years. Atorvastatin significantly reduced the rate of coronary events (fatal coronary heart disease or non-fatal MI) with a relative risk reduction of 36%, p =0.0005 which was consistent regardless of age, smoking status, obesity, or renal dysfunction. The effect of 10 mg/day of atorvastatin on lipid levels was similar to that seen in previous clinical trials. Atorvastatin also reduces total cholesterol, LDL, and triglycerides in patients with hyperlipidemia (heterozygous familial and nonfamilial) and mixed dyslipidemia. In two multicenter, placebo-controlled, dose-response trials in patients with hyperlipidemia, atorvastatin given as a single dose over 6 weeks, significantly reduced total cholesterol, LDL, and triglycerides.

The most common adverse reactions caused by atorvastatin that led to treatment discontinuation include myalgia (0.7%), diarrhea (0.5%), nausea (0.4%), alanine aminotransferase increase (0.4%), and hepatic enzyme increase (0.4%). Geriatric patients had similar safety and efficacy results when compared to adult patients. Patients who were older than 65 years old were at greater risk for atorvastatin-associated myopathy and rhabdomyolysis and require cautious dose selection.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: Dr. Kerry Kilkenny asked if the atorvastatin tablets can be crushed and made into a suspension. Kelly Faust, Pharm.D., stated that it states in the package insert not to crush but that members with difficulty swallowing would not be required to fail other formulary alternatives. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Atorvaliq is a pharmacy benefit that will not be added to the Commercial/Exchange/CHIP formularies. The following criteria will be applied:

- Medical record documentation of an age greater than or equal to 10 years **AND**
- Medical record documentation of inability to tolerate or swallow tablets **OR**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to up to three (3) preferred formulary statins of the same prescribed intensity*, one of which must be atorvastatin tablets

RPH SIGNOFF REQUIRED: No

GPI LEVEL: GPI-12

QUANTITY LIMIT: 20 mL per day

NOTE: High-, Moderate-, and Low-Intensity Statin Therapy

	High Intensity	Moderate Intensity	Low Intensity
LDL-C Lowering	≥ 50%	30-49%	< 30%
Statins	Atorvastatin 40 mg, 80 mg Rosuvastatin 20 mg, 40 mg	Atorvastatin 10 mg, 20 mg Rosuvastatin 5 mg, 10 mg Simvastatin 20 – 40 mg	Simvastatin 10 mg
		Pravastatin 40 mg, 80 mg Lovastatin 40 mg, 80 mg Fluvastatin XL 80 mg Fluvastatin 40 mg BID Pitavastatin 1 – 4 mg	Pravastatin 10 – 20 mg Lovastatin 20 mg Fluvastatin 20 – 40 mg

Grundy SM, Stone NJ, Bailey AL, Beam C, Birtcher KK, Blumenthal RS, Braun LT, de Ferranti S, Faiella-Tommasino J, Forman DE, Goldberg R, Heidenreich PA, Hlatky MA, Jones DW, Lloyd-Jones D, Lopez-Pajares N, Ndumele CE, Orringer CE, Peralta CA, Saseen JJ, Smith SC Jr, Sperling L, Virani SS, Yeboah J. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. 2019 Jun 18;139(25):e1046-e1081. doi: 10.1161/CIR.0000000000000624. Epub 2018 Nov 10. Erratum in: Circulation. 2019 Jun 18;139(25):e1178-e1181. PMID: 30565953.

Additional Recommendations: The following recommendations are made to keep policies consistent among non-formulary branded statin medications:
Update Policy 598.0 Ezallor to specifically identify statins of the same intensity as formulary alternatives that must be tried prior to approval and add statin intensity table:

- Medical record documentation of difficulty swallowing **OR**
- Medical record documentation of administration through a nasogastric tube **OR**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to ~~three (3) formulary alternatives~~ up to three (3) preferred formulary statins of the same prescribed intensity*, one of which must be rosuvastatin

NOTE: High-, Moderate-, and Low-Intensity Statin Therapy

	High Intensity	Moderate Intensity	Low Intensity
LDL-C Lowering	≥ 50%	30-49%	< 30%
Statins	Atorvastatin 40 mg, 80 mg Rosuvastatin 20 mg, 40 mg	Atorvastatin 10 mg, 20 mg Rosuvastatin 5 mg, 10 mg Simvastatin 20 – 40 mg	Simvastatin 10 mg
		Pravastatin 40 mg, 80 mg Lovastatin 40 mg, 80 mg Fluvastatin XL 80 mg Fluvastatin 40 mg BID Pitavastatin 1 – 4 mg	Pravastatin 10 – 20 mg Lovastatin 20 mg Fluvastatin 20 – 40 mg

Grundy SM, Stone NJ, Bailey AL, Beam C, Birtcher KK, Blumenthal RS, Braun LT, de Ferranti S, Faiella-Tommasino J, Forman DE, Goldberg R, Heidenreich PA, Hlatky MA, Jones DW, Lloyd-Jones D, Lopez-Pajares N, Ndumele CE, Orringer CE, Peralta CA, Saseen JJ, Smith SC Jr, Sperling L, Virani SS, Yeboah J. 2018

AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. 2019 Jun 18;139(25):e1046-e1081. doi: 10.1161/CIR.0000000000000624. Epub 2018 Nov 10. Erratum in: Circulation. 2019 Jun 18;139(25):e1178-e1181. PMID: 30565953.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

ARIKAYCE (amikacin liposome)

Review: Arikayce is amikacin liposome inhaled suspension, and it is an inhaled aminoglycoside antibiotic indicated in adults, who have limited or no alternative treatment options, for the treatment of Mycobacterium avium complex (MAC) lung disease as part of a combination antibacterial drug regimen in patients who do not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug regimen therapy. Use is not recommended for patients with non-refractory MAC lung disease. Due to limited clinical safety and effectiveness data and accelerated approval based on achieving sputum culture conversion (defined as 3 consecutive negative monthly sputum cultures) by month 6, Arikayce is reserved for use in adults who have limited or no alternative treatment options. To note, continued approval for this indication is contingent upon verification and description of clinical benefit in trials.

Arikayce is supplied as a sterile, white, milky, aqueous, liposome suspension in a unit-dose 10mL glass vial containing amikacin 590mg/8.4mL (equivalent to amikacin sulfate 623mg/8.4mL). It is dispensed as a 28-vial kit. Arikayce is for oral inhalation via nebulization only, and it is to be administered strictly with the Lamira Nebulizer System. If patient uses a bronchodilator, pre-treatment with medication should be used prior to Arikayce administration. Arikayce's recommended dosing in adults is the inhalation of the contents of one vial using the Lamira Nebulizer machine once daily. Typically, it can take up to 6 months to see conversion to negative sputum conversion. Once achieved, the therapy is continued for 12 months from the point of sputum conversion.

Arikayce use is contraindicated in patients with hypersensitivity to any aminoglycoside. Warnings and precautions with higher frequency with Arikayce versus background regimen alone include hypersensitivity, pneumonitis, hemoptysis, bronchospasm, exacerbation of underlying pulmonary disease, and ototoxicity (including tinnitus, vertigo, presyncope, and deafness). Other warnings with no high frequency with Arikayce versus background regimen alone include nephrotoxicity, neuromuscular blockade, and embryo-fetal toxicity. Other adverse reactions commonly reported are dysphonia, cough, musculoskeletal pain, airway irritation, fatigue, diarrhea, nausea, headache, pneumonia, pyrexia, change in sputum and chest discomfort.

The CONVERT trial, an open label randomized (2:1), multi-center trial, was conducted which assessed patients with refractory MAC lung disease as confirmed by at least 2 sputum culture results. They were considered refractory if they did not achieve negative sputum cultures after a minimum duration of 6 consecutive months of background regimen therapy that was either ongoing or stopped no more than 12 months before the screening visit. Patients were randomized to either Arikayce plus background regimen or background regimen alone. The surrogate endpoint was based on achieving culture conversion (3 consecutive monthly negative sputum cultures) by month 6. Patients who achieved culture conversion by Month 6 were continued on study drug for a total of 12 months after the first negative sputum culture. 336 patients were randomized 2:1, with a mean age of 64.7 years, 69.3% were females. The proportion of patients achieving culture conversion (3 consecutive monthly negative sputum cultures) by month 6 was significantly greater ($p<0.0001$) for Arikayce plus background regimen (29%) compared to background regimen alone (8.9%). Of those receiving Arikayce plus background regimen, 18.3% achieved culture conversion by month 6 and sustained sputum culture conversion of no positive cultures for up to 12 months after that first negative culture, compared to 2.7% of patients receiving background regimen alone. At 3 months after completion of treatment, 16.1% of patients with Arikayce plus background regimen maintained durable culture conversion, compared to 0% of patients who had received background regimen alone.

No observed risk was seen in elderly, although renal considerations may be higher. A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Arikayce is a pharmacy benefit that will not be added to Commercial, Exchange, or CHIP formularies. The following prior authorization criteria will apply:

- Medical record documentation that member is at least 18 years of age or older **AND**
- Prescription is written by a pulmonologist, infectious disease specialist, or *Mycobacterium avium* complex (MAC) lung disease specialist **AND**
- Medical record documentation of a diagnosis of *Mycobacterium avium* complex (MAC) lung disease as confirmed by a MAC-positive sputum culture **AND**
- Medical record documentation that the patient has NOT achieved negative sputum cultures after a minimum of 6 consecutive months of receiving a multidrug background regimen containing at least 2 to 3 of the following agents: **AND**
    - Macrolide antibiotic [e.g., azithromycin, clarithromycin]
        - If macrolide-resistant [clofazimine]
    - Rifamycin antibiotic [e.g., rifampin, rifabutin]
    - Ethambutol
- Medical record documentation that the medication will be used in conjunction with a multidrug background regimen, including 2 to 3 of the following agents:
    - Macrolide antibiotic [e.g., azithromycin, clarithromycin]
        - If macrolide-resistant [clofazimine]
    - Rifamycin antibiotic [e.g., rifampin, rifabutin]
    - Ethambutol

AUTHORIZATION DURATION: Initial approval will be for **6 months** or less if the provider feels it is medically appropriate. Subsequent approvals will be for **12 months** or less if the reviewing provider feels it is medically appropriate and will require the following criteria:

- Prescription is written by a pulmonologist, infectious disease specialist, or Mycobacterium avium complex (MAC) lung disease specialist **AND**
- Medical record documentation that the medication will continue to be used in conjunction with a multidrug background regimen, including 2 to 3 of the following agents: **AND**
    - Macrolide antibiotic [e.g., azithromycin, clarithromycin]
        - If macrolide-resistant [clofazimine]
    - Rifamycin antibiotic [e.g., rifampin, rifabutin]
    - Ethambutol
- One of the following:
    - Medical record documentation that patient has achieved a negative sputum culture for Mycobacterium avium complex (MAC) in last 6 months
    - **OR**
    - Medical record documentation that patient has NOT achieved a negative sputum culture for Mycobacterium avium complex (MAC) **AND**
    - Medical documentation of physician attestation that the patient has demonstrated clinical benefit while on Arikayce

GPI LEVEL: GPI-12

QUANTITY LIMIT: 28 vials per 28 days

RPH SIGNOFF REQUIRED: Yes

NOTE: The duration of use of Arikayce has not been studied past 18 months of treatment. (6 months of initial treatment plus 12 additional months from the first negative culture).

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

ERMEZA (levothyroxine)

Review: Ermeza (levothyroxine solution) is FDA approved for the treatment of hypothyroidism (as replacement in primary, secondary, and tertiary congenital or acquired hypothyroidism) as well as for pituitary thyrotropic suppression (as an adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer) in adult & pediatric patients (including neonates). Ermeza is available as a 30mcg per mL solution in both 90mL and 180mL bottles and is dosed once daily, preferably on an empty stomach 30 to 60 minutes prior to breakfast. As with other levothyroxine products, Ermeza is not indicated for suppression of benign thyroid nodules and nontoxic diffuse goiter in iodine sufficient patients or for the treatment of hypothyroidism during the recovery phase of subacute thyroiditis. Ermeza should only be administered using the 5mL or 10mL syringe provided in the original carton.

No efficacy or safety studies were performed with Ermeza, due to the “wealth of efficacy and safety information that has already been established for levothyroxine in Hypothyroidism and Pituitary Thyrotropic (Thyroid-Stimulating Hormone, TSH) Suppression” as noted in the NDA application. The approval of Ermeza was based on a single bioequivalence study that establishes a clinical bridge to Synthroid.

Ermeza is contraindicated in patients with uncorrected adrenal insufficiency and those with hypersensitivity to glycerin and edetate disodium (inactive ingredients in Ermeza). The other warnings and precautions with Ermeza are similar to that of other levothyroxine products and include the following: serious risks relate to over/undertreatment (due to narrow therapeutic index), cardiac adverse reactions in the elderly & those with underlying cardiovascular disease, myxedema coma, acute adrenal crisis in patients with concomitant adrenal insufficiency worsening of diabetic control, and decreased bone mineral density associated with thyroid hormone over-replacement.

In the geriatric population, initiate Ermeza at less than the full replacement dose due to risk of atrial arrhythmias in this population. A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Ermeza is a pharmacy benefit and will not be added to the Commercial/Exchange/CHIP formularies. Ermeza will require a prior authorization and will be reviewed under the existing policy 3.0 with the following criteria:

- Medical record documentation of therapeutic failure on, contraindication to, or intolerance to three (3) formulary alternatives.

GPI LEVEL: GPI-14

RPH SIGNOFF REQUIRED: Yes

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

SKYCLARYS (omaveloxolone)

Review: Skyclarys is a once daily oral nuclear factor erythroid 2-related factor 2 (Nrf2) activator indicated for the treatment of Friedreich's ataxia (FA or FRDA) in adults and adolescents 16 years of age and older. Skyclarys is the first FDA approved therapy for patients with FA. Skyclarys is available as a 50 mg capsule and the recommended dosage is 150 mg (3 capsules) by mouth once daily. Skyclarys should be administered on an empty stomach at least 1 hour before eating and should be swallowed whole.

Approval of Skyclarys is based on the safety and efficacy data from the phase 2 MOXIe part 1, part 2 trials and the open-label MOXIe extension trial. Part 1 was a 12 week international, multicenter, randomized, double-blind, placebo-controlled, dose-ranging trial utilized to determine the most effective and safe dose of Skyclarys. Part 2 was a 24-week, international, multi center, randomized, double blind, placebo controlled parallel group registration trial to evaluate the safety and efficacy of 150 mg daily in 103 patients with FA. And lastly the extension phase of the trial assessed long term safety of Skyclarys in select patients who completed part 1 or part 2.

The primary endpoint of the MOXIe part 2 trial was the change in baseline of the modified Friedreich's Ataxia Rating Scale (mFARS). mFARS is a rating system utilized to track progression of FA with scores from 0 to 93-a lower score indicates better function. Patients in the part 2 trial had baseline mFARS scores between 20 to 80. In order to be included patients had to have genetically confirmed FA, be able to swallow capsules and complete exercise testing on a stationary bike. Patients with pes cavus were included in the study but limited to 20% of total subject enrolled and not included in the efficacy analysis. Because patients with pes cavus in part 1 of the study showed less of an mFARS improvement it was deemed that patients with pes cavus have a more severe form of FA. Patients were excluded if they had uncontrolled diabetes (A1c>11%), BNP>200 pg/mL, clinically significant left-sided heart disease or clinically significant cardiac disease. Although ambulation was not a requirement, 92% of patients were ambulatory at the beginning of the trial. Skyclarys met its primary endpoint in the MOXIe part 2 trial, showing a statistically significant effect on neurologic function in patients with FA as measured by mFARS. The placebo-corrected difference between the two groups was -2.40points (95% CI, -4.31 to -0.50, p= 0.014). However, the MOXIe part 2 trial did not demonstrate significant improvements over placebo in secondary outcome measures like neurologic measures, patient and clinician improvement assessments and activities of daily living.

Prior to initiating Skyclarys therapy, monthly for the first three months and throughout the course of therapy it is recommended to obtain baseline ALT, AST, bilirubin, Btype natriuretic peptide (BNP), and lipid parameters. For patients with moderate hepatic impairment the recommended dose is 100 mg once daily. Further dose reduction to 50 mg daily is recommended if adverse reactions occur. Skyclarys should be avoided in patients with severe hepatic impairment. Most common adverse reactions included elevated AST/ALTs, headache, nausea, abdominal pain, fatigue, diarrhea and musculoskeletal pain.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Skyclarys will be a pharmacy benefit. Skyclarys will be added to the Commercial/Exchange/CHIP formularies at the Specialty Tier or Brand Non-Preferred Tier for members with a 3-tier benefit. The following prior authorization criteria will be required:

- Medical record documentation of age greater than or equal to 16 years **AND**
- Medical record documentation that the prescription is written by or in consultation with a Neurologist **AND**
- Medical record documentation of a diagnosis of Friedrich's Ataxia **AND**

- Medical record documentation of genetic testing confirming Frataxin (FXN) gene mutation **AND**
- Medical record documentation of baseline modified Friedreich's Ataxia Rating Scale (mFARS) score

AUTHORIZATION DURATION: Initial approval will be for 12 months. Subsequent approvals will be for an additional 12 months with medical record documentation that the member is responding positively to therapy as evidenced by slowed disease progression or documentation of a positive clinical response (ex. through mFARS-modified functional assessment rating scale)

- Medical record documentation that the member is responding positively to therapy as evidenced by slowed disease progression or documentation of a positive clinical response (ex. through mFARS-modified functional assessment rating scale)

GPI LEVEL: GPI-12

QUANTITY LIMIT: 3 capsules per day; 30 day supply per fill

RPH SIGNOFF REQUIRED: Yes

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

KONVOMEP (omeprazole and sodium bicarbonate)

Review: Konvomep is a combination of the proton pump inhibitor, omeprazole, and sodium bicarbonate, which is indicated for the treatment of active benign gastric ulcer and the reduction of upper gastrointestinal bleeding in critically ill patients. It is currently available as a suspension in 90mL, 150mL, and 300mL bottles, which is composed of 2mg of omeprazole and 84mg of sodium bicarbonate. It is available in a kit for reconstitution which must be completed by health care providers. The kit is comprised of one bottle which contains omeprazole, and a second bottle which contains the strawberry flavored diluent sodium bicarbonate. For the treatment of an active benign gastric ulcer the recommended adult dosing is 40mg once daily for 4 to 8 weeks. For the risk reduction of upper gastrointestinal bleeding in critically ill patients, the recommended dosing for adults is 40mg initially followed by 40mg 6 to 8 hours later, which is then followed by 40mg once daily for a total treatment period of 14 days.

Konvomep must be reconstituted by a health care provider before it can be dispensed to a patient. Once reconstituted, the suspension is viable for up to 30 days if refrigerated between 2°C and 8°C.It can be administered through an orogastric tube or nasogastric tube for patients who cannot swallow. When a patient is given Konvomep through an NG or orogastric tube, a feeding should not be given within 3 hours prior to, or 1 hour after Konvomep is given. When comparing the Konvomep suspension to an oral capsule of omeprazole and sodium bicarbonate, the oral capsule is preferred in patients who can take medications by mouth, and the Konvomep suspension is preferred in patients who cannot take food or medications by mouth. The omeprazole and sodium bicarbonate oral capsule cannot be opened and sprinkled into food or placed into feeding tubes for patients who are not able to take medications by mouth.

A multicenter, double-blind study was performed in the U.S. to evaluate the effectiveness of Konvomep for the treatment of active benign gastric ulcers with the results shown in Table 1. 520 patients were enrolled after all patients were endoscopically diagnosed with a gastric ulcer. During this study patients received either a low dose of omeprazole that was not specified, a 40mg dose of omeprazole, or placebo once daily. 214 patients were allocated to receive 40mg of omeprazole daily, 104 patients were allocated to receive placebo daily and 202 patients were unaccounted for. Patients were then assessed at 4 weeks and 8 weeks by remeasuring the size of the ulcer. The low dose of omeprazole was not included in Table 1 because for patients with ulcers measuring less than or equal to 1 cm, there was no difference in healing rates at 4 or 8 weeks when comparing between the 40mg omeprazole dose and the low dose of omeprazole. When comparing the 40mg dose of omeprazole to the lower dose of omeprazole for patients

who had an ulcer size greater than 1cm, at 8 weeks of therapy the 40mg dose was shown to be statistically more effective than the lower dose. When looking at the percentage of patients healed after 4 weeks of treatment, 55.6% of patients being treated with omeprazole 40mg were healed, whereas only 30.8% of patients being given placebo were healed. When looking at the percentage of patients healed after 8 weeks of treatment, 82.7% of patients were healed with Omeprazole 40mg, whereas only 48.1% of patients in the placebo group were healed. Results for the patients being treated with omeprazole 40mg once daily were statistically significant, with p values less than 0.01.

A double-blind, randomized, non-inferiority clinical trial was performed in the U.S. to evaluate the effectiveness at reducing the risk of upper gastrointestinal bleeding in critically ill patients. This study enrolled 359 patients aged 19 to 91 years old. The study compared an omeprazole and sodium bicarbonate suspension 40mg/1680mg against intravenous cimetidine 300mg bolus and 50 to 100mg/hr continuous infusion. 178 patients were being treated prophylactically with omeprazole and sodium bicarbonate, while 181 patients were being treated prophylactically with cimetidine. The omeprazole and sodium bicarbonate oral suspension was administered via an orogastric or nasogastric tube. It was initially given as two doses 6 to 8 hours apart, followed by one dose daily the following days. Cimetidine was administered as an IV bolus followed by a continuous infusion for up to 14 days. 7 patients being treated with omeprazole and sodium bicarbonate experienced clinically significant upper gastrointestinal bleeding, or 3.9% of this treatment group. 10 patients being treated with cimetidine experienced clinically significant gastrointestinal bleeding, or 5.5% of this treatment group. Based on these results, the study concluded that the omeprazole and sodium bicarbonate oral suspension was non-inferior to intravenous cimetidine.

Contraindications include a known hypersensitivity to any components of this formulation, and for any patients receiving rilpivirine containing products. Warnings include gastric malignancy where patients should receive additional follow up. Acute tubulointerstitial nephritis can occur in patients at any time during treatment and should be discontinued if this occurs. Konvomep has a high sodium concentration and should be used in caution with patients who are on a sodium restricted diet or at risk for congestive heart failure. It should not be given to patients with Barrer's syndrome, hypokalemia, hypocalcemia, or acid base problems due to the sodium content. Patients are at an increased risk for developing Clostridium difficile associated diarrhea. Osteoporosis related bone fractures are increased while patients are taking Konvomep, and patients should be on it for the lowest dose for the shortest duration to reduce this risk. Severe skin reactions can occur such as Stevens-Johnsons syndrome (SJS), toxic epidermal necrosis (TEN), drug reaction with eosinophilia and systemic symptoms (DRESS) and acute generalized exanthematous pustulosis (AGEP), and should be discontinued if symptoms occur. Cutaneous lupus erythematosus (CLE) and systemic lupus erythematosus (SLE) can occur from days to years after therapy. Konvomep should not be given for more than 4 to 12 weeks to avoid the risk of CLE or SLE. Cyanocobalamin deficiency could occur over an extended period of treatment, and patients should be monitored and treated as necessary. Hypomagnesemia and mineral metabolism can occur and can be symptomatic or asymptomatic, which can lead to imbalances in other minerals. If this occurs, Konvomep should be discontinued, and the patient should be treated as needed. When used longer than a year, fundic gland polyps can occur, therefore Konvomep should be used for the shortest duration possible.

The use of Konvomep in the population of 65 years and older has not been established, however in clinical trials with omeprazole there is no difference in safety and efficacy when comparing the use in the elderly population and the younger adult population. A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Konvomep is a pharmacy benefit and will not be added to the Commercial, Exchange, or CHIP formularies. It will be added to policy 753.0 Non-Preferred Alternative Admin Policy. No additional prior authorization criteria will apply:

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to lansoprazole orally dissolving tablets (ODT) **AND**
- Medical record documentation of one of the following:
    - Medical record documentation that member has difficulty swallowing or has a nasogastric tube (NG) tube **OR**
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to two generic formulary alternatives (omeprazole capsules, pantoprazole tablets, lansoprazole capsules, esomeprazole capsules, rabeprazole tablets, or omeprazole/sodium bicarbonate capsules*), one of which must contain the same active ingredient as the product requested, if available

Additional Recommendations: Update Policy 36.0 to include omeprazole/sodium bicarbonate capsules only:
Medical record documentation of a contraindication to, intolerance to, or therapeutic failure on the maximal doses of omeprazole, pantoprazole, lansoprazole, rabeprazole, dexlansoprazole*, and esomeprazole

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

ELFABRIO (pegunigalsidase alfa)

Review: Elfabrio is a hydrolytic lysosomal neutral glycosphingolipid-specific enzyme indicated for the treatment of adults with confirmed Fabry disease. Elfabrio provides an exogenous source of alpha-galactosidase A which is deficient in Fabry disease. Elfabrio is internalized and transported into lysosomes where it is thought to exert enzymatic activity and reduce accumulated globotriaosylceramide (Gb3). It is the second enzyme replacement therapy (ERT) approved for the treatment of Fabry Disease after Fabrazyme was approved in 2003. Elfabrio is considered a “biobetter” to Fabrazyme and was designed to have a longer half-life, lower immunogenicity, and an improved safety profile.

Elfabrio is administered as a 1 mg/kg intravenous infusion every two weeks based on actual body weight. Infusion rate is based on previous ERT experience. Patients who are ERT naïve should consider pretreatment with antihistamines, antipyretics, and/or corticosteroids. Patients who are ERT-experienced and who previously used pretreatment with antihistamines, antipyretics, and/or corticosteroids should consider similar pretreatment before the first several Elfabrio infusions.

The efficacy and safety of Elfabrio was evaluated in a dose-finding study, as well as two open label cross over studies (BRIDGE and BRIGHT) in patients previously treated with Fabrazyme, and a randomized active comparator study (BALANCE) which compared Elfabrio to patient treated with Fabrazyme for at least one year prior to trial entry. Patients were randomized 2:1 to receive Elfabrio (n=52) or Fabrazyme (n=25) every 2 weeks for 104 weeks. The primary efficacy endpoint was annualized rate of change In eGFR assessed over 104 weeks. The estimated mean eGFR slope was -2.4 and -2.3 mL/min/1.73 m2 /year on Elfabrio and Fabrazyme, respectively.

Elfabrio includes warnings and precautions for hypersensitivity reactions Including anaphylaxis and Infusion-associated reactions which is consistent with the safety profile of Fabrazyme. In clinical trials, Elfabrio demonstrated fewer treatment emergent adverse reactions and had a favorable tolerability profile compared to Fabrazyme.

Patients who were previously treated with ERT are more likely to have pre-existing anti-drug antibodies to Elfabrio which could be due to ADA cross-reactivity. Pre-existing ADA may reduce the plasma concentrations of Elfabrio and Increase the risk of Elfabrio related hypersensitivity and infusion related

reactions. Of the patients who experienced serious hypersensitivity reactions during the first Elfabrio infusion and had pre-infusion samples and samples available for testing at the time of the event, all but one had pre-existing IgE ADAs and tested positive for IgE ADAs at the time of the reaction. In the overall clinical program, IARs occurred In 51% of patients who were IgG ADA positive at baseline compared to 16% In IgG ADA negative patients. Overall in clinical trials, Elfabrio demonstrated a favorable immunogenicity profile compared to Fabrazyme, with the proportion of patients with neutralizing ADA declining over time with Elfabrio but not with Fabrazyme.

During clinical trials, the most common adverse reactions reported with Elfabrio were infusion-related reactions which occurred In 17 patients, followed by nasopharyngitis, headache, diarrhea, fatigue, nausea, back pain, pain in extremity, and sinusitis. One Elfabrio treated patient experienced a severe hypersensitivity reaction during the first infusion and withdrew from the trial following a moderate hypersensitivity reaction during the second infusion.

The safety and efficacy of Elfabrio has not been established In pediatric patients. Clinical trials of Elfabrio did not include patients 65 years of age and older to determine if they respond differently from younger adult patients.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: Phil Krebs asked if there was any mention of the use of this or similar medications for treatment of tick-borne illness. Kim Reichard, Pharm.D., stated she did not see anything mentioned while reviewing this drug. Dr. Bret Yarczower asked if this was indicated for all 3 phenotypes of Fabry disease. Kim Reichard, Pharm.D., stated the FDA-approved indication did not specify a phenotype so she assumes it applies to all phenotypes. This is being used anywhere you would use Fabrazyme to treat, but Kim Reichard volunteered to research further. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: Dr. Bret Yarczower asked if this was weight-based dosing and if lean body weight can be used. Kim Reichard, Pharm.D., responded that dosing is based on actual body weight. Dr. Yarczower suggested contacting a specialist at Duke to gain additional information. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Elfabrio is a medical benefit and will require a prior authorization. Elfabrio will be added to the medical benefit cost share list. When processed at a specialty pharmacy, Elfabrio will process at the Specialty tier or Brand non-preferred tier for members with a three-tier benefit. The following prior authorization criteria will apply:

- Medical record documentation of a diagnosis of Fabry disease **AND**
- Prescribed by a metabolic specialist with experience in treating Fabry disease

AUTHORIZATION DURATION: Initial approval will be for 6 months. Subsequent approvals will be for an additional 6 months and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

GPI LEVEL: GPI-12

RPH SIGNOFF REQUIRED: Yes

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

UZEDY (risperidone)

Review: Uzedy is an atypical antipsychotic indicated for the treatment of schizophrenia in adults. Uzedy is supplied as risperidone extended-release injectable suspension in single-dose kits. Uzedy is available in the following strengths: 50 mg/0.14 mL single-dose prefilled syringe, 75 mg/0.21 mL single-dose prefilled syringe, 100 mg/0.28 mL single-dose prefilled syringe, 125 mg/0.35 mL single-dose prefilled syringe, 150 mg/0.42 mL single-dose prefilled syringe, 200 mg/0.56 mL single-dose prefilled syringe, and 250 mg/0.7 mL single-dose prefilled syringe. Oral tolerability needs to be established prior to initiating Uzedy. Uzedy must be administered by a healthcare professional as an abdominal or upper arm subcutaneous injection. Uzedy should be administered as a once monthly injection (50 mg, 75 mg, 100 mg, or 125 mg) or once every 2 month injection (100 mg, 150 mg, 200 mg, or 250 mg), the day after the last dose of oral therapy. Neither loading dose nor supplement oral risperidone doses are recommended when switching.

Uzedy is available as a subcutaneous injection which may be more desirable than IM injections. Perseris is another subcutaneous risperidone ER injection. Uzedy is available as ready to use injection and Perseris requires reconstitution. Neither Uzedy or Perseris requires a loading dose or oral supplementation. Uzedy has an option of flexible dosing (1 or 2 months) compared to Perseris which is monthly dosing. Uzedy has other benefits including ability to store unopened at room temperature for up to 90 days and a smaller needle (21G). Perseris may be stored in the unopened package for up to 30 days at room temperature and Perseris requires an 18G-needle.

The efficacy of Uzedy for the treatment of schizophrenia in adults is based on the established effectiveness of oral risperidone as well as in a randomized withdrawal study with Uzedy in adults who met the DSM-5 criteria for schizophrenia. The study was a randomized withdrawal study consisting of a 12-week open-label oral risperidone (2 mg to 5 mg) stabilization phase, followed by a placebo-controlled phase in which patients were randomized to Uzedy once monthly or once every 2 months at doses of 50 mg to 250 mg compared to monthly placebo. Patients were required to have a Positive and Negative Syndrome Scale (PANSS) total score lower than 100 at the screening visit. The primary endpoint was time to impending relapse. Time to impending relapse was defined by one or more of the following items: Clinical Global Impression-Improvement (CGI-I) of ≥ 5 and increase in any of the following individual Positive and Negative Syndrome Scale (PANSS) items: conceptual disorganization, hallucinatory behavior, suspiciousness, unusual thought content, to a score of > 4 with an absolute increase of ≥ 2 on that specific item since randomization OR an increase in any of the following 4 individual PANSS items: conceptual disorganization, hallucinatory behavior, suspiciousness, and unusual thought content, to a score of > 4 and an absolute increase of ≥4 on the combined score of these 4 PANSS items since randomization; hospitalization due to worsening of psychotic symptoms; CGI-Severity of Suicidality (CGI-SS) of 4 (severely suicidal) or 5 (attempted suicide) on Part 1 and/or 6 (much worse) or 7 (very much worse) on Part 2; violent behavior resulting in clinically significant self-injury, injury to another person, or property damage. The study met its prespecified primary endpoint for both the Uzedy once monthly and once every 2 month dosing regimens. Time to relapse was statistically significantly longer in the Uzedy-treated groups compared to the placebo group (see Figure 1). Uzedy reduced the risk of relapse by 80% in patients once-monthly dosing and in 62.5% of patients with once-every-2-months dosing, compared to placebo. Subgroup analyses by gender, age, and race did not suggest any clear evidence of differential responsiveness to Uzedy. Stabilized patients on Uzedy showed improvement in PANSS scores over a 64-week treatment period (exploratory endpoint) with a mean change from baseline in overall PANSS total score of -4.10 compared to +1.11 with placebo.

Clinical studies of Uzedy in the treatment of schizophrenia did not include patients older than 65 years to determine whether or not they respond differently from younger patients. In patients with renal or hepatic impairment, oral risperidone should be titrated up to at least 2 mg daily and the recommended dose is 50 mg once monthly. Patients with Parkinson’s disease or dementia with Lewy bodies can experience increased sensitivity to Uzedy. A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Uzedy will be a medical benefit. Uzedy will be added to the medical benefit cost share list. If processed at a specialty pharmacy, Uzedy will process at the Specialty tier or Brand Non-Preferred tier for those with a three tier benefit. Uzedy will require a prior authorization and be added to MBP 106.0:

- Medical record documentation of a diagnosis of schizophrenia **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of therapeutic failure on or intolerance to the oral equivalent form of the medication.
- Medical record documentation that the patient is 18 years of age or older **AND**
- Medical record documentation of a history of poor adherence to oral medications and documentation that education to improve adherence has been attempted **AND**
- Medical record documentation of use for an FDA approved indication.
    - Abilify Maintena – Schizophrenia or maintenance monotherapy treatment of Bipolar I Disorder
    - Aristada – Schizophrenia
    - Aristada Initio – Initiation of Aristada (in combination with oral aripiprazole) to treat schizophrenia
    - Invega Hafyera - Schizophrenia
    - Invega Sustenna – Schizophrenia or Schizoaffective disorders as monotherapy and as an adjunct to mood stabilizers or antidepressants
    - Invega Trinza – Schizophrenia
    - Perseris- Schizophrenia
    - Risperdal Consta – Schizophrenia or Bipolar I Disorder as monotherapy or as adjunctive therapy to lithium or valproate
    - Zyprexa Relprevv – Schizophrenia
    - Uzedy- Schizophrenia
- In addition: The following criteria should apply to Invega Trinza:
    - Medical record documentation that the patient has been adequately treated with Invega Sustenna for at least 4 months.
- In addition: The following criteria should apply to Invega Hafyera:
    - Medical record documentation that the patient has been adequately treated with Invega Sustenna for at least 4 months OR Invega Trinza for at least 3 months.

QUANTITY LIMIT: One syringe per 28 days (50 mg/0.14 mL, 75 mg/0.21mL, 100 mg/0.28mL, 125 mg/0.35mL), one syringe per 56 days (150 mg/0.42 mL, 200 mg/0.56 mL, 250 mg/0.7 mL)

GPI LEVEL: GPI-12

RPH SIGNOFF REQUIRED: No

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

ABILIFY ASIMTUFII (aripiprazole)

Review: Abilify Asimtufii (aripiprazole) is an atypical antipsychotic indicated for the treatment of schizophrenia in adults and as maintenance monotherapy treatment of bipolar I disorder in adults. Abilify Asimtufii is an extended-release injectable suspension supplied as a 960mg/3.2ml and 720mg/2.4ml single-dose pre-filled syringe. Tolerability should be established with oral aripiprazole prior to initiating treatment with Abilify Asimtufii. The recommended dosage of Abilify Asimtufii is 960mg, administered as an intramuscular gluteal injection, once every 2 months. Doses must be administered by a healthcare

professional. Patients receiving oral aripiprazole or patients stable on another oral antipsychotic (and known to tolerate aripiprazole from previous use) should continue with oral aripiprazole (10mg or 20mg) or their current oral antipsychotic for 14 consecutive days after the initial Abilify Asimtufii injection. For patients receiving Abilify Maintena, the first dose of Abilify Asimtufii should be administered in place of the next scheduled Abilify Maintena dose. If patients experience adverse reactions at the recommended 960mg dosage, the dosage may be reduced to 720mg once every 2 months. Dosage adjustments are also recommended for patients who are CYP2D6 poor metabolizers and/or in patients taking concomitant CYP3A4 inhibitors or CYP2D6 inhibitors for more than 14 days. Abilify Asimtufii joins several other extended interval long-acting injectable antipsychotics that offer dosing options beyond 4 week dosing (Aristada (aripiprazole lauroxil) up to 8-week dosing, Invega Trinza (paliperidone) 3-month dosing, Invega Hafyera (paliperidone) 6-month dosing, Uzedy (risperidone) up to 2-month dosing.

The efficacy of Abilify Asimtufii (once every 2-month dosing) for the treatment of schizophrenia in adults is based on adequate and well-controlled studies of Abilify Maintena (once monthly dosing). The efficacy of Abilify Maintena (once monthly dosing) for treatment of schizophrenia was established in one short-term (12-week), randomized, double-blind, placebo-controlled trial in acutely relapsed adults (Study 1) and one longer-term, double-blind, placebo-controlled, randomized-withdrawal (maintenance) trial in adults (Study 2). Study 1 included adult inpatients who met DSM-IV-TR criteria for schizophrenia. In addition, all patients entering the trial must have experienced an acute psychotic episode as defined by both Positive and Negative Syndrome Scale (PANSS) Total Score ≥80 and a PANSS score of >4 on each of four specific psychotic symptoms (conceptual disorganization, hallucinatory behavior, suspiciousness/persecution, unusual thought content) at screening and baseline. The primary endpoint was the change from baseline in (PANSS) total score to week 10. Abilify Maintena was superior to placebo in improving PANSS total score at the end of week 10 (Mean change from baseline -26.8 (Abilify Maintena) vs -11.7 (placebo)). Study 2 evaluated the efficacy of Abilify Maintena in maintaining symptomatic control in schizophrenia and included patients who met DSM-IV-TR criteria for schizophrenia and who were being treated with at least one antipsychotic medication. Patients had at least a 3-year history of illness and a history of relapse or symptom exacerbation when not receiving antipsychotic treatment. This trial included an oral conversion phase for patients on antipsychotic medications other than aripiprazole, an oral aripiprazole stabilization phase that required stabilization for four consecutive weeks on oral aripiprazole, followed by a 12-week Abilify Maintena stabilization phase (Abilify Maintena every 4 weeks in conjunction with oral aripiprazole for the first 2 weeks), and a final withdrawal phase to observe for relapse. The primary efficacy endpoint was time from randomization to relapse. Relapse was defined as the first occurrence of one or more of the following criteria: CGI-I of ≥5 (minimally worse) and an increase on any of the following individual PANSS items (conceptual disorganization, hallucinatory behavior, suspiciousness, unusual thought content) to a score >4 with an absolute increase of ≥2 on that specific item since randomization or an increase on any of the following individual PANSS items (conceptual disorganization, hallucinatory behavior, suspiciousness, unusual thought content) to a score >4 and an absolute increase ≥4 on the combined four PANSS items (conceptual disorganization, hallucinatory behavior, suspiciousness, unusual thought content) since randomization; Hospitalization due to worsening of psychotic symptoms (including partial hospitalization), but excluding hospitalization for psychosocial reasons; CGI-SS of 4 (severely suicidal) or 5 (attempted suicide) on Part 1 and/or 6 (much worse) or 7 (very much worse) on Part 2, or; Violent behavior resulting in clinically significant self-injury, injury to another person, or property damage. A pre-planned interim analysis demonstrated a statistically significantly longer time to relapse in patients randomized to the Abilify Maintena group compared to placebo-treated patients and the trial was subsequently terminated early because maintenance of efficacy was demonstrated. The final analysis demonstrated a statistically significantly longer time to relapse in patients randomized to the Abilify Maintena group than compared to placebo-treated patients.

The efficacy of Abilify Asimtufii (once every 2-month dosing) for the treatment of maintenance monotherapy treatment of bipolar I disorder in adults is based on a 52-week, double-blind, placebo-controlled, randomized withdrawal trial of Abilify Maintena (once monthly dosing) in adult patients who were experiencing a manic episode at trial entry, met DSM-IV-TR criteria for bipolar I disorder, and had a history of at least one previous manic or mixed episode with manic symptoms of sufficient severity to require one of the following interventions: hospitalization and/or treatment with a mood stabilizer, and/or

treatment with an antipsychotic agent. The trial included an oral conversion phase for patients on treatments for bipolar I disorder other than aripiprazole, a 2 to 8 week oral aripiprazole stabilization phase, followed by a 12 week Abilify Maintena stabilization phase (Abilify Maintena every 4 weeks in conjunction with oral aripiprazole for the first 2 weeks), and a final withdrawal phase to observe for relapse. The primary efficacy endpoint was time from randomization to recurrence of any mood episode. Recurrence was defined as the first occurrence of one or more of the following criteria: 1) Hospitalization for any mood episode OR 2) Any of the following: a. YMRS total score ≥15 OR b. MADRS total score ≥15 OR c. Clinical Global Impression - Bipolar Version-Severity (CGIBP-S) score >4 (overall score) OR 3) Serious adverse event (SAE) of worsening disease (bipolar I disorder) OR 4) Discontinuation due to lack of efficacy or discontinuation due to an adverse event (AE) of worsening disease OR 5) Clinical worsening with the need for addition of a mood stabilizer, antidepressant treatment, antipsychotic medication, and/or increase greater than the allowed benzodiazepine doses for treatment of symptoms of an underlying mood disorder OR 6) Active suicidality, which is defined as a score of 4 or more on the MADRS item 10 OR an answer of “yes” on question 4 or 5 on the C-SSRS. Analysis demonstrated a statistically significantly longer time to recurrence of any mood episode in subjects randomized to the Abilify Maintena group than compared to placebo-treated subjects. Analysis by type of mood recurrence demonstrated a statistically significantly longer time to recurrence for both manic and mixed mood episodes in subjects treated with Abilify Maintena compared to those treated with placebo. There was no substantial difference between treatment groups in delaying time to recurrence of depressive mood episodes.

The most common adverse reactions (incidence ≥5%) were decreased HDL cholesterol, increased LDL and serum cholesterol, increased triglycerides, weight gain, increased serum glucose, constipation, nausea, neutropenia, akathisia, headache, injection site pain, and sedation. Patients receiving Abilify Asimtufii reported a higher incidence of injection site reactions compared to Abilify Maintena (19% vs 9%) however the incidence decreased on subsequent dosing. Warnings and Precautions for Abilify Asimtufii are the same as Abilify Maintena and include a Black Box warning for increased mortality in elderly patients with dementia-related psychosis as well as warnings for increased risk and incidence of the following: cerebrovascular adverse reactions in elderly patients with dementia-related psychosis; neuroleptic malignant syndrome; tardive dyskinesia; metabolic changes including hyperglycemia/diabetes mellitus, dyslipidemia, and body weight gain; pathological gambling and other compulsive behaviors; orthostatic hypotension and syncope; falls; leukopenia, neutropenia and agranulocytosis; seizures; potential for cognitive and motor impairment; body temperature regulation; and dysphagia.

Clinical studies of Abilify Asimtufii did not include sufficient numbers of subjects aged 65 years and over to determine whether they respond differently from younger subjects. Dosage adjustment is recommended in known CYP2D6 poor metabolizers. There are no dosage adjustments needed for patients with renal or hepatic impairment. A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Abilify Asimtufii will be a medical benefit. Abilify Asimtufii will be added to the medical benefit cost share list. If processed at a specialty pharmacy, Abilify Asimtufii will process at the Specialty tier or Brand Non-Preferred tier for those with a three tier benefit. Abilify Asimtufii will require a prior authorization and be added to MBP 106.0:

- Medical record documentation of a diagnosis of schizophrenia **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of therapeutic failure on or intolerance to the oral equivalent form of the medication.
- Medical record documentation that the patient is 18 years of age or older **AND**

- Medical record documentation of a history of poor adherence to oral medications and documentation that education to improve adherence has been attempted **AND**
- Medical record documentation of use for an FDA approved indication.
    - Abilify Asimtufii – Schizophrenia or maintenance monotherapy treatment of Bipolar I Disorder
    - Abilify Maintena – Schizophrenia or maintenance monotherapy treatment of Bipolar I Disorder
    - Aristada – Schizophrenia
    - Aristada Initio – Initiation of Aristada (in combination with oral aripiprazole) to treat schizophrenia
    - Invega Hafyera - Schizophrenia
    - Invega Sustenna – Schizophrenia or Schizoaffective disorders as monotherapy and as an adjunct to mood stabilizers or antidepressants
    - Invega Trinza – Schizophrenia
    - Perseris- Schizophrenia
    - Risperdal Consta – Schizophrenia or Bipolar I Disorder as monotherapy or as adjunctive therapy to lithium or valproate
    - Zyprexa Relprevv – Schizophrenia
    - Uzedy- Schizophrenia
- In addition: The following criteria should apply to Invega Trinza:
    - Medical record documentation that the patient has been adequately treated with Invega Sustenna for at least 4 months.
- In addition: The following criteria should apply to Invega Hafyera:
    - Medical record documentation that the patient has been adequately treated with Invega Sustenna for at least 4 months OR Invega Trinza for at least 3 months.

QUANTITY LIMIT: One syringe per 56 days (960 mg/3.2 mL, 720 mg/2.4 mL)

GPI LEVEL: GPI-12

RPH SIGNOFF REQUIRED: No

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

FILSPARI (sparsentan)

Review: Filspari is an endothelin and angiotensin II receptor antagonist indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥1.5 g/g. This indication is approved under accelerated approval based on reduction of proteinuria. It has not been established whether Filspari slows kidney function decline in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial.

Prior to initiating treatment with Filspari, discontinue use of renin-angiotensin-aldosterone system (RAAS) inhibitors, endothelin receptor antagonists (ERAs) or aliskiren. Initiate treatment with Filspari at 200 mg orally once daily. After 14 days, increase to the recommended dose of 400 mg once daily, as tolerated. When resuming treatment with Filspari after an interruption, consider titration of Filspari as with initial treatment.

The accelerated approval for Filspari in IgAN was based on results from the ongoing Phase 3 PROTECT trial, a randomized, double-blind, active-controlled, multicenter, global study (NCT03762850) in adults with biopsy-proven IgAN, eGFR ≥30 mL/min/1.73 m2, and total urine protein ≥1.0 g/day on a maximized stable dose of RAS inhibitor treatment that was at least 50% of maximum labeled dose. Patients were

randomly assigned in a 1:1 ratio to either Filspari or irbesartan (active control). The primary analysis was change in proteinuria (UPCR) from baseline at Week 36. Filspari significantly reduced proteinuria compared with irbesartan after 36 weeks of treatment. Patients who received Filspari achieved mean proteinuria reductions of 49.8% from baseline, versus a 15.1% reduction in the control group (P <0.0001). Rescue immunosuppressive treatment was initiated in 1.4% and 5.7% of patients receiving Filspari and irbesartan, respectively. As with all FDA accelerated approvals, continued approval of Filspari is contingent upon confirmation of a clinical benefit. The trial's confirmatory endpoint analysis will assess the treatment effect on eGFR slope over 110 weeks. This analysis will measure the rate of change in eGFR (i.e. kidney function) and will be able to demonstrate whether patients receiving Filspari are still likely to progress to an eGFR requiring intervention (i.e. eGFR <15 mL/min generally requires dialysis). Topline results from the 2-year confirmatory endpoints in the PROTECT study are expected in 4Q 2023 and are intended to support traditional approval of Filspari.

Although Filspari did not demonstrate severe liver toxicity in the PROTECT study, elevations in ALT or AST of at least 3-fold ULN have been observed in up to 2.5% of Filspari-treated patients and based on data from animal reproduction studies, Filspari can cause fetal harm when administered to a pregnant patient and is contraindicated during pregnancy. The FDA has required a Risk Evaluation and Mitigation Strategy (REMS) program for the monitoring of potential liver abnormalities and the prevention of pregnancy in patients receiving Filspari. This is similar to the requirements for ERAs (i.e. ambrisentan and bosentan). It is a condition of the Filspari REMS program to measure alanine aminotransferase (ALT), aspartate aminotransferase (AST), and bilirubin before initiating treatment and monthly for the first 12 months and then every three months during treatment. For patients who can become pregnant, pregnancy testing is required before treatment initiation, during treatment, and one month after discontinuation of treatment. Patients who can become pregnant must also use effective contraception before treatment initiation, during treatment, and for one month after discontinuation of treatment. Filspari has been relatively well tolerated across clinical trials. Adverse reactions reported in ≥2% in patients treated with Filspari included peripheral edema (14%), hypotension (14%), dizziness (13%), hyperkalemia (13%), anemia (5%), acute kidney injury (4%), and transaminase elevations (2.5%). Note that the initiation of Filspari may cause an initial small decrease in eGFR that occurs within the first 4 weeks of starting therapy and then stabilizes.

No overall differences in safety or effectiveness were observed between geriatric subjects and younger subjects. A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: Dr. Bret Yarczower asked if there is a way to tell how soon the reduction in proteinuria is observed, as well as if there were patients without a reduction would the drug be stopped. Kelly Faust, Pharm.D., stated she did not think they looked at the results aside from 9 months, but she can confirm there were no other time points evaluated. Dr. Yarczower also asked what the variance in response was since it was reported as an average. Kelly Faust, Pharm.D., stated she will share the study results with Dr. Yarczower to review together. Dr. Yarczower asked if we are requiring biopsy-proven IgA nephropathy. Kelly Faust, Pharm.D., confirmed that we are. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Filspari is a pharmacy benefit. Filspari will be added to the Commercial/Exchange/CHIP formularies at the Specialty Tier or BrandNP tier for members with a 3 Tier benefit. The following prior authorization criteria will apply:

- Medical record documentation of age ≥ 18 years **AND**
- Medical record documentation of primary immunoglobulin A nephropathy (IgAN) verified by biopsy **AND**
- Medical record documentation that the medication is prescribed by or in consultation with a nephrologist **AND**

- Medical record documentation that patient is at high risk of disease progression, defined as urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g or proteinuria ≥ 1g/day **AND**
- Medical record documentation that patient has received ≥ 90 days of optimized supportive care, including blood pressure management, lifestyle modification, and cardiovascular risk modification **AND**
- Medical record documentation of eGFR ≥ 30 mL/min/1.73 m2 **AND**
- Medical record documentation that patient has received a stable dose of a RAS Inhibitor (ACE inhibitor or ARB) at a maximally tolerated dose for ≥ 90 days **AND**
- Medical record documentation that RAS inhibitor (ACE inhibitor or ARB) will be discontinued prior to initiation of treatment with Filspari **AND**
- Medical record documentation that Filspari will NOT be used in combination with any RAS inhibitors (ACE inhibitor or ARB), endothelin receptor antagonists, or aliskiren

AUTHORIZATIONDURATION: Initial approval will be for **9 months** and subsequent approvals will be for **12 months**. Requests for continuation of coverage will be approved for members who meet the following criteria:

- Medical record documentation of continued disease improvement or lack of disease progression according to prescriber (i.e. decreased levels of proteinuria from baseline or decreased UPCR from baseline) **AND**
- Medical record documentation that Filspari will NOT be used in combination with any RAS inhibitors (ACE inhibitor or ARB), endothelin receptor antagonists, or aliskiren

QUANTITY LIMIT: 1 tablet per day, 30-day supply per fill

GPI LEVEL: GPI-12

RPH SIGNOFF REQUIRED: Yes

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

LAMZEDE (velmanase alfa)

Review: Lamzede is the first enzyme replacement therapy approved in the United States for the treatment of non-central nervous system manifestations of alpha-mannosidosis (AM) in adult and pediatric patients. Lamzede is lysosomal alpha-mannosidase produced by recombinant DNA technology in Chinese Hamster Ovary cells. The amino acid sequence of the monomeric protein is identical to the naturally occurring human enzyme, alpha-mannosidase.

Lamzede is manufactured in 10 mg single-dose vials for reconstitution. The recommended dosage is 1 mg/kg based on actual body weight administered once every week as an intravenous infusion. Consider pretreating with antihistamines, antipyretics, and/or corticosteroids before use.

Trial 1 was a phase 3 multicenter, randomized, double-blind, placebo-controlled, parallel group trial in adult and pediatric patients with AM. The trial evaluated the efficacy of Lamzede over 52 weeks at a dose of 1 mg/kg given weekly as an intravenous infusion. A total of 25 patients were enrolled (14 males, 11 females), including 13 adult patients (age range: ≥ 18 to 35 years; mean: 25 years) and 12 pediatric patients (age range ≥ 6 to < 18 years; mean: 11 years). All patients were white. All patients had alpha-mannosidase activity below 11% of normal and in the range of 8 to 29 µmol/h/mg at baseline. All patients were naïve to Lamzede. 15 patients (8 adult and 7 pediatric) received Lamzede and 10 patients (5 adult and 5 pediatric) received placebo. All patients completed the trial. The efficacy results for the clinical endpoints were assessed at 12 months. This included the 3-minute stair climbing test (3MSCT), 6-minute walking test (6MWT), and forced vital capacity (FVC, % predicted). The results of these favored the

Lamzede group, however none were statistically significant, and were supported by a reduction in serum oligosaccharide concentration, which was statistically significant.

Lamzede was also evaluated in a Phase 2 single-arm trial that included 5 pediatric patients less than 6 years of age with AM. All patients had alpha-mannosidase activity below 10% of normal at baseline. Patients ranged from 3.7 to 5.9 years of age, with a mean age of 4.5 years. Patients received Lamzede 1 mg/kg as an intravenous infusion once weekly (4 patients for 24 months and 1 patient for 40 months). The mean (standard deviation) absolute and percentage changes from baseline for serum oligosaccharides at 24 months were -7.7 (4.27) µmol/L and -65.8%, respectively.

Clinical trials of Lamzede did not include patients 65 years of age and older since AM is largely a disease of pediatric and young adult patients. A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Lamzede will be a medical benefit and will be added to the medical benefit cost share list. If processed at a specialty pharmacy, Lamzede will process at the Specialty tier or the Brand Non-preferred tier for members with a three-tier benefit. The following prior authorization criteria will apply:

- Medical record documentation of a diagnosis of alpha-mannosidosis supported by:
    - Enzyme assay demonstrating alpha-mannosidase activity less than 10% of normal activity (<0.54 nmol/min/mg) **OR**
    - Molecular genetic testing that reveals pathogenic variants in the MAN2B1 gene

AND

- Medical record documentation that the patient is being treated for non-central nervous system manifestations of alpha-mannosidosis **AND**
- Medical record documentation of a consultation with a metabolic specialist and/or biochemical geneticist **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

AUTHORIZATIONDURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression (i.e., improvement or stabilization in motor function, improvement in forced vital capacity % (FVC), reduction in frequency of infections, etc.).

RPH SIGNOFF REQUIRED: Yes

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

REZVOGLAR (insulin glargine)

Review: Rezvoglar is a long-acting basal insulin indicated for glycemic control in adult and pediatric patients with diabetes mellitus. Rezvoglar is not recommended for the treatment of diabetic ketoacidosis. It is supplied as a 3 mL single-patient-use KwikPen prefilled pen. Rezvoglar is the second interchangeable biosimilar to Lantus to be approved. Rezvoglar's label does not specify whether it is interchangeable with Semglee, only that is interchangeable with Lantus. Rezvoglar should be

administered into the abdominal area, thigh, or deltoid, subcutaneously once daily at the same time every day. It should not be administered intravenously or via an insulin pump. The dosage should be adjusted based on patient's metabolic needs and glycemic control goal. Rezvoglar must be used with short-acting insulin in patients with Type 1 Diabetes.

The approval for Rezvoglar relied on the safety and efficacy clinical trials used for the approval of Lantus. There were no specific Rezvoglar trials performed.

Rezvoglar is contraindicated during episodes of hypoglycemia and in patients with hypersensitivity to insulin glargine products or any of the excipients in Rezvoglar. Like other insulin pens, Rezvoglar pens should never be shared between patients, even if the needle is changed. Warnings and precautions for Rezvoglar include hyperglycemia or hypoglycemia with changes in insulin regimen; hypoglycemia; hypoglycemia due to medication errors; hypokalemia; hypersensitivity reactions; and fluid retention and heart failure with concomitant use of thiazolidinediones (TZDs).

Of the total number of patients in clinical studies for patients with Type 1 or Type 2 Diabetes, 15% were 65 years of age or older, and 2% were 75 years of age or older. No overall differences in safety and effectiveness of Rezvoglar have been observed between patients 65 years of age and older and younger adult patients.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Rezvoglar is a pharmacy benefit and will not be added to Commercial, Marketplace, and CHIP formularies. It will be added to the Commercial Policy 474.0 Basaglar and Semglee, which has the following prior authorization criteria:

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Lantus **OR** Toujeo

GPI LEVEL: NDC-9

RPH SIGNOFF REQUIRED: No

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

OMISIRGE (omidubicel)

Review: Omisirge is an allogeneic hematopoietic progenitor cell (HPC) therapy derived from cord blood indicated for use in adults and pediatric patients 12 years and older with hematologic malignancies who are planned for umbilical cord blood transplantation following myeloablative conditioning to reduce the time to neutrophil recovery and the incidence of infection. Omisirge is manufactured utilizing nicotinamide (NAM) based technology which overcomes the induction of accelerated proliferation, differentiation, cellular stress, and signaling pathways that are typically activated when HPCs are removed from their natural environment. Transplantation with Omisirge results in rapid and broad immune reconstitution of dendritic cells, monocytes, Natural Killer (NK), CD4+ T cells and CD8+ T cells as early as one-week post transplantation, and B cells 28 days post transplantations and all lineages throughout the one-year follow-up treatment.

Omisirge is a one-time intravenous administration of a single dose containing:

- a Cultured Fraction (CF): a minimum of 8.0 × 108 total viable cells of which a minimum of 8.7% is CD34+ cells and a minimum of 9.2 × 107 CD34+ cells, and
- a Non-cultured Fraction (NF): a minimum of 4.0 × 108 total viable cells with a minimum of 2.4 × 107 CD3+ cells

The CF and NF are both derived from the same patient-specific cord blood unit (CBU). They are supplied cryopreserved separately in two bags which are thawed and diluted with two infusion solution (IS) bags prior to administration. Infusion of the NF bag should begin within 1 hour after completion of the CF infusion. Prior to the infusions, patients should be premedicated with diphenhydramine or dexchlorpheniramine, hydrocortisone, and acetaminophen.

Omisirge was evaluated in Study P0501, an open-label, multicenter, randomized study comparing Omisirge (n=62) transplantation or UCB transplantation (n=63) following myeloablative conditioning in patients with hematologic malignancies. Multiple conditioning regimens were used, including Total Body Irradiation (TBI)-based or chemotherapy-based options. Forty-eight percent of patients had AML, 33% had ALL, 7% had MDS, 5% had CML, 4% had lymphoma, and 3% had other rare leukemias. Baseline disease status (remission vs. overt disease) varied depending on the hematologic malignancy. Of the patients randomized to Omisirge, 8% of patients (5/62) were not able to receive Omisirge due to manufacturing failure. The efficacy of Omisirge was established based on time to neutrophil recovery following transplantation and the incidence of BMT CTN Grade 2/3 bacterial and Grade 3 fungal infections through Day 100 following transplantation.

Neutrophil recovery occurred in 87% of patients in the Omisirge arm and 83% in the UCB arm. The median time to neutrophil recovery was 12 days in the Omisirge arm and 22 days in the UCB arm. Blood and Marrow Transplant Clinical Trials Network (BMT CTN) Grade 2/3 bacterial or Grade 3 fungal infections through Day 100 following transplantation occurred in 39% of patients in the Omisirge arm and 60% of patients in the UCB arm. Of note, Omisirge did not demonstrate statistically significant improvements in non-relapse mortality, disease relapse, disease-free survival (DFS), OS, or GVHD compared to UCB.

Warnings and precautions of Omisirge include hypersensitivity reactions, infusion reactions, acute and chronic Graft-versus-Host Disease, engraftment syndrome, graft failure, malignancies of donor origin, transmission of serious infections, and transmission of rare genetic diseases.

During Study P-501, fatal adverse reactions occurred in 17% of patients treated with Omisirge, including infection, acute GvHD, veno-occlusive disease (VOD)/sinusoidal obstruction syndrome (SOS), thrombotic thrombocytopenic purpura (TTP)/thrombotic microangiopathy (TMA), and pulmonary hemorrhage. Fatal adverse reactions occurred in 29% of patients treated with UCB, including infection/sepsis, respiratory disorders, GvHD, and VOD/SOS. Infusion reactions occurred in 29 patients in the Omisirge arm and in 40 patients in the UCB arm. The most common infusion reactions were hypertensions, mucosal inflammation, arrythmia, and fatigue.

Grade II to IV acute GvHD were reported in 62% if of patients treated with Omisirge and 43% in patients treated with UCB. Grade III to IV acute GvHD was reported in 15% versus 21% of patients, respectively. Chronic GvHD was reported in 35% of patients in the Omisirge arm and 25% in the UCB arm. Primary graft failure occurred in 2% of patients treated with Omisirge compared to 11% of patients treated with UCB. One patient treated with Omisirge had a secondary graft failure approximately 6 months following transplantation, concurrent with a diagnosis of ALL relapse. Disease relapse occurred in 21% of patients treated with Omisirge compared to 13% of patients treated with UCB. The most common adverse reactions for patients treated with Omisirge were pain, mucosal inflammation, hypertensions, and gastrointestinal toxicity.

Clinical studies did not include patients aged 65 years and over, therefore, it cannot be determined whether patients 65 years and older respond differently from younger patients. A Clinical Review

including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: Dr. Bret Yarczower commented on the number of people who died as a cause of the drug and that it's hard to tie reimbursement to the outcome. Kim Reichard, Pharm.D., commented there was no way to discern the cause of death based on the information given. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome: Omisirge is a medical benefit that will be added to the medical benefit cost share list and will require a prior authorization. The following prior authorization criteria will apply:

- Medical record documentation that Omisirge is prescribed by a hematologist and/or oncologist **AND**
- Medical record documentation of age greater than or equal to 12 years of age **AND**
- Medical record documentation of a diagnosis of a hematological malignancy planned for umbilical cord blood transplantation following myeloablative conditioning **AND**
- Medical record documentation that a matched related donor (MRD), matched unrelated donor (MUD), mismatched unrelated donor (MMUD), or haploidentical donor is not readily available **AND**
- Medical record documentation that patient has not had a prior allogeneic hematopoietic stem cell transplantation (HSCT)

GPI LEVEL: GPI-12

RPH SIGNOFF REQUIRED: Yes

QUANTITY LIMIT: one time authorization for one administration of Omisirge

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

CLASS REVIEWS

ASTHMA BIOLOGICS CLASS REVIEW

Review: Asthma: a heterogeneous disease, usually characterized by chronic airway inflammation. It is defined by the history of respiratory symptoms, such as wheeze, shortness of breath, chest tightness and cough, that vary over time and in intensity, together with variable expiratory airflow limitation. Common Phenotypes include:

- Allergic: Frequently arises in childhood and is associated with personal or family history of allergic disease. Sputum from these patients prior to treat commonly indicates eosinophilic airway inflammation. Typically respond well to inhaled corticosteroid (ICS).
- Non-Allergic: Sputum composition may vary between eosinophilic, neutrophilic, or paucigranulocytic. Typically have less pronounced short-term response to ICS.
- Adult-Onset: Present with asthma for the first time as adults. More common in women, and typically non allergic. These patients often need higher doses of ICS or may not respond well even to high doses of ICS.
- Persistent Airflow Limitation: Some patients with long history of asthma develop incompletely reversible airflow limitation. This is believed to be caused by remodeling of the airway.

Global Initiative for Asthma 2023 Report – *Recommendations for add-on biologic therapy for severe asthma*

- Consider an add-on Type 2 targeted biologic for patients with exacerbations or poor symptom control despite taking at least high dose ICS/long-acting beta agonist, with allergic or eosinophilic biomarkers or on maintenance OCS.
- Consider cost, comorbid conditions, and predictors of response when determining therapy.
- Review response to treatment after 3-4 months, and then every 3-6 months while on therapy.
    - Evaluate symptom control, frequency/severity of exacerbations, lung function, need for OCS, side effects
- Discontinue biologic if inadequate response; can consider trial of another agent that patient is eligible for.
- If patient has good response to biologic therapy, it should be continued for at least 12 months before withdrawal and should only be withdrawn if asthma remains controlled on medium dose ICS and (for allergic asthma) there is no further exposure to allergic trigger.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: Dr. Bret Yarczower stated this will be met with positive views from the Geisinger providers. The work on Carepath has shown that approval rates for these agents from Geisinger providers is 80%, while non-Geisinger providers is 60-70%. The Carepath plans on working with the providers to understand what is being done differently to hopefully reduce the number of denial in the future. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome:

Medication	Current Policy	Recommendations
Tezspire	**Tezspire Policy 754.0:** • Medical record documentation that Tezspire is prescribed by or in consultation with an allergist, immunologist, or pulmonologist **AND** • Medical record documentation of age greater than or equal to 12 years **AND** • Medical record documentation of severe asthma **AND** • Medical record documentation that Tezspire will be used as an add-on maintenance treatment **AND** • Medical record documentation that Tezspire will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Xolair, Nucala, Fasenra, Dupixent, Cinqair) **AND** • Medical record documentation of one of the following: ○ Poor control or intolerance, despite a 3 month trial of: medium-high dose ICS and another controller medication (long-acting beta agonists, long-acting muscarinic antagonist, or leukotriene receptor antagonists) with or without oral corticosteroids **OR** ○ Two or more asthma exacerbations requiring systemic corticosteroid treatment or one asthma exacerbation resulting in hospitalization in the past 12 months despite current therapy of medium-high ICS and another controller medication (long-acting beta agonists, long-acting muscarinic antagonist, or leukotriene receptor antagonists) **Tezspire Medical Policy MBP 259:** • Prescription written by or in consultation with an allergist, immunologist, or pulmonologist **AND** • Medical record documentation of age greater than or equal to 12 years **AND** • Medical record documentation of severe asthma **AND** • Medical record documentation that Tezspire will be used as an add-on maintenance treatment **AND** • Medical record documentation of one of the following:	**No changes recommended**

	○ Poor control or intolerance, despite a 3 month trial of: medium –high dose inhaled corticosteroids and another controller medication (long-acting beta agonists, long-acting muscarinic antagonist, or leukotriene receptor antagonists) with or without oral corticosteroids **OR** ○ Two or more asthma exacerbations requiring systemic corticosteroid treatment or one asthma exacerbation resulting in hospitalization in the past 12 months despite current therapy to medium- high inhaled corticosteroids and another controller medication (long-acting beta agonists, long-acting muscarinic antagonist, or leukotriene receptor antagonists) **AND** • Medical record documentation that Tezspire will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Xolair, Nucala, Fasenra, Dupixent, Cinqair).	
Dupixent	**Dupixent Policy 457.0:** • Medical record documentation that Dupixent is prescribed by or in consultation with an allergist, immunologist, or pulmonologist **AND** • Medical record documentation of age greater than or equal to 6 years **AND** • Medical record documentation of <u>one</u> of the following: ○ A diagnosis of moderate to severe eosinophilic asthma AND a blood eosinophilic count greater than or equal to 150 cells/microL **OR** ○ A diagnosis of oral corticosteroid dependent asthma **AND** • Medical record documentation that Dupixent will be used as an add-on maintenance treatment **AND** • Medical record documentation of <u>one</u> of the following: ○ Contraindication, intolerance to, or poorly (not well) controlled symptoms despite at least a 3-month trial of: maximally tolerated inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR** ○ One exacerbation in the previous 12 months requiring additional medical treatment (oral corticosteroids,	**No changes recommended**

	emergency department or urgent care visits, or hospitalization) despite current therapy agonist **OR** ○ Intolerance to inhaled corticosteroids plus a long-acting beta agonist **AND** • Medical record documentation that Dupixent will not be used in combination with another biologic medication indicated for asthma treatment (e.g., Xolair, Fasenra, Nucala, Cinqair, or Tezspire) **AND** • Medical record documentation that the member is receiving an appropriate dose based on patient's age and weight	
Fasenra	**Fasenra Policy 593.0:** • Medical record documentation that Fasenra is prescribed by an allergist/immunologist or pulmonologist **AND** • Medical record documentation of age greater than or equal to 12 years **AND** • Medical record documentation of a diagnosis of severe eosinophilic asthma **AND** • Medical record documentation that Fasenra is being used as add-on maintenance treatment **AND** • Medical record documentation of a blood eosinophil count greater than 150 cells/mcL within the past 3 months **AND** • Medical record documentation of: ○ Intolerance to or not well controlled or very poorly controlled symptoms despite at least a 3-month trial of: high-dose ICS and/or oral systemic corticosteroids plus a long-acting beta agonist **OR** ○ Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose ICS plus a long-acting beta agonist **AND** • Medical record documentation that member is adherent to current therapeutic regimen and must demonstrate appropriate inhaler technique **AND**	**No changes recommended**

	• Medical record documentation that known environmental triggers within the member's control have been eliminated **AND** • Medical record documentation that Fasenra will not be used in combination with another biologic medication indicated for asthma treatment (e.g., Xolair, Dupixent, Nucala, Cinqair, or Tezspire). **Fasenra Prefilled Syringe Medical Policy MBP 173:** • Prescribed by an allergist/immunologist or pulmonologist **AND** • Patient is 12 years of age or older **AND** • Medical record documentation of a diagnosis of severe eosinophilic asthma AND that Fasenra is being used as add-on maintenance treatment **AND** • Medical record documentation of blood eosinophil count >150 cells/microL (0.15 x 10E3/uL) within the past 3 months **AND** • Medical record documentation of: ○ Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3-month trial of high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR** ○ Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist **AND** • Medical record documentation that individual is adherent to current therapeutic regimen and has demonstrated appropriate inhaler technique **AND** • Medical record documentation that known environmental triggers within the member's control have been eliminated **AND** • Medical record documentation that the medication will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Xolair (omalizumab),	

	Nucala (mepolizumab), Dupixent (dupilumab), Cinqair (reslizumab), Tezspire (Tezepelumab)).	
Cinqair	**Cinqair Medical Policy MBP 145:** • Documentation of patient age > 18 years **AND** • Patient must have severe persistent eosinophilic asthma **AND** • Cinqair is being used as add-on maintenance treatment **AND** • Prescription written by an allergist or pulmonologist **AND** • Medical record documentation of a blood eosinophil count of > 400 cells/mcL since the time of asthma diagnosis **AND** • Medical record documentation of: ○ Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3 month trial of: high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR** ○ Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist **AND** • Insured individual must be adherent with current therapeutic regimen and must demonstrate appropriate inhaler technique **AND** • Known environmental triggers within the member's control have been eliminated **AND** • Medical record documentation that the medication will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Fasenra (benralizumab), Nucala (mepolizumab), Dupixent (dupilumab), Xolair (omalizumab), Tezspire (tezepelumab)) **AND** • Medical record documentation of therapeutic failure on, intolerance to, or contraindication to the use of Nucala.	**Cinqair Medical Policy MBP 145:** • Documentation of patient age > 18 years **AND** • Patient must have severe persistent eosinophilic asthma **AND** • Cinqair is being used as add-on maintenance treatment **AND** • Prescription written by an allergist or pulmonologist **AND** • Medical record documentation of a blood eosinophil count of > 400 cells/mcL since the time of asthma diagnosis **AND** • Medical record documentation of: ○ Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3 month trial of: high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR** ○ Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist **AND** • Insured individual must be adherent with current therapeutic regimen and must demonstrate appropriate inhaler technique **AND** • Known environmental triggers within the member's control have been eliminated **AND** • Medical record documentation that the medication will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Fasenra (benralizumab), Nucala (mepolizumab), Dupixent (dupilumab), Xolair (omalizumab), Tezspire (tezepelumab)) **AND** • Medical record documentation of therapeutic failure on, intolerance to, or contraindication to the use of

		~~Nucala~~ two preferred biologic agents for severe asthma (Dupixent, Fasenra, Nucala, Tezspire, Xolair). *(Guidelines do not recommend one biologic over another so failure of 2 formulary agents is appropriate).*
Nucala	**Nucala Policy 592.0:** • Medical record documentation that Nucala is prescribed by an allergist or pulmonologist **AND** • Medical record documentation of age greater than or equal to 6 years **AND** • Medical record documentation of a diagnosis of severe eosinophilic asthma AND that Nucala is being used as add-on maintenance treatment **AND** • Medical record documentation of a blood eosinophil count of either greater than 300 cells/mcL during the 12-month period before screening and/or greater than 150 cells/mcL within 3 months of the start of therapy **AND** • Medical record documentation of: ○ intolerance to or not well controlled or very poorly controlled symptoms despite at least a 3- month trial of: high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR** ○ two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose ICS plus a long-acting beta agonist **AND** • Medical record documentation that member is adherent to current therapeutic regimen and must demonstrate appropriate inhaler technique **AND** • Medical record documentation that known environmental triggers within the member's control have been eliminated **AND** • Medical record documentation that Nucala will not be used in combination with another biologic medication indicated for asthma treatment (e.g., Xolair, Fasenra, Dupixent, Cinqair, or Tezspire). **Nucala Vial Medical Policy MBP 141:**	**No changes recommended**

	Severe Eosinophilic Asthma • Documentation of patient age > 6 years **AND** • Medical record documentation of a diagnosis of severe eosinophilic asthma AND that Nucala is being used as add-on maintenance treatment **AND** • Prescription written by an allergist or pulmonologist **AND** • Medical record documentation of a blood eosinophil count of either > 300 cells/mcL during the 12-month period before screening and/or > 150 cells/mcL within 3 months of the start of therapy **AND** • Medical record documentation of: ○ Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3 month trial of: high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR** ○ Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist **AND** • Insured individual must be adherent with current therapeutic regimen and must demonstrate appropriate inhaler technique **AND** • Known environmental triggers within the member's control have been eliminated **AND** • Medical record documentation that the medication will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Fasenra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab), Xolair (omalizumab)).	
Xolair	**Xolair Policy 661.0:** • Medical record documentation that Xolair is prescribed by an allergist or pulmonologist **AND** • Medical record documentation of age greater than or equal to 6 years **AND** • Medical record documentation that member is compliant with current therapeutic regimen **AND**	**No changes recommended**

	• Medical record documentation of diagnosis of moderate to severe persistent asthma with evidence of reversible airway disease [i.e., greater than 12% improvement in forced expiratory volume in one second with at least 200 ml increase or at least a 20% or greater improvement in peak expiratory flow after administration of albuterol] **AND** • Medical record documentation of inadequate control or intolerance, despite a 3 month trial of: medium to high dose ICS or systemic corticosteroids AND long-acting beta agonists or leukotriene receptor antagonists **AND** • Medical record documentation of the following: ○ For members age 12 and older, an IgE level of greater than 30 IU/ml and less than 700 IU/ml **OR** ○ For members age 6 through 11, an IgE level of greater than 30 IU/ml and less than 1300 IU/ml **AND** • Medical record documentation of evidence of a specific allergic reactivity to a perennial aeroallergen by positive skin or blood test for a specific IgE **AND** • Medical record documentation that known environmental triggers within the member's control have been eliminated **AND** • Medical record documentation that Xolair will not be used in combination with another biologic medication indicated for asthma treatment (e.g., Dupixent, Fasenra, Nucala, Cinqair, or Tezspire). **Xolair Medical Policy MBP 022:** <u>Asthma</u> • Must be prescribed by an allergist or pulmonologist **AND** • Insured individual must be compliant with current therapeutic regimen **AND** • Insured individual is at least 6 years of age **AND** • Physician provided documentation of a diagnosis of moderate to severe persistent asthma* with evidence of reversible airway disease [i.e. greater than 12% improvement in forced expiratory volume in one second (FEV1) with at least 200 ml increase or at least a 20% or greater improvement in peak expiratory flow (PEF) after administration of albuterol] **AND**	

	• Physician provided documentation of inadequate control or intolerance, despite a 3 month trial of: medium –high dose inhaled corticosteroids or systemic corticosteroids and long-acting beta agonists or leukotriene receptor antagonists **AND** • Physician provided documentation of an IgE level of greater than 30 IU/ml and less than 700 IU/ml for individuals age 12 and older OR IgE level of greater than 30 IU/ml and less than 1300 IU/ml for individuals age 6 through 11 **AND** • Physician provided documentation of evidence of a specific allergic reactivity to a perennial aeroallergen by positive skin or blood test for a specific IgE **AND** • Known environmental triggers within the member's control have been eliminated **AND** • Medical record documentation that Xolair will not be used in combination with another biologic medication indicated for asthma treatment (e.g. Tezspire, Nucala, Fasenra, Dupixent, Cinqair).	

No additional recommendations based on cost analysis.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

HEPATITIS C CLASS REVIEW

Review: Hepatitis C is a virus that causes inflammation and damage to the liver. It is a blood-borne pathogen that can infect people in an acute or progress to a chronic stage. Its severity can range from a mild to serious infection that can lead to liver cirrhosis and cancer. In 2016, it was estimated that 2.4 million people had an active HCV infection. People infected with Hepatitis C usually have no symptoms. Symptoms usually do not occur until people have an advanced form of disease. Its most common risk factors are sharing needles or unsafe tattoo practices. Other methods of transmission are from mother to child, receiving a Hepatitis C infected organ, blood transfusions or transplantation before 1992, or sharing personal items like razors, toothbrushes, etc with an infected person. It can be transmitted via sex, but this is rare.

Tests are usually performed to check the Hepatitis C antibody in patients greater than 18 years and older (at least once in a lifetime), are pregnant, are injecting drugs or have ever injected drugs in the past, coinfected with HIV, have abnormal liver function, are on dialysis, received donated organs or transfusions before 1992, have been exposed to blood of a person infected with Hepatitis C, or were born to a mother with Hepatitis C. If the HCV antibody is positive, they will test to see if there is active virus in a PCR test called the HCV RNA. If positive, treatment is recommended. It is possible for our bodies to clear Hepatitis C without treatment; this happens frequently in babies infected with HCV from their mother. The CDC recommends people with risk factors to be tested regularly. The Hepatitis C antibody will always remain positive, even after the active infection is eradicated. Also, there is no immunity to Hepatitis C. People can be reinfected with risky behavior.

If the HCV RNA is positive, treatment is recommended regardless of fibrosis. The guidelines still recommend patients to be evaluated by a healthcare provider with expertise in assessment of liver disease severity and HCV treatment. Direct acting antiviral therapy (DAA) is recommended for all people infected with HCV, except those with a short life expectancy or during pregnancy. Treatment has really progressed in the last few years, and HCV can be cured in as little as 8 to 12 weeks in most cases. DAA therapy is greater than 90% effective with little to no side effects. Before the initiation of treatment, patients should be educated about how to prevent further liver damage, including abstinence of alcohol. Other tests that are routinely recommended include analyzing fibrosis and evaluation of coexisting Hepatitis B and/or HIV. Hepatitis B that lays dormant can reactivate when initiating Hepatitis C treatment. HIV is transmitted in a similar form to HCV, and drugs used to treat HIV can interact with DAA. The genotype used to be routinely recommended, but it not always necessary now that they are pangenotypic regimens on the market. With that being said, some regimens may differ by genotype in those with cirrhosis or with treatment experience, and genotype is thus recommended in these instances. Also, this may play a role in treatment failure versus reinfection in those who get lost to follow up and never get official SVR12. Previous treatments and results should always be assessed and documented. Vaccination against Hepatitis A and Hepatitis B is recommended with for all patients with an HCV infection. In addition, all patients should be educated on how to prevent HCV transmission to others.

The staging of hepatic fibrosis is essential to treatment. Also potential drug interactions should be assessed prior to treatment. Other recommended laboratory tests include the CBC, INR, hepatic function panel, and eGFR. Treatment is recommended using the AASLD (American Association for the Study of Liver Diseases) and IDSA (Infectious Diseases Society of America) Guidelines. Patients with advanced liver disease (Metavir Stage 3 or 4) are at more risk of developing complications of liver disease, including hepatic decompensation. These cases are specially treated, and recommendations can be found in the Guidelines under special populations. The regimens usually include the addition of ribavirin, which comes with its own set of monitoring parameters. Resistance testing should be performed when recommended. In addition, special populations such as transplants and treatment in children ≥ 3 years old are discussed under the Unique and Key populations tab. Patients that have been previously treated with a Hepatitis C regimen have recommendations under the Treatment Experienced tab.

The SVR (Sustained Virologic Response) is the goal of HCV treatment. The SVR12 is defined as the absence of detectible HCV RNA at least 12 weeks after the end of treatment. It is the marker of cure of

HCV. Touchpoints between a healthcare professional and patient are known to improve compliance and therefore cure.

WHO 2030 has a goal of Hepatitis C eradication target. This is defined as a 90% reduction in new chronic infections and a 65% reduction in mortality, compared with the 2015 baseline. Because of increased recommendation of screening, IPD estimates this could increase DAA use between 10-25%.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Financial Discussion: No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

Outcome:

Medication	Current Policy	Recommendations
Mavyret	**Mavyret Policy 461.0 - See updates**	6 month labs, simplify policy, keep as preferred option due to rebating opportunities; make Packets at parity with tablets
Epclusa and Sofosbuvir/Velpatasvir	**Epclusa and Sofosbuvir/Velpatasvir Policy 434.0 – See updates**	6 month labs, simplify policy
Harvoni and Ledipasvir/Sofosbuvir	**Harvoni and Ledipasvir/Sofosbuvir 90/400mg tablet Policy 358.0 – See updates**	6 month labs, simplify policy; remove from Marketplace formulary
Vosevi	**Vosevi Policy 460.0 – See updates**	6 month labs, simplify policy
Sovaldi	**Sovaldi Policy 326.0 – See updates**	6 month labs, simplify policy
Zepatier	**Zepatier Policy 419.0 – See updates**	6 month labs, simplify policy

Additional evidence of the criteria used to make this decision as well as specific policy updates can be found in the drug review presented to the committee.

FAST FACTS

QULIPTA (atogepant)

Clinical Summary: Qulipta is now indicated for the preventive treatment of migraine in adults (which includes both episodic and chronic migraine). Previously Qulipta was indicated for the preventing treatment of episodic migraine in adults. There is no change to the dosage for the prevention of episodic migraine (10 mg, 30 mg, or 60 mg once daily). For the prevention of chronic migraine, the recommended dosage is 60 mg once daily.

The efficacy of Qulipta for prevention of chronic migraine in adults was evaluated in Study 3, a randomized, double-blind, placebo-controlled study. Patients included in the study had at least a 1-year history of chronic migraine. Patients were randomized to Qulipta (n=262) or placebo (n=259) for 12 weeks. A subset of patients was allowed to use one concomitant migraine prevention medication. Patients were allowed to use acute headache treatments as needed. The use of a concomitant medication that acts on the CGRP pathway was not permitted for acute or preventive treatment of migraine.

The primary endpoint was change from baseline in mean monthly migraine days (MDD) across the 12-week treatment period. Secondary endpoints included change from baseline in mean monthly headache days and mean monthly acute medication use days, the proportion of patients achieving at least a 50% reduction from baseline in mean MMD, change from baseline in mean monthly AIM-D PDA and PI (Activity Impairment in Migraine-Diary Performance of Daily Activities and Physical Impairment) domain scores, and change from baseline for MSQ v 2.1 RFR (Migraine Specific Quality of Life Questionnaire version 2.1 Role Function-Restrictive) domain scores.

Since the initial approval of Qulipta, a new warning for the risk of hypersensitivity reactions has been added to the labeling. Hypersensitivity reactions, including anaphylaxis, dyspnea, rash, pruritis, urticaria, and facial edema have been reported with Qulipta.

Current Formulary Status: Brand NP, PA, QL all strengths: 1 tablet per day, Auth Duration: 6 months initial, 12 months continuation

Recommendation: There are no changes recommended to the formulary placement, authorization duration, and current quantity limits. The following changes are recommended to Commercial Policy 696.0:

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of migraine with or without aura **AND**
- Medical record documentation of number of baseline migraine or headache days per month **AND**
- ~~Medical record documentation of diagnosis of episodic migraine (no more than 14 headache days per month) AND~~
- Medical record documentation that Qulipta will not be used concomitantly with another calcitonin gene-related peptide (CGRP) receptor antagonist indicated for the preventive treatment of migraine **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least two (2) of the following:
    - One (1) beta blocker (metoprolol, propranolol, timolol, atenolol, nadolol)
    - Topiramate
    - Divalproex/sodium valproate
    - Amitriptyline
    - Venlafaxine **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to two (2) of the following: Aimovig, Emgality, and Nurtec ODT **AND**
- Medical record documentation that Qulipta will not be used in combination with botulinum toxin for the preventive treatment **OR**

- Medical record documentation of therapeutic failure on a minimum 3 month trial of at least one CGRP antagonists without the concomitant use of Botox **AND**
- Medical record documentation of therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of a CGRP antagonist

Discussion: No comments or questions.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

ENJAYMO (sutimlimab)

Clinical Summary: Enjaymo is now indicated for the treatment of hemolysis in adults with cold agglutinin disease (CAD). The recommended dosage of Enjaymo for patients with CAD is based on body weight. For patients weighing 39 kg to less than 75 kg, the recommended dose is 6,500 mg and for patients weighing 75 kg or more, the recommended dose is 7,500 mg. Administer Enjaymo intravenously weekly for the first two weeks, with administration every two weeks thereafter. Administer Enjaymo at the recommended dosage regimen time points, or within two days of these time points.

The efficacy of Enjaymo was assessed in a placebo-controlled 6-month trial in 42 patients (CADENZA, NCT 03275454). Following the completion of the 6-month treatment period (Part A) in which 22 patients received Enjaymo and 20 patients received placebo, 39 patients (19 patients on Enjaymo and 20 patients on placebo) continued to receive Enjaymo in a long-term safety and durability of response extension phase (Part B) for an additional 12 months following last patient out from Part A. The trial included a 9 week safety follow-up after the last dose of ENJAYMO. Patients with a confirmed diagnosis of CAD based on chronic hemolysis, poly-specific direct antiglobulin test (DAT), monospecific DAT specific for C3d, cold agglutinin titer ≥64 at 4°C, an IgG DAT ≤1+ and no history of transfusion within 6 months, or more than one blood transfusion in the 12 months prior to enrollment in the trial were administered 6.5 g or 7.5 g Enjaymo (based on body weight) intravenously over approximately 60 minutes on Day 0, Day 7, and every 14 days thereafter; or placebo. Patients with cold agglutinin disease secondary to infection, rheumatologic disease, systemic lupus erythematosus, or overt hematologic malignancy were excluded, whereas patients with a history of or concomitant low grade lymphoproliferative disease were not excluded.

The data from this study demonstrated a statistically significant treatment effect of Enjaymo over placebo in terms of the rate of patients who met the efficacy criteria (responder) as well as improving symptoms and impacts of fatigue (FACIT-Fatigue). The responder rate difference between Enjaymo and placebo was 58.78% (95% CI: 34.6% to 82.96%) with a p-value of 0.0004. At the treatment assessment timepoint (TAT), 16 of 22 patients on Enjaymo (72.7%; 95% CI: 49.8% to 89.3%) and 3 of 20 patients on placebo (15.0%; 95% CI: 3.2% to 37.9%) met primary criteria. Efficacy of Enjaymo in the inhibition of hemolysis in patients with CAD was demonstrated across multiple end points.

The efficacy of Enjaymo was assessed in an open-label, single-arm, 6-month trial in 24 patients (CARDINAL, NCT03347396). Following the completion of the 6-month treatment period (Part A), patients continued to receive Enjaymo in a long-term safety and durability of response extension phase (Part B) for an additional 24 months following last patient out from Part A. The trial included a 9 week safety follow-up after the last dose of Enjaymo. Efficacy was based on the proportion of patients who met the following criteria: an increase from baseline in Hgb level ≥2 g/dL or a Hgb level ≥12 g/dL at the treatment assessment time point (mean value from Weeks 23, 25, and 26), no blood transfusion from Week 5 through Week 26, and no treatment for CAD beyond what was permitted per protocol from Week 5 through Week 26. Efficacy of Enjaymo in patients with CAD is described. After the last dose of Enjaymo in the study, signs and symptoms of recurrent hemolysis were observed, nine weeks after the last dose in

Part B; mean hemoglobin decreased by 2.28 g/dL (SE: 0.402) and mean bilirubin increased by 1.42 mg/dL (SE: 0.192) from the last available values during treatment.

Current Formulary Status: Enjaymo is currently a medical benefit requiring prior authorization.

Recommendation: The following changes are recommended to MBP 264.0 for Enjaymo:

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Enjaymo is prescribed by or in consultation with hematologist **AND**
- Medical record documentation of a diagnosis of primary cold agglutinin disease (CAD). confirmed by all of the following:
    - Evidence of chronic hemolysis (examples: high reticulocyte count, High LDL, high indirect bilirubin, low haptoglobin) **AND**
    - Positive polyspecific direct antiglobulin test (DAT) **AND**
    - Positive monospecific DAT specific for C3d **AND**
    - Cold agglutinin titer ≥ 64 at 4 degrees Celsius

  AND
- Medical record documentation of hemoglobin level ≤ 10.0 g/dL **AND**
- Medical record documentation that secondary causes of cold agglutinin disease (CAD) have been ruled out **AND**
- Medical record documentation of a prescribed dose that is consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature **AND**
- Medical record documentation that Enjaymo will not be used in combination with rituximab ± bendamustine or fludarabine **AND**
- Medical record documentation that patient is vaccinated against encapsulated bacteria (e.g., Streptococcus pneumoniae, Neisseria meningitidis, and Haemophilus influenzae subgroup B) at least 2 weeks prior to treatment **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to rituximab ± bendamustine or fludarabin

Discussion: Tricia Heitzman, Pharm.D., questioned if we should be removing the “OR transfusion dependent for new starts”. Mike Spishock, RPh, responded that the indication was updated to state they don’t have to be transfusion dependent, but we can still leave the “OR transfusion dependent”.

Outcome: The committee voted by majority to accept the recommendations as presented

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

UPDATES

BOTULINUM TOXIN UPDATE

Background: The following update contains a review of the botulinum toxin policy for temporomandibular joint disorders, trigeminal neuralgia, and other related disorders. In addition, the update contains a review of all applicable FDA approved indications for the varying botulinum toxin products.

Dose criteria: Botulinum toxin should be used at the appropriate dose and injected into the appropriate sites for the requested indication.

Hemifacial spasm: Local coverage determination (LCD) L38809 lists cranial nerve VII disorder as another name for hemifacial spasm in adults.

Spasmodic torticollis: UpToDate states cervical dystonia was previously known as spasmodic torticollis.

Oromandibular dystonia: LCD L38809 lists oromandibular dystonia as an acceptable off label use of Botox and Dysport as first line therapy for this indication.

Chronic anal fissure: UpToDate and Facts and Comparisons list chronic anal fissure as an acceptable off label use of Botox and Dysport as subsequent therapy. LCD L38809 also lists chronic anal fissure as an acceptable off label use of Botox as subsequent therapy.

Chronic sialorrhea: Facts and Comparisons lists chronic sialorrhea in adults as an acceptable off label use of Botox in patients with various neurological conditions and as subsequent therapy. Facts and Comparisons lists chronic sialorrhea as an acceptable off label use of Dysport in patients with various neurological conditions and as subsequent therapy. Myobloc is FDA approved for chronic sialorrhea in adults. Xeomin is FDA approved for chronic sialorrhea in patients 2 years of age and older.

Spasticity: The Department of Human Services (DHS) policy for Botulinum Toxins requires patients to have documentation that spasticity interferes with activities of daily living and have therapeutic failure on, contraindication to, or intolerance to one oral medication for spasticity. Other managed care organizations require spasticity associated with neurological conditions. Spasticity should be a result of a condition, or affect activities of daily living, and first line measures should be trialed before botulinum toxin is considered, when applicable.

Quantity limit: Up to 10,000 units of Myobloc can be used for cervical dystonia per FDA labeling.

Authorization duration: Clinical efficacy should be documented at least within 12 months from starting botulinum toxin therapy.

Unproven and investigational diagnoses: Evidence in temporomandibular joint disorders, trigeminal neuralgia, and gastroparesis does not adequately support the use of botulinum toxin in the aforementioned disorders.

Recommendations: It is recommended botulinum toxin for the use of temporomandibular joint disorders (TMD) and trigeminal neuralgia (TN) be considered not medically necessary. It is recommended to update Medical Benefit Policy (MBP) 11.0 to reflect the decision regarding TMD and TN. It is also recommended to update MBP 11.0 for other applicable diagnoses, for the authorization duration, and for applicable quantity limits:

Botulinum Toxin Type A, **OnabotulinumtoxinA (Botox** ~~and Xeomin~~) is ~~are~~ considered to be medically necessary for the commercial, exchange, and CHIP lines of business for following indications when the following criteria are met (Note: The Medicare line of business is reviewed according to Centers for Medicare and Medicaid Services [CMS] Local Coverage Determination [LCD]):

- Medical record documentation that the proposed injection sites and dosage regimen are consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature for the requested indication **AND**

- Medical record documentation of a diagnosis of:
  1. **Strabismus in members ≥ 12 years of age**
  2. **Blepharospasm associated with dystonia in members ≥ 12 years of age**
  3. **Facial nerve (VII) disorders (Hemifacial spasm)**
  4. **Cervical dystonia (Spasmodic torticollis)**
  5. **Chronic Migraine Headache**

     Botulinum toxin A for the treatment of chronic migraine headache may be considered medically necessary when all of the following criteria are met:
     - Physician provided medical record documentation of a history of 15 or more migraine headache days per month that last 4 or more hours per day **AND**
     - Physician provided medical record documentation that Botox is prescribed by or in consultation with a neurologist or headache specialist **AND**
     - Physician provided medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least two (2) of the following:
       - One (1) beta blocker (metoprolol, propranolol, timolol, atenolol, nadolol)
       - Topiramate
       - Divalproex/sodium valproate
       - Amitriptyline
       - Venlafaxine

       AND
     - Medical record documentation that Botox will not be used in combination with a CGRP antagonist **OR**
     - If the request is for use in combination with a CGRP antagonist, all of the following must be met:
       - Medical record documentation of a therapeutic failure on a minimum 3 month trial of at least one CGRP antagonists without the concomitant use of Botox AND
       - Medical record documentation of therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of a CGRP antagonist
  6. **Primary Axillary Hyperhidrosis**

     Botulinum toxin A for the treatment of severe primary axillary, palmer or pedal hyperhidrosis may be considered medically necessary when the following criteria are met:
     - Physician provided documentation of failure of a 6 month trial of non-surgical treatments with topical dermatologics (e.g., aluminum chloride, tannic acid, luteraldehyde, antichloinergics) **AND**
     - Medical record documentation of one of the following:
       - Underlying chronic medical condition such as dermatitis, fungal condition, skin maceration, or secondary microbial condition as a result of hyperhidrosis **OR**
       - Sweating is intolerable and causes functional impairment that interferes with member's ability to perform age-appropriate professional or social normal daily activities
  7. **Urinary incontinence due to neurogenic bladder**

     Botulinum toxin A for the treatment of urinary incontinence due to neurogenic bladder is considered medically necessary when the following criteria are met:
     - Medical record documented failure of anticholinergic medication therapy
  8. **Overactive Bladder**

     Botulinum toxin A for the treatment of overactive bladder is considered medically necessary when the following criteria are met:
     - Medical record documentation of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency in adults **AND**
     - Medical record documentation of failure of two anticholinergic medication therapies **AND**

- Medical record documentation of a minimum of three urinary urgency incontinence episodes and at least 24 micturations in three days

9. **Torsion dystonia**
10. **Orofacial dyskinesia**
11. **Oromandibular dystonia**
12. **Spasmodic torticollis**
13. **Organic writer's cramp**
14. **Hereditary spastic paraplegia**
15. **Multiple sclerosis**
16. **Neuromyelitis optica**
17. **Schilder's disease**
18. **Spastic hemiplegia**
19. **Infantile cerebral palsy**
20. **Esotropia**
21. **Exotropia**
22. **Intermittent heterotropia**
23. **Other and unspecified heterotropia**
24. **Heterophoria**
25. **Paralytic strabismus**
26. **Mechanical strabismus**
27. **Unspecified disorder of eye movements**
28. **Laryngeal spasm**
29. **Achalasia and cardiospasm**
30. **Anal spasm**
31. **Chronic anal fissure**

    Botulinum toxin A for the treatment of chronic anal fissure may be considered medically necessary when the following criteria is met:
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to first line therapy (can include but is not limited to fiber, sitz bath, topical analgesic, or topical vasodilators [nifedipine or nitroglycerin])
32. **Chronic Sialorrhea in members ≥18 years of age**

    Botulinum toxin A for the treatment of chronic sialorrhea may be considered medically necessary when all of the following criteria is met:
    - Medical record documentation of chronic sialorrhea caused by a neurological disease (eg. Parkinson's Disease, Cerebral Palsy, Amyotrophic Lateral Sclerosis [ALS]) **AND**
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to first line therapy (can include but is not limited to glycopyrrolate, hyoscyamine, amitriptyline, or atropine)

33. **Upper and/or Lower Limb Spasticity in members ≥2 years of age**

    Botulinum toxin A for the treatment of upper limb spasticity is considered medically necessary when the following criteria are met:
    - Medical record documentation of one of the following:
        - The spasticity is associated with a condition causing limb spasticity (can include but is not limited to cerebral palsy [including spastic equinus foot deformities], multiple sclerosis, neuromyelitis optica, or other injury, disease or tumor of the brain or spinal cord) **OR**
        - The spasticity interferes with activities of daily living

    AND
    - Medical record documentation of one of the following:
        - Therapeutic failure on, intolerance to, or contraindication to an oral medication for spasticity (can include but is not limited to baclofen, tizanidine, diazepam, or dantrolene) **OR**
        - The oral medications for spasticity are not expected to adequately treat the condition

- Patient is at least 2 years of age **AND**
- Medical record documentation that Botox or Xeomin is being used for the treatment of upper limb spasticity

Geisinger Health Plan approved FDA labeled indications for Botulinum Toxin Type A (**Botox** only) are:

1. **Lower Limb Spasticity**
   - Medical record documentation that Botox is being used for the treatment of lower limb spasticity to decrease the severity of increased muscle tone in ankle and toe flexors (gastrocnemius, soleus, tibialis posterior, flexor hallucis longus, and flexor digitorum longus) **AND**
   - Documentation that patient is at least 2 years of age **AND**
   - Medical record documentation of failure to control spasticity with conventional therapies, e.g., physical therapy, splinting/bracing, or systemic antispasticity medication

Geisinger Health Plan approved FDA labeled indications for Botulinum Toxin Type A (**Dysport**) are:

1. **Cervical dystonia**

   OR
2. **Upper Limb Spasticity**
   - Medical record documentation that Dysport is being used for the treatment of upper limb **AND**
   - Documentation that the patient is ≥ 2 years of age.

   OR
3. **Lower Limb Spasticity**
   - Medical record documentation that Dysport is being used for the treatment of the lower limb(s) **AND**
   - Documentation that the member is ≥ 2 years of age.

Geisinger Health Plan approved FDA labeled indications for Botulinum Toxin Type A (**Xeomin** only) are:

1. Sialorrhea
   - Documentation that patient is at least 2 years of age **AND**
   - For adults ages 18 years or older: Medical record documentation of a diagnosis of chronic sialorrhea resulting from Parkinson's disease, atypical parkinsonism, stroke, or traumatic brain injury **OR**
   - For pediatric patients ages 2 to 17 years: Medical record documentation of a diagnosis of chronic sialorrhea resulting from cerebral palsy, other genetic or congenital disorders, or traumatic brain injury

Geisinger Health Plan approved FDA labeled indications for Botulinum Toxin Type B (**Myobloc**):

1. Cervical dystonia in adults
2. Chronic Sialorrhea in adults

Botulinum Toxin Type A, **AbobotulinumtoxinA** (**Dysport**) is considered to be medically necessary for the commercial, exchange, and CHIP lines of business for following indications when the following criteria are met (Note: The Medicare line of business is reviewed according to Centers for Medicare and Medicaid Services [CMS] Local Coverage Determination [LCD]):

- Medical record documentation that the proposed injection sites and dosage regimen are consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature for the requested indication **AND**

- Medical record documentation of a diagnosis of:
  1. **Cervical dystonia (Spasmodic torticollis)**
  2. **Upper or Lower Spasticity in members ≥2 years of age**
     - Medical record documentation of one of the following:

- The spasticity is associated with a condition causing limb spasticity (can include but is not limited to cerebral palsy [including spastic equinus foot deformities], multiple sclerosis, neuromyelitis optica, or other injury, disease or tumor of the brain or spinal cord) **OR**
- The spasticity interferes with activities of daily living

AND

- Medical record documentation of one of the following:
  - Therapeutic failure on, intolerance to, or contraindication to an oral medication for spasticity (can include but is not limited to baclofen, tizanidine, diazepam, or dantrolene) **OR**
  - The oral medications for spasticity are not expected to adequately treat the condition

3. **Chronic anal fissure**
   - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to first line therapy (can include but is not limited to fiber, sitz bath, topical analgesic, or topical vasodilators [nifedipine or nitroglycerin])
4. **Primary Axillary Hyperhidrosis**
   - Physician provided documentation of failure of a 6 month trial of non-surgical treatments with topical dermatologics (e.g., aluminum chloride, tannic acid, luteraldehyde, antichloinergics) **AND**
   - Medical record documentation of one of the following:
     - Underlying chronic medical condition such as dermatitis, fungal condition, skin maceration, or secondary microbial condition as a result of hyperhidrosis **OR**
     - Sweating is intolerable and causes functional impairment that interferes with member's ability to perform age-appropriate professional or social normal daily activities
5. **Chronic Sialorrhea**
   - Medical record documentation of chronic sialorrhea caused by a neurological disease (eg. Parkinson's Disease, Cerebral Palsy, Amyotrophic Lateral Sclerosis [ALS]) **AND**
   - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to first line therapy (can include but is not limited to glycopyrrolate, hyoscyamine, amitriptyline, or atropine)
6. **Blepharospasm**
7. **Facial nerve (VII) disorders (Hemifacial spasm)**
8. **Orofacial dyskinesia**
9. **Oromandibular dystonia**

Botulinum Toxin Type A, **IncobotulinumtoxinA** (**Xeomin**) is considered to be medically necessary for the commercial, exchange, and CHIP lines of business for following indications when the following criteria are met (Note: The Medicare line of business is reviewed according to Centers for Medicare and Medicaid Services [CMS] Local Coverage Determination [LCD]):

- Medical record documentation that the proposed injection sites and dosage regimen are consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature for the requested indication **AND**

- Medical record documentation of a diagnosis of:

1. **Chronic Sialorrhea in patients 2 years of age and older**
   - Medical record documentation of chronic sialorrhea caused by a neurological disease (eg. Parkinson's Disease, Cerebral Palsy, Amyotrophic Lateral Sclerosis [ALS]) **AND**
   - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to first line therapy (can include but is not limited to glycopyrrolate, hyoscyamine, amitriptyline, or atropine)
2. **Blepharospasm**
3. **Cervical Dystonia (Spasmodic torticollis)**
4. **Upper Limb Spasticity**
   - Medical record documentation of one of the following:

- If the patient is ≥ 18 years of age: The spasticity is associated with a condition causing limb spasticity (can include but is not limited to cerebral palsy [including spastic equinus foot deformities], multiple sclerosis, neuromyelitis optica, or other injury, disease or tumor of the brain or spinal cord) OR the spasticity interferes with activities of daily living **OR**
- If the patient is 2 to 17 years of age (inclusive): The spasticity is NOT caused by cerebral palsy

AND

- Medical record documentation of one of the following:
  - Therapeutic failure on, intolerance to, or contraindication to an oral medication for spasticity (can include but is not limited to baclofen, tizanidine, diazepam, or dantrolene) **OR**
  - The oral medications for spasticity are not expected to adequately treat the condition

Geisinger Health Plan approved FDA labeled, and medically necessary, indications for Botulinum Toxin Type B, **RimabotulinumtoxinB** (**Myobloc**):

- Medical record documentation that the proposed injection sites and dosage regimen are consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature for the requested indication **AND**

- Medical record documentation of a diagnosis of:
  1. **Cervical dystonia (Spasmodic torticollis)**
  2. **Chronic Sialorrhea in patients ≥18 years of age**
     - Medical record documentation of chronic sialorrhea caused by a neurological disease (eg. Parkinson's Disease, Cerebral Palsy, Amyotrophic Lateral Sclerosis [ALS]) **AND**
     - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to first line therapy (can include but is not limited to glycopyrrolate, hyoscyamine, amitriptyline, or atropine)
  3. **Upper Limb Spasticity**
     - Medical record documentation of one of the following:
       - The spasticity is associated with a condition causing limb spasticity (can include but is not limited to cerebral palsy [including spastic equinus foot deformities], multiple sclerosis, neuromyelitis optica, or other injury, disease or tumor of the brain or spinal cord) **OR**
       - The spasticity interferes with activities of daily living

     AND
     - Medical record documentation of one of the following:
       - Therapeutic failure on, intolerance to, or contraindication to an oral medication for spasticity (can include but is not limited to baclofen, tizanidine, diazepam, or dantrolene) **OR**
       - The oral medications for spasticity are not expected to adequately treat the condition

The following applies to all botulinum toxin products (Botox, Dysport, Myobloc, Xeomin):

Quantity Limit: One (1) visit per 12 weeks (3 months)*

**Note: Patients utilizing botulinum toxin products for more than one indication may require additional visits. The following cumulative doses should not be exceeded if being used for 1 (or more) indication(s):*

- *Botox – 400 units per 12 weeks (3 months)*
- *Dysport – 1,500 units per 12 weeks (3 months)*
- *Myobloc – ~~5000~~ 10,000 units per 12 weeks (3 months)*
- *Xeomin – 400 units per 12 weeks (3 months)*

AUTHORIZATION DURATION: Initial approval will be for ~~**6 months**~~ **12 months** or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional **12 months** or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of the following:

- Medical record documentation of continued disease improvement or lack of disease progression** **AND**
- Medical record documentation of one of the following:
    - Repeated administrations are not being given more frequently than once every 12 weeks **OR**
    - Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing more frequently than every 12 weeks.

  AND
- For Chronic Migraines:
    - Medical record documentation of continued or sustained reduction in migraine or headache frequency or has experienced a decrease in severity or duration of migraine **AND**
    - Medical record documentation that Botox will not be used in combination with a CGRP antagonist **OR**
    - If the request is for use in combination with a CGRP antagonist, all of the following must be met:
        - Medical record documentation of a therapeutic failure on a minimum 3 month trial of at least one CGRP antagonists without the concomitant use of Botox AND
        - Medical record documentation of therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of a CGRP antagonist

***Note: The requested medication will no longer be covered if the patient fails to present clinical benefit after two sequential therapies using maximum doses.*

Botulinum toxin is considered **unproven** (data is inconclusive) for:

- Temporomandibular joint disorders (TMJ or TMD) and/or Myofascial pain of the muscles of mastication

Botulinum toxin is considered **investigational** for:

- headache or migraine other than chronic migraine
- myofascial pain syndrome
- tremors such as benign essential tremor, chronic motor tic disorder, and tics associated with Tourette syndrome
- Trigeminal neuralgia
- Gastroparesis

As treatment of wrinkles or other cosmetic indications. Cosmetic procedures are an exclusion per the "Exclusions" section of the applicable benefit documents

Discussion: No comments or questions.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

TRASTUZUMAB UPDATE

Background: Rebate opportunities have been analyzed by Expion (formerly Exponent) and sent to Geisinger Health Plan for further review and consideration with regards to Herceptin (trastuzumab) and the five available biosimilars. The five trastuzumab biosimilars are trastuzumab-anns (Kanjinti), trastuzumab-dkst (Ogivri), trastuzumab-dttb (Ontruzant), trastuzumab-qyyp (Trazimera), and trastuzumab-pkrb (Herzuma). As a medical benefit, Herceptin and all biosimilars are currently covered without a prior authorization for all lines of business. For Medicare Part D, Herceptin is currently not on the formulary, however all five biosimilars are without prior authorization.

With regards to rebate opportunities, Expion analyzed usage data and pricing for Commercial, Exchange and Medicare and sent four different options for review. All four options were thoroughly reviewed and analyzed by Geisinger Health Plan. Cost savings and patient outcomes were considered. The option selected to move forward with is one that labels Herceptin as non-preferred and labels all five biosimilars as preferred (biosimilar parity). As a medical benefit, the biosimilar drugs would not require a prior authorization but brand Herceptin would require a prior authorization for all lines of business. ASP pricing was reviewed for Medicare and the price of all five biosimilars are less expensive than Herceptin. This will allow Herceptin and biosimilars to become part of Medicare Part B Step Therapy.

The anticipated net savings for the Commercial line of business based on WAC would be $237,879. The anticipated net savings for the Commercial line of business based on MED200 would be $217,333. The anticipated net savings for the Exchange line of business based on WAC would be $39,668. The anticipated net savings for the Exchange line of business based on the MED200 would be $48,360. The anticipated net savings for the Medicare line of business based on WAC would be $134,340. The anticipated net savings for the Medicare line of business based on the ASP pricing would be $194,305.

Recommendation: It is recommended that a prior authorization be added and a policy created for Herceptin for Commercial/Exchange/CHIP/Medicaid. The proposed policy is included below:

- For trastuzumab reference product requests (i.e. Herceptin), medical record documentation of a therapeutic failure of, intolerance to, or contraindication to all of the following: trastuzumab-anns (Kanjinti), trastuzumab-dkst (Ogivri), trastuzumab-dttb (Ontruzant), trastuzumab-qyyp (Trazimera), or trastuzumab-pkrb (Herzuma)

AUTHORIZATION DURATION:

- <u>For Adjuvant Treatment:</u> Authorization will be for one (1) 12 month approval. Authorization of Herceptin for adjuvant treatment should not exceed the FDA-approved treatment duration of 1 year (12 months). For requests exceeding the above limit, medical record documentation of the following is required:
    - Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration
- <u>For All Other Indications:</u> Authorization will be open-ended

Discussion: No comments or questions.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

NOXAFIL PACKETS (posaconazole)

Background: When Noxafil was reviewed in November 2021, we recommended assessing Noxafil PowderMix once it was commercially available. Noxafil PowderMix packets are recommended for

pediatric patients ages 2 to less than 18 years of age, weighing 10 to 40 kg for the prophylaxis of invasive aspergillus and candida infections. Pediatric patients weighing over 40 kg are able to use Posaconazole delayed release tablets and patients 13 years of age and older are able to use posaconazole oral suspension. For patients under 13 years of age and under 40 kg, Noxafil PowderMix is the only oral treatment formulation.

Recommendation: It is recommended that the Noxafil PowderMix Packets be added to the Specialty tier, or Brand NP tier for members with a three tier benefit for Commercial, Marketplace, and GHP Kids. It will be reviewed with Policy 142.0 for Posaconazole with the following updates to criteria and QL:

Prophylaxis of Invasive Aspergillus or Candida Infections

- Medical record documentation that posaconazole is prescribed by an oncologist, hematologist, infectious disease specialist, or transplant service provider **AND**
- Medical record documentation of use for prophylaxis of invasive Aspergillus or Candida infections in patients at high risk of developing these infections due to being severely immunocompromised **AND**
- Medical record documentation of one of the following:
    - If request is for Noxafil oral suspension: medical record documentation of age greater than or equal to 13 years **OR**
    - If request is for posaconazole delayed release tablets: medical record documentation of age greater than or equal to 2 years and documentation of weight greater than 40 kilograms **OR**
    - If request is for Noxafil PowderMix: medical record documentation of age greater than or equal to 2 years and to less than 13 years of age AND documentation of weight greater than or equal to 10 kg to less than 40 kilogram

QUANTITY LIMIT: 300 mg PowderMix: Initial QL: 31 packets per 30 days, Maintenance QL: 30 packets per 30 days

Discussion: No comments or questions.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

BRONCHITOL TOLERANCE TEST QL

Background: Bronchitol was previously reviewed and a quantity limit of 560 per 28 days was recommended. Prior to the administration of Bronchitol, a Bronchitol Tolerance Test (BTT) must be administered to determine a patient's tolerance to Bronchitol treatment. The Bronchitol Tolerance Test is supplied as one inhaler containing 10 capsules (NDC: 10122-0214-01).

Recommendation: It is recommended that the following QL be added to include the Bronchitol Tolerance Test: Bronchitol Tolerance test 40 mg Capsules: 10 capsules per lifetime

Discussion: No comments or questions.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

QUARTERLY CASE AUDIT

The Quarterly Case Audit for 1st quarter 2023 was held on June 1st, 2023. There were no formulary changes proposed at this meeting. We will continue to look for opportunities to create more drug specific policies at future quarterly case audit meetings.

Discussion: No comments or questions.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

CONTROLLED SUBSTANCE/BUPRENORPHINE EDIT UPDATE

Background: An edit is currently in place to deny controlled substances when processed following a prescription for a buprenorphine prescription if the prescriptions are not written by the same physician. All controlled substances deny with the exception of products such as testosterone, modafinil, and antiepileptics. A total of 30 prior authorization requests were received in the last year, 22 of which were approved.

Recommendation: As providers now have access to controlled substance prescribing information via the Prescription Drug Monitoring Program (PDMP) and due to the love volume of requests and high volume of approvals, it is recommended that the controlled substance/buprenorphine edit be updated for 1/1/2024. The edit will be updated to deny only opioids, benzodiazepines, and sedative hypnotics when prescribed concurrently with a buprenorphine product.

Discussion: No comments or questions.

Outcome: The committee unanimously voted to accept the recommendations as presented. None were opposed.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Meeting adjourned at 4:37 pm.

The next bi-monthly scheduled meeting will be held on September 19th, 2023 at 1:00 p.m.

Meeting will be held virtually via phone/Microsoft Teams.