P&T Committee Meeting Minutes
Commercial/Marketplace
March 19, 2019

Present:	**Absent:**
Bret Yarczower, MD, MBA – Chair	Kenneth Bertka, MD
Kristen Bender, PharmD – via phone	Beverly Blaisure, MD
Kim Castelnovo, RPh – via phone	Holly Bones, Pharm.D.
Rajneel Chohan Pharm.D.	Dean Christian, MD
Kimberly Clark, Pharm.D.	Alyssa Cilia, RPh
Tricia Heitzman, Pharm.D.	Michael Evans, RPh
Jason Howay, Pharm.D. – via phone	Perry Meadows, MD
Keith Hunsicker, Pharm.D.	Stephen Moscola, RPh
Kelli Hunsicker, Pharm.D. – via phone	Jonas Pearson, RPh
Steven Kheloussi, Pharm.D. – via phone	
Phillip Krebs, R.EEG T. – via phone	
Jamie Miller, RPh	
Aubrielle Prater Pharm.D.	
Kimberly Reichard Pharm.D.	
Angela Scarantino	
Kristen Scheib, Pharm.D. – via phone	
William Seavey, Pharm.D. – via phone	
Richard Silbert, MD – via phone	
Michael Spishock, RPh – via phone	
Todd Sponenberg, Pharm.D.	
Jill Stone, Pharm.D. – via phone	
Hilary Weismantel Pharm.D. – via phone	
Kevin Szczecina, RPh	
Kelly Yelenic Pharm.D.	

Call to Order:
Dr. Bret Yarczower called the meeting to order at 1:02 p.m., Tuesday, March 19, 2019.

Review and Approval of Minutes:
Dr. Bret Yarczower asked for a motion or approval to accept the January 15, 2019 minutes as written. Keith Hunsicker accepted the motion and Kimberly Clark seconded the motion. None were opposed.

DRUG REVIEWS

ARAKODA (tafenoquine)

Review: Arakoda is an antimalarial agent indicated for the prophylaxis of malaria in patients 18 years of age and older. Arakoda provides activity against the major species of malarial parasites, P. falciparum and P. vivax. All recommended malaria prophylaxis regimens consist of taking the medication prior to, during, and post-travel to a malaria-endemic area. Initiating therapy prior to travel allows the drug to be in the blood before exposure to the malaria parasites. Multiple factors play a role in the choice of antimalarial regimen, such as location of travel, reports of antimalarial resistance, and other co-morbid conditions. Currently, CDC recommendations for antimalarial prophylaxis include Malarone (atovaquone-proguanil), chloroquine and hydroxychloroquine, doxycycline, mefloquine, and primaquine. Arakoda joins this group of agents in the prophylaxis space for malaria and offers another chemoprophylaxis option for adults traveling to malaria-endemic countries.

There are no black box warnings associated with the use of Arakoda. Contraindications include patients with a history of psychotic disorders or current psychotic symptoms, G6PD deficiency or unknown G6PD status, breastfeeding by a lactating woman when the infant is found to be G6PD deficient or has unknown G6PD status, and known hypersensitivity reactions to tafenoquine, other 8-aminoquinolines, or any component of Arakoda. There are warnings and precautions for hemolytic anemia, G6PD deficiency in pregnant or breastfeeding women, methemoglobinemia, psychiatric effects, hypersensitivity reactions, and delayed adverse reactions notably due to Arakoda's long half-life.

All patients must be tested for G6PD deficiency prior to the prescribing of Arakoda. Arakoda should be administered with food and can be given for up to 6 months of continuous dosing. The full course of Arakoda should be completed, including the loading doses, maintenance doses, and the terminal dose.

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 questions or comments. Todd Sponenberg made a motion to accept the recommendations as presented. Keith Hunsicker seconded the motion. None were opposed.

Financial Discussion: No questions or comments. Aubrielle Prater made a motion to accept the recommendations as presented. Todd Sponenberg seconded the motion. None were opposed.

Outcome: Arakoda will be covered as a pharmacy benefit. Arakoda will not be added to the formulary. The following prior authorization criteria will apply:

- Medical record documentation of age 18 years or older **AND**
- Medical record documentation that Arakoda is being used for prophylaxis of malaria **AND**
- Medical record documentation of G6PD deficiency testing with documented normal levels of G6PD **AND**
- Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on three (3) formulary agents

AUTHORIZATION DURATION: 6 months

NOTE: G6PD deficiency testing should be done prior to prescribing to ensure normal levels of G6PD. If the member is G6PD deficient or there is an unknown G6PD status Arakoda is contraindicated due to the risk of hemolytic anemia.

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

REVCOVI (elapegademase-lvlr)

Review: Revcovi is the only medication indicated for adenosine deaminase severe combined immune deficiency (ADA-SCID) and is indicated in both adults and pediatric patients. Revcovi provides an exogenous source of ADA enzyme which catalyzes the deamination of both adenosine and deoxyadenosine and increases the number of lymphocytes, therefore improving immune response. Observations in clinical trials indicated that patients achieved detoxification based on trough dAXP level and trough plasma ADA activity, and showed stable or slightly increased lymphocyte counts during Revcovi treatment relative to values recorded during the Adagen lead-in phase. Revcovi was found to demonstrate the ability to achieve and sustain higher and less variable levels of ADA plasma activity compared to Adagen. Adagen was an exogenous bovine source of ADA by the same manufacturer, which has been discontinued since the approval of Revcovi. Revcovi should be used in caution or avoided in patients with thrombocytopenia due to the risk of bleeding at the injection site. Precautions to protect immune deficient patients from infections should be maintained until improvement in immune function. Injection site pain is the only adverse effect attributed to Revcovi during clinical trials. Revcovi is dosed based on previous Adagen usage or Adagen-naivety. Adagen-treated patients should receive an equivalent converted dose, which can be titrated based on response. Adagen-naïve patients should receive a starting dose of 0.4 mg/kg weekly based on ideal body weight and should be treated for a minimum of 12-24 weeks. Their dose should then be titrated based on response.

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. Keith Hunsicker made a motion to accept the recommendations as presented. Tricia Heitzman seconded the motion. None were opposed.

Financial Discussion: No questions or comments. Kevin Szczecina made a motion to accept the recommendations as presented. Tricia Heitzman seconded the motion. None were opposed.

Outcome: Revcovi will be covered as a medical benefit requiring prior authorization. The following prior authorization criteria will apply:

- If the patient is Adagen-naïve, medical record documentation that Revcovi dosing is based on ideal body weight (IBW) **AND**
- Medical record documentation that Revcovi is prescribed by or in consultation with an immunologist, geneticist, or a physician who specializes in inherited metabolic disorders **AND**
- Medical record documentation of a diagnosis of adenosine deaminase deficiency-associated severe combined immune deficiency (ADA-SCID) as confirmed by the following:
    - Very low presence or absence of ADA (adenosine deaminase) activity in red blood cells or other samples **AND**
    - Increase in adenosine, deoxyadenosine, and deoxyadenosine triphosphate (dATP) levels in red blood cells, plasma, or urine

    OR
    - Biallelic mutations in the *ADA1* gene

AUTHORIZATION DURATION:

- Approval for new starts of Revcovi will be given for an initial duration of six (6) months.

- After the initial six (6) month approval, subsequent approvals for coverage will be for an additional six (6) months. Reevaluation of coverage will be every six (6) months and will require:
    - Medical record documentation of continued or sustained improvement in trough plasma ADA and dAXP levels while on Revcovi therapy **AND**
    - Medical record documentation of planned hematopoietic cell transplantation or gene therapy **OR** medical record documentation that the patient is not a suitable candidate for hematopoietic cell transplantation and gene therapy at the time of the request.

NOTE:

- Males IBW = 50 kg + 2.3 kg for each inch over 5 feet
- Females IBW = 45.5 kg + 2.3 kg for each inch over 5 feet

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

XEPI (ozenoxacin)

Review: Xepi is a quinolone antimicrobial indicated for the topical treatment of impetigo due to *Staphylococcus aureus* or *Streptococcus pyogenes* in adult and pediatric patients 2 months of age and older. Xepi joins other topical antimicrobials, Bactroban (mupirocin) and Altabax (retapamulin), which both share the same spectrum of activity and are commonly recommended to treat impetigo. Due to increasing MRSA rates and emerging antimicrobial resistance, Xepi, a quinolone, could act as an alternative topical treatment option.

Bactroban (mupirocin) and Altabax (retapamulin) are considered the topical treatment options of choice by both the IDSA and AAFP guidelines, and both are equally effective. In general, the treatment duration with topical antibiotics is application twice daily for 5 days. To date, neither the IDSA nor AAFP guidelines make recommendation regarding the use of Xepi for impetigo, but both guidelines were published prior to the approval of Xepi by the FDA.

Xepi is supplied as a 1% pale, yellow cream. It is available as a 10g, 30g, or 45g tube. Each gram of cream contains 10 mg of ozenoxacin.

In clincal trials, the efficacy of Xepi for the treatment of impetigo was evaluated in Trials 1 and 2, two multi-center, randomized, double-blind placebo controlled trials. In both studies, the success rates for Xepi were significantly higher than placebo (Trial 1: 34.8% vs. 19.2%, p=0.002; Trial 2: 54.4% vs. 37.9%, p=0.001).

There are no contraindications or black box warnings associated with the use of Xepi. There is a warning for nonsusceptible bacterial overgrowth with prolonged use of Xepi, illustrating the importance of adhering to the 5-day treatment duration. Only one patient out of the total patient population in 2 trials experienced adverse effects, which included rosacea and seborrheic dermatitis.

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

Clinical Discussion: Tricia Heitzman made a recommendation to update the age criteria to greater than or equal to two months based on the FDA approved labeling. Keith Hunsicker made a motion to accept the recommendations as amended. Aubrielle Prater seconded the motion. None were opposed

Financial Discussion: No comments or questions. Kevin Szczecina made a motion to accept the recommendations as presented. Aubrielle Prater seconded the motion. None were opposed.

Outcome: Xepi will be covered as a pharmacy benefit. Xepi will be added to the formulary on the brand tier requiring prior authorization. The following prior authorization criteria will apply:

- Medical record documentation of a diagnosis of impetigo **AND**
- Medical record documentation of age greater than or equal to 2 months **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to mupirocin ointment **AND** oral antibiotic therapy

AUTHORIZATION DURATION: 5 days, RX count 1

Additional Recommendations: To ensure consistency between policies for branded topical antimicrobials for impetigo across all lines of business, it is recommended that the following be added to the Altabax policies for each line of business:

AUTHORIZATION DURATION: 5 days, RX count 1

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

JIVI (antihemophilic factor VIII [recombinant])

Review: Jivi, antihemophilic factor (recombinant), PEGylated-aucl, is a recombinant DNA-derived, factor VIII concentrate indicated for use in previously treated adults and adolescents (12 years of age and older) with hemophilia A (congenital factor VIII deficiency) for: on-demand treatment and control of bleeding episodes, perioperative management of bleeding, and routine prophylaxis to reduce the frequency of bleeding episodes. Jivi joins Adynovate as the second recombinant FVIII concentrate to harness PEGylation technology for on-demand treatment, perioperative management, and routine prophylaxis of patients with hemophilia A. Other extended half-life FVIII products that also enable twice weekly dosing are Afstyla and Eloctate (which utilize non-PEGylation technologies). In comparison to Adynovate (the other PEGylated FVIII product), Jivi shares the similar indications; however, Adynovate is approved for use in children (<12 years) and adults with hemophilia A, whereas Jivi is limited to previously treated adolescents (≥ 12 years) and adults. Dosing recommendations are detailed in the labeling (see full drug review) for on-demand treatment/control of bleeding episodes, perioperative management, and routine prophylaxis. Doses and frequency should be adjusted according to the patient's clinical response. Jivi is intended to be given only intravenously following reconstitution.
The efficacy of Jivi for on-demand treatment, perioperative management of bleeding, and routine prophylaxis in males with severe hemophilia A was evaluated in a multinational, open-label, uncontrolled, partially randomized study. The study included a Part A (weeks 0-36), extension phase of Part A, and Part B (perioperative). The study population included previously treated patients (PTPs; ≥ 150 exposure days) who were between the ages of 12 to 65 years with severe hemophilia A (FVIII activity <1%) and no history of FVIII inhibitors. The primary efficacy variable was annualized bleed rate (ABR). In Part A (weeks 0-36), approximately 90% of the bleeds were successfully treated with 1 or 2 infusions in both the on-demand and prophylaxis groups. 73.3% of responses to bleed treatment were assessed as

"excellent" or "good" for both the on-demand and prophylaxis treatment groups. In the open-label extension patients were on twice weekly dosing, every 5 day dosing, or every 7 day dosing. 90% of patients remained on their assigned treatment until week 36. Treatment success in the every 7-day arm was not established. An analysis comparing ABRs between the on-demand group and the different prophylaxis regimens indicated that ABR was significantly reduced by 88.2% in the every 5-day prophylaxis arm in comparison with on-demand treatment ($p<0.0001$). There was no significant difference in ABRs between the twice-weekly and extended-interval treatment arms. Using Jivi for hemostasis, a total of 17 subjects successfully completed 20 major surgeries in Part B of Study 1. Treatment with Jivi provided "good" or "excellent" hemostatic control during all 20 surgeries. The median number of infusions on day of surgery was 2. The median total dose per surgery was 219 IU/kg, with a median of 35 IU/kg/infusion and 7 infusions per surgery (up to 3 weeks).
There are no black box warnings associated with the use of Jivi; however, it is contraindicated in patients with a history of hypersensitivity reactions to the active substance, polyethylene glycol (PEG), mouse or hamster proteins, or other product constituents. Warnings and precautions consist of hypersensitivity reactions (including severe allergic reactions), development of FVIII neutralizing antibodies (inhibitors), and immune responses to PEG (manifested as symptoms of acute hypersensitivity and/or loss of drug effect). The most frequently (≥ 5%) reported adverse reactions in clinical trials in PTPs aged 12 years and older were headache, cough, nausea and fever.
Management of hemophilia A involves both on-demand (episodic) and prophylactic treatment strategies. FVIII replacement products (see Table 1) are typically used for on-demand management of bleeding episodes, perioperative management, and routine prophylaxis to reduce bleeding frequency. The Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation recommends recombinant FVIII products as the treatments of choice for patients with hemophilia A due to their lower risk of human viral transmission as compared to plasma-derived agents.

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

Clinical Discussion: No comments or questions. Kevin Szczecina made a motion to accept the recommendations as presented. Kelly Yelenic seconded the motion. None were opposed

Financial Discussion: No comments or questions. Todd Sponenberg made a motion to accept the recommendations as presented. Rajneel Chohan seconded the motion. None were opposed

Outcome: Jivi may be covered as a pharmacy benefit requiring prior authorization or a medical benefit not requiring prior authorization. Jivi will be added to the formulary on the brand tier benefit requiring prior authorization. Jivi will be added to the existing policy 1447.0F, Antihemophilic Agents for Hemophilia A with the following prior authorization criteria will apply:

- Medical record documentation of a diagnosis of hemophilia A (a documented Factor VIII deficiency) **AND**
- Medical record documentation that the antihemophilic agent will be for outpatient use **AND**
- Medical record documentation that the antihemophilic agent will be used appropriate for routine prophylaxis, on-demand treatment/control of bleeding episodes, **OR** perioperative management of bleeding **AND**
- If request is for Jivi, the following criteria must be met:
    - Member is ≥ 12 years of age **AND**
    - Medical record documentation that the member has previously received treatment for hemophilia A with a Factor VIII product

	Routine Prophylaxis	On-Demand/ Perioperative
Advate	X	X
Adynovate	X	X
Afstyla	X	X
Eloctate	X	X
Helixate FS	X	X
Hemofil M		X
Jivi	X	X
Koate/Koate-DVI		X
Kogenate FS	X	X
Kovaltry	X	X
Monoclate-P		X
Novoeight	X	X
Nuwiq	X	X
Obizur		X
Recombinate		X
Xyntha/Xyntha Solofuse		X

Note: Obizur is indicated for adult patients with acquired hemophilia A.

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

PANZYGA (immune globulin intravenous, human – ifas)

Review: Panzyga is an intravenous immune globulin indicated for the treatment of patients with primary humoral immunodeficiency (PI) (2 years of age and older) and chronic immune thrombocytopenia (cITP) (in adults). The use of IVIG in these indications generally follows prednisone in cITP and is the mainstay of treatment in primary humoral immunodeficiency. Panzyga joins various intravenous immune globulin and subcutaneous immune globulin products, which are already available on the market.

In clinical trials for primary humoral immunodeficiency, Panzyga maintained low rates of bacterial infections, low amounts of hospitalizations, and low rates of missed days of school/work. Additionally, serum IgG levels were nearly constant for patients receiving treatment. In clinical trials for cITP, treated patients responded well to Panzyga within the first 7 days after the first infusion. Adequate increases in the platelet count were achieved and were maintained on average for about 12 days. Most patients ceased bleeding once Panzyga was received.

The safety profile of Panzyga is similar to the other available immune globulin therapies. Panzyga maintains a black box warning for thrombosis, renal issues, and infusion rate. Panzyga is contraindicated in patients with a history of anaphylactic or severe systemic reactions to human immune globulin and in IgA-deficient patients with antibodies against IgA and a history of hypersensitivity. Panzyga carries the following warnings and precautions: hypersensitivity, renal failure, hyperproteinemia, increased serum osmolarity, hyponatremia, thrombotic events, aseptic meningitis syndrome, hemolysis, pulmonary adverse reactions (transfusion-related acute lung injury [TRALI]), hypertension, volume overload, laboratory test monitoring, and possible containment of infectious agents such as viruses, variant Creutzfeldt-Jakob disease agent, and Creutzfeldt-Jakob disease agent. The most common adverse reactions in clinical trials included headache, nausea, fever, fatigue, abdominal pain, vomiting, dizziness, and anemia. The listed drug interactions are as a result of the passive transfer of antibodies. This passive transfer of antibodies may confound the results of serological testing and may interfere with the immune response to live viral vaccines such as measles, mumps, and rubella.

Many immune globulin products are in short supply due to the inability of manufacturers to supply enough product to meet the current demand. Often, different administration sites will only have access to specific products, and those products may change depending on the products available in the market.

Currently, Geisinger Health System's primary preferred IVIG product is Privigen and primary preferred SQIG product is Hizentra.

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

Clinical Discussion: No comments or questions. Kevin Szczecina made a motion to accept the recommendations as presented. Rajneel Chohan seconded the motion. None were opposed

Financial Discussion: No comments or questions. Kevin Szczecina made a motion to accept the recommendations as presented. Todd Sponenberg seconded the motion. None were opposed

Outcome: Panzyga will be covered as a medical benefit requiring prior authorization. Panzyga will be added to the existing medical IVIG policy (MBP 4.0) with the following prior authorization criteria:

- **Primary Humoral Immunodeficiencies, including combined immunodeficiencies**
  Congenital Agammaglobulinemia (X-linked agammaglobulinemia)
  Autosomal recessive agammaglobulinemia
  Common Variable Immunodeficiency (CVID)
  Wiskott-Aldrich Syndrome
  X-linked or autosomal recessive immunodeficiency with hyperimmunoglobulin M
  Severe Combined Immunodeficiency (SCID)
  Ataxia-telangectasia
  DiGeorge syndrome
  Nijmegen breakage syndrome
  Gruscelli syndrome
  NEMO deficiency
  WHIM (warts, hypogammaglobulinemia, immunodeficiency, and myelokathexis) syndrome
  X-linked lymphoproliferative disease (in patients with hypogammaglobulinemia or dysgammaglobulinemia and infections)
  Hypogammaglobulinemia provided the appropriate work up is performed to determine extent (ex. flow cytometry and anamnestic response to recall antigens)

  Patients with primary immunodeficiencies must meet the following criteria:
  1. Medical record documentation/laboratory results of immunoglobulin deficiency; **AND**
  2. Medical record documentation of an inability to amount an adequate immunologic response to inciting antigens; **AND**
  3. Medical record documentation of persistent and severe infections

- **Idiopathic Thrombocytopenia Purpura (ITP)**
  1. Acute ITP when either of the following are present:
     - Active bleeding and a platelet count of less than 30,000/mm^3; **AND**
     - Medical record documentation of use in conjunction with a corticosteroid or a contraindication to or failure on corticosteroid therapy; **OR**
     - As a preoperative treatment prior to major invasive surgical procedures **AND**
     - IVIG be used with corticosteroids when a more rapid increase in platelet count is required

  2. Chronic ITP when the following criteria are met:
     - Platelet count less than 30,000/mm^3 in children or less than 20,000/mm^3 in adults; **AND**
     - No concurrent illness or disease explaining thrombocytopenia; **AND**
     - Medical documentation of prior treatment with a long course or high dose of corticosteroids (ex, prednisone 1 mg/kg orally for 21 days then tapered off), a splenectomy;
       OR

- Active bleeding and a platelet count of less than 30,000/mm^3; **OR**
- As a preoperative treatment prior to major invasive surgical procedures

3. ITP in pregnancy with medical documentation of any of the following:
   - Platelet counts less than 10,000/mm^3 during the third trimester
   - Platelet count of 10,000/mm^3 to 30,000/mm^3 and active bleeding
   - Platelet counts less than 10,000/mm^3 after steroid failure
   - Platelet count of 10,000/mm^3 to 30,000/mm^3 and active bleeding after steroid failure
   - Platelet count of 10,000/mm^3 to 30,000/mm^3 during third trimester and asymptomatic after steroid failure

4. Secondary ITP
   a. *H-pylori*-associated
      i. Eradication of H-pylori in patients testing positive

- **Acquired Hypogammaglobulinemia Secondary to Chronic B-cell Lymphocytic Leukemia or Multiple Myeloma**
  The following criteria must be met:
  1. IgG less than 500 mg/dl, **AND**
  2. a documented history of repeated bacterial infection two times in one year or a severe bacterial infection within the last 6 months

- **Post-transfusion purpura**
  The following criteria must be met:
  1. Medical documentation of failure, intolerance, or contraindication to corticosteroids and plasmapheresis; **OR**
  2. Platelet count less than 10,000/mm^3 with bleeding

- **Kawasaki Disease**
  The following criteria must be met:
  1. Documentation of a diagnosis of Kawasaki disease.
  2. Treatment with IVIG is begun within 10 days of the onset of fever.

- **Pediatric HIV infection – Bacterial infection prevention**
  The following criteria must be met:
  1. Indicated in HIV positive children with humoral immunodeficiency AND
  2. Entry CD4+ lymphocyte count of 200/mm^3 or greater AND
  3. Hypogammaglobulinemia AND one or more of the following:
  4. Recurrent serious bacterial infections OR
  5. Failure to form antibodies to common antigens OR
  6. There is a high risk for measles OR
  7. There is a documented bronchiectasis that has not adequately responded to antimicrobial and pulmonary therapy.

- **Bone Marrow Transplantation (for lines of business not covered by the transplant vendor only)**
  The following criteria must be met:
  1. The transplant recipient is within the first 100 days after transplant from a matched unrelated donor; OR
  2. Documentation of treatment of Graft vs. Host Disease in a transplant recipient receiving allogenic matched bone marrow transplant with chronic repeated infections or hypogammaglobulinemia (IgG levels less than 400 mg/dL); OR
  3. Documentation of autologous transplant with hypogammaglobulinemia (IgG level less than 400 mg/dL) or repeated infections.

- **Myasthenia Gravis (Acute use)**
  The following criteria must be met:

1. Must be prescribed by a neurologist; AND
2. Documentation of therapeutic failure on, intolerance to, or contraindication to at least two standard treatments (e.g. cholinesterase inhibitors, azathioprine, corticosteroids) and /or a combination of these treatments for a minimum of 3 months; AND

Medical documentation of one of the following indications:

3. Diagnosis of acute myasthenic crisis with decompensation; OR
4. Use during postoperative period following a thymectomy; OR
5. Use prior to planned thymectomy

- **Refractory Chronic Debilitating Myasthenia Gravis**
  1. Medical record documentation of refractory Chronic Debilitating Myasthenia Gravis AND
  2. Prescribed by or in consultation with a neuromuscular specialist AND
  3. Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one corticosteroid AND
  4. Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one cholinesterase inhibitor AND
  5. Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one non-steroidal immunosuppressive therapy

- **Dermatomyositis and Polymyositis**
  All of the following criteria must be met:
  1. Diagnosis of dermatomyositis or polymyositis confirmed by biopsy AND
  2. Documented evidence of active disease AND
  3. Must be prescribed by a neurologist AND
  4. Documented evidence that the condition is refractory to both of the following therapies
     A) First line therapy: corticosteroids (at least 4 months of therapy)
     B) Second line therapy: at least two immunosuppressants (e.g. cyclosporine, azathioprine, methotrexate, cyclophosphamide)

- **Guillain-Barre Syndrome/Ascending Paralysis**
  The following criteria must be met:
  1. Adults with a diagnosis of either acute or chronic Guillain-Barre syndrome; AND
  2. Must be prescribed by a neurologist AND
  3. IVIG will be initiated within 2 weeks but no longer than 4 weeks of neuropathic symptom onset if acute onset; AND.
  4. No plan for combining IVIG with plasma exchange or sequential plasma exchange and IVIG.

- **Chronic Inflammatory Demyelinating Polyneuropathy**
  All of the following criteria must be met:
  1. Must be prescribed by a neurologist; AND
  2. Documented evidence of focal or symmetric neurologic deficits that are slowly progressive or relapsing over 12 weeks or longer AND
  3. Physician provided documentation of EMG abnormalities consistent with the diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy (a minimum of 3 of the following must be documented):
     a. Partial conduction block of one or more motor nerves
     b. Decreased conduction velocity of two or more motor nerves
     c. Prolongation of distal latency of two or more motor nerves
     d. Prolongation or absence of F-wave latencies in two or more motor nerves

Improvement should be apparent after 8 weeks of treatment; otherwise, requests for further treatment will require Medical Director review.

Relapses may require periodic isolated treatments with a single dose of IVIG.

- **Fetal or Neonatal Alloimmune Thrombocytopenia (FAIT)**

  The following criteria must be met:

  1. There has been a history of a previous pregnancy affected by FAIT and the father is homozygous for HPA-1a; OR
  2. At 20 weeks, cordocentesis reveals fetal platelets less than 100,000uL; OR
  3. Neonate with severe thrombocytopenia, who is at high risk of developing intracranial hemorrhage and washed irradiated maternal platelets are not available, have not been successful, have become intolerable, or are contraindicated

- **Multifocal Motor Neuropathy**

  The following criteria must be met:

  1. Must be prescribed by a neurologist; AND
  2. Medical documentation of progressive symptoms for a minimum of 2 months; AND
  3. Documentation of a diagnosis of multifocal motor neuropathy with conduction block as shown on electrophysiologic study as evidenced by:
     - Conduction block on a single nerve or probable conduction block in two or more nerves
     - Normal sensory nerve conduction in upper limb segments and normal sensory nerve action potential (SNAP) amplitude

  Treatment is limited to one course of therapy defined as 3 months if approved. Requests for further treatment will require Medical Director review.

- **CMV Interstitial Pneumonia in Allogenic Bone Marrow Transplant or HSCT patients** **(Ib/A)**

  The following criteria must be met:

  1. Medical record documentation of CMV pneumonia
  2. Medical record documentation that IVIG is being used in combination with or patient has a contraindication to ganciclovir

- **Toxic shock syndrome** **(III/C)**

  The following criteria must be met:

  1. Used in conjunction with conventional therapy
  2. Caused by staphylococcal or streptococcal organisms

- **Neonatal sepsis** **(Ia/A)**

  The following criteria must be met:

  1. Used in conjunction with conventional therapy

- **Graves' Ophthalmopathy** **(Ib/A)**

  The following criteria must be met:

  1. Medical record documentation of failure on, contraindication to, or intolerance to conventional treatment (corticosteroids)
  2. Prescription must be written by an ophthalmologist

- **Autoimmune Mucocutaneous Blistering Diseases (pemphigus, pemphigoid, pemphigus vulgaris, pemphigus foliaceus, Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis** **(III/C)**

  The following criteria must be met:

  1. Diagnosis must be substantiated by biopsy; AND
  2. Failure or contraindication to two or more conventional therapies (corticosteroids, azathioprine, cyclophosphamide, etc.);
     OR
  3. Have rapidly progressive disease in which a clinical response could not be quickly achieved utilizing conventional therapy. IVIG would be given in conjunction with conventional therapy and only until such time as conventional therapy could take effect

Note: IVIG for the treatment of autoimmune mucocutaneous blistering disease must be used only for short-term therapy and not as maintenance therapy.

- **Solid Organ Transplant**
  The following criteria must be met:
  Prevention of acute humoral rejection
    - Medical record documentation that patient is at high risk for antibody-mediated rejection, including highly sensitized patients or receiving ABO incompatible organ

  OR
  Treatment of acute humoral rejection
    - Medical record documentation of antibody-medicated rejection

- **Rasmussen's Encephalitis** **(IIb/B)**
  The following criteria must be met:
    1. Medical record documentation that short term amelioration of encephalitis is needed prior to definitive surgical therapy
    2. Medical record documentation of intractable focal motor seizures and progressive neurologic deterioration

- **Stiff-Person Syndrome** **(Ib/A)**
  The following criteria must be met:
    1. Prescription written by a neurologist
    2. Medical record documentation of failure on, intolerance to, or contraindication to all standard therapies (muscle relaxants, benzodiazepines, and gabapentin-related medications)
- **Eaton-Lambert myasthenic syndrome** **(Ib/A)**
  All of the following criteria must be met:
  1. Prescription written by a neurologist
  2. Medical record documentation of failure on, contraindication to, or intolerance to other treatments including corticosteroids or other immunosuppressants, cholinesterase inhibitors, and 3,4-diaminopyridine.

- **Multiple Sclerosis (relapsing/remitting type)**
  All of the following criteria must be met:
  1. Must be prescribed by a neurologist; AND
  2. Medical record documentation of RRMS **AND**
  3. Medical record documentation of current MS exacerbation **AND**
  4. Medical record documentation of therapeutic failure on, contraindication to, or intolerance to an appropriate trial of high dose corticosteroids

Improvement should be apparent after 2 courses of monthly treatment, otherwise, requests for further treatment will require Medical Director review of supporting documentation of expected outcome.

Note: IVIG is considered investigational for primary or progressive multiple sclerosis and will not be covered.

- **Warm Antibody Autoimmune hemolytic anemia** **(III/D)**
  The following criteria must be met:
  1. Refractory to or contraindicated to corticosteroids and immunosuppressive agents
  2. Refractory to splenectomy

- **Parvovirus B19 Infection**
  All of the following criteria must be met
  1. Prescribed by or in consultation with an infectious disease specialist, immunologist, hematologist, or transplant specialist
  2. Medical record documentation of chronic immunodeficient condition (HIV, solid organ transplant etc)
  3. Medical record documentation of chronic parvovirus B19 infection
  4. Medical record documentation of severe anemia as defined by hemoglobin < 8 g/dL

- **Catastrophic Antiphospholipid Syndrome (CAPS)** **(III/C)**

  All of the following criteria must be met:

  1. Documentation of a life-threatening condition
  2. Documentation of severe thrombocytopenia and microangiopathic hemolytic anemia
  3. Documentation of failure on, contraindication to, or intolerance to conventional treatment with anticoagulation and steroids
  4. Should be used in combination with plasma exchange

AUTHORIZATION DURATION: Each treatment period will be defined as 6 months or less, unless otherwise stated (e.g. Chronic Inflammatory Demyelinating Polyneuropathy, Multiple Sclerosis, and Multifocal Motor Neuropathy). Re-review will occur every 6 months or less, dependent on the indication. Documentation of clinical response to therapy is required after initiation of therapy. If initial benefit is seen and continued therapy is deemed necessary, documentation of objective monitoring must be seen. Clinical improvement is superior to laboratory monitoring. IVIG will no longer be covered if there is a medical record documentation of disease progression.

LIMITATIONS: When approved, IVIG will be administered in a setting determined by the Plan, in consultation with the requesting physician to be the most clinically appropriate and/or medically necessary.

Initial Dosing: Dosing should be calculated using adjusted body weight (ABW) if one or more of the following criteria are met:

- Patient's body mass index (BMI) is 30 kg/m^2 or more
- Patient's actual body weight is 20% higher than his or her ideal body weight (IBW)

Dosing formulas:

- BMI = weight in kg / height in meters^2
- IBW (kg) for males = 50 + [2.3 (height in inches – 60)]
- IBW (kg) for females = 45.5 + [2.3 * (height in inches – 60)]
- ABW = IBW + 0.5 (actual body weight – IBW)

Geisinger Health Plan considers some conditions other than those listed under Indications to be **Experimental, Investigational or Unproven** and **NOT Medically Necessary**. These conditions include:

- Alzheimer's disease
- amyotrophic lateral sclerosis
- atopic dermatitis
- autism
- chronic fatigue syndrome
- chronic mucocutaneous candidiasis (CMCC)
- complex regional pain syndrome (CRPS)
- epilepsy
- inclusion body myositis
- Lyme disease
- neuromyelitis optica (NMO) (Devic's Disease)
- optic neuritis
- paraproteinemic demyelinating neuropathy (PDN)
- post-polio syndrome
- recurrent spontaneous miscarriage
- rheumatic fever
- secondary progressive multiple sclerosis (SPMS)

systemic lupus erythematosus

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

XERAVA (eravacycline)

Review: Xerava is part of the tetracycline class of antibiotics indicated for the treatment of complicated intra-abdominal infections caused by susceptible microorganisms: *Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii, Enterobacter cloacae, Klebsiella oxytoca, Enterococcus faecalis, Enterococcus faecium, Staphylococcus aureus, Streptococcus anginosus group, Clostridium perfringens, Bacteroides species,* and *Parabacteroides distasonis* in patients 18 years or older. The recommended dose regimen of Xerava is 1 mg/kg IV every 12 hours for a recommended duration of treatment of 4 to 14 days. Two phase 3 clinical trials have established Xerava as noninferior to ertapenem and meropenem in complicated intraabdominal infections with the microbiological intent-to-treat analysis showing cure rates of 86.8% for Xerava and 87.6% for ertapenem in IGNITE 1, and 90.8% for Xerava and 91.2% for meropenem in IGNITE 4. Warnings and precautions include life threatening anaphylactic reactions, tooth discoloration and enamel hypoplasia, inhibition of bone growth, Clostridium difficile-associated diarrhea, photosensitivity, pseudotumor cerebri, increased BUN, azotemia, acidosis, hyperphosphatemia, and pancreatitis. Xerava requires no renal dose adjustments, should be adjusted in severe hepatic impairment, and only hepatic function should be monitored periodically during treatment.
A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, and Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. Rajneel Chohan made a motion to accept the recommendations as presented. Kevin Szczecina seconded the motion. None were opposed

Financial Discussion: No comments or questions. Aubrielle Prater made a motion to accept the recommendations as presented. Tricia Heitzman seconded the motion. None were opposed

Outcome: Xerava will be covered as a medical benefit requiring prior authorization. The following prior authorization criteria will apply:

- Documentation that the patient is at least 18 years of age **AND**
- Prescribed by or in consultation with an infectious disease specialist
- Medical record documentation of a diagnosis of a complicated intra-abdominal infection (cIAI) caused by one of the following susceptible microorganisms: *Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii, Enterobacter cloacae, Klebsiella oxytoca, Enterococcus faecalis, Enterococcus faecium, Staphylococcus aureus, Streptococcus anginosus* group, *Clostridium perfringens, Bacteroides species,* and *Parabacteroides distasonis* **AND**
- Medical record documentation of culture and sensitivity showing the patient's infection is not susceptible to all generic formulary alternative antibiotic treatments OR a documented history of previous intolerance to or contraindication to all generic formulary alternative antibiotics shown to be susceptible on the culture and sensitivity **OR**
- <u>If initiated during an inpatient say</u>: Medical record documentation of a culture and sensitivity showing the patient's infection is not susceptible to all alternative antibiotic treatments listed on the formulary OR a documented history of previous intolerance to or contraindication to all other generic formulary antibiotics shown to be susceptible on the culture and sensitivity **AND**

AUTHORIZATION DURATION: Up to a maximum of 14 days

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

TEGSEDI (inotersen)

Review: Tegsedi is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR) in adults. Tegsedi is the second approved agent for the treatment of the polyneuropathy of hATTR, a rare, genetic, and progressive multi-organ disorder. Treatment options for hATTR have historically been limited to organ transplantation (liver, heart) or investigational agents, as well as the newly approved Onpattro. Tegsedi is the fifth FDA approval of an agent that utilizes antisense technology, though is the first antisense oligonucleotide (ASO) agent approved for hATTR. Tegsedi causes degradation of mutant and wild-type TTR mRNA through binding to the TTR mRNA to induce cleavage with RNAse, which prevents the production of the protein and leads to a reduction in serum TTR protein and TTR deposits in tissues. Onpattro, a small interfering RNA (siRNA), is another agent approved for hATTR that utilizes the same mechanism, though targets a different specific location in TTR gene synthesis interruption. Both siRNA and ASO have similar mechanisms of action by targeting the mRNA of TTR, but differ by drug delivery, administration, efficacy, and safety.

Tegsedi is available as a 284 mg/1.5 mL single-dose prefilled syringe. The recommended dose of Tegsedi is 284 mg administered as a subcutaneous injection once weekly and is intended for patient self-administration. The first injection administered by the patient or caregiver should be guided by a healthcare professional. Platelets need to be monitored at least weekly, serum creatinine/eGFR/urinalysis/urine protein to creatine ratio should be monitored every 2 weeks, and AST/ALT/bilirubin should be monitored every 4 months.

The safety and efficacy for Tegsedi was demonstrated in a Phase 2/3 randomized, double-blind, placebo-controlled, multi-center clinical trial in adult patients (range: 18 to 82 years) with polyneuropathy caused by hATTR. Patients included in the trial had Stage 1 (patient is ambulatory) or Stage 2 (patient is ambulatory with assistance) hATTR-PN. Patients that received previous treatment with any oligonucleotide or small interfering ribonucleic acid within 6 months of screening were excluded from the trial. Patients were randomized in a 2:1 ratio to receive either Tegsedi 300 mg (equivalent to 284 mg of parent acid) (N=113) or placebo (N=60) once weekly for 65 weeks (3 doses were administered the first week of treatment). Following completion of end of treatment, eligible patients had the option to enroll in an open-label extension study to continue to receive weekly doses of Tegsedi. The co-primary endpoints were the change from baseline to week 66 in the modified Neuropathy Impairment Score +7 (mNIS +7) composite score and the Norfolk Quality of Life-Diabetic Neuropathy (QoL-DN) total score. The change from baseline to week 66 on both co-primary endpoints met statistical significance in favor of Tegsedi. Tegsedi has been show to slow disease progression and improve quality of life. Patients receiving Tegsedi experienced similar improvements relative to placebo in mNIS+7 and Norfolk QoL-DN score across all subgroups (age, sex, race, region, NIS score, Val30Met mutation status, and disease stage). Polyneuropathy disability (PND) score was assessed as an exploratory endpoint. Patients in both treatment groups had PND score I, II, or III at baseline. Improved PND scores at Week 65 were observed in a higher proportion of patients in the inotersen group (10.5%) compared with placebo (3.8%). Approximately 25% of patients in both treatment groups had PND scores that worsened by Week 65 while on treatment. In the 10.5% of patients that experienced improvement, their PND scores shifted from II (difficulty walking but no need for stick/crutch) to I (sensory disturbances but preserved walking capacity) and III (1 stick/crutch required) to II (difficulty walking but no need for stick/crutch). There were also 8 patients with PND IV (2 sticks/crutches required) in the Tegsedi group vs 3 patients in the placebo group at baseline. These patients experienced disease stabilization and did not become confirmed to a bed or wheelchair. Eligible subjects who completed the NEURO-TTR study received 300 mg Tegsedi

once weekly for up to 260 weeks (5 years). Efficacy was measured by mNIS+7 and the Norfolk QoL-DN total score as secondary endpoints. The trial is still ongoing. However, interim results have shown that changes from baseline in both the mNIS+7 and Norfolk QoL-DN endpoints demonstrated a clinically significant benefit in favor of long-term treatment with Tegsedi. Continued slowing of disease progression was observed in the Tegsedi-Tegsedi group. Based on the results, it is suggested that there was an increased benefit with early initiation of Tegsedi and this persisted over time. There was no new signals or safety concerns from longer use of treatment with Tegsedi.

Unlike Onpattro, Tegsedi carries some black box warnings, which include thrombocytopenia (may result in sudden and unpredictable thrombocytopenia, which can be life-threatening) and glomerulonephritis (may result in dialysis-dependent renal failure). Because of these risks, which require frequent monitoring, Tegsedi is available only through a restricted distribution program under a Risk Evaluation and Mitigation Strategy (REMS) called the Tegsedi REMS Program. Contraindications include a history of hypersensitivity reactions, history of acute glomerulonephritis caused by Tegsedi, and platelet count less than 100 x 109/L. There are warnings for stroke and cervicocephalic arterial dissection, inflammatory/immune effects, liver effects, hypersensitivity reactions, reduced serum vitamin A levels, and uninterpretable platelet counts. The most common adverse reactions that occurred in at least 20% of Tegsedi-treated patients and more frequently than on placebo were injection site reactions, nausea, headache, fatigue, thrombocytopenia, and fever. The safety and effectiveness in pediatric patients have not been established.

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

Clinical Discussion: No comments or questions. Kevin Szczecina made a motion to accept the recommendations as presented. Kelly Yelenic seconded the motion. None were opposed.
Financial Discussion: No comments or questions. Todd Sponenberg made a motion to accept the recommendations as presented. Tricia Heitzman seconded the motion. None were opposed.

Outcome: Tegsedi will be covered as a pharmacy benefit requiring prior authorization. Tegsedi will be added to the formulary on the brand tier. The following prior authorization criteria will apply:

- Prescription written by or in consultation with a neurologist, geneticist, or specialist with experience in the treatment of hereditary transthyretin-mediated amyloidosis (hATTR) **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of diagnosis of hereditary transthyretin-mediated amyloidosis as confirmed by genetic testing to confirm a pathogenic mutation in TTR **AND** one of the following:
    - Biopsy of tissue/organ to confirm amyloid presence **OR**
    - A clinical manifestation typical of hATTR (Neuropathy and/or CHF) without a better alternative explanation **AND**
- Medical record documentation that Tegsedi will be used to treat polyneuropathy **AND**
- Medical record documentation of familial amyloid polyneuropathy (FAP) stage 1-2 and/or polyneuropathy disability score (PND) indicating the patient is <u>not</u> wheelchair bound or bedridden **AND**
- Medical record documentation that Tegsedi will not be used in combination with other RNA interference treatment

NOTE:

<u>FAP stage:</u>

1-unimpairmend ambulation
2- assistance with ambulation

3- wheelchair-bound or bedridden

Polyneuropathy disability score:

I- preserved walking, sensory disturbances
II- impaired walking without need for stick/crutches
IIIa- walking with 1 stick/crutch
IIIb- walking with 2 sticks/crutches
IV-wheelchair-bound or bedridden

Polyneuropathy disability score (used in Neuro-TTR trial):

I- preserved walking, sensory disturbances
II- impaired walking without need for stick/crutches
III- walking with 1 stick/crutch
IV- walking with 2 sticks/crutches
V-wheelchair-bound or bedridden

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 an additional 12 months or less if the reviewing provider feels it is medically appropriate. The medication will no longer be covered if the member progresses to FAP stage 3 and/or polyneuropathy disability score indicating the patient is wheelchair-bound or bedridden.

QUANTITY LIMIT: 6 mL per 28 days

Additional Recommendations: Based on the findings/specialist feedback from the Tegsedi review, it is recommended to update the Onpattro policy (711.0D and 188.0) for all lines of business to the following (updates highlighted in yellow):

- Prescription written by or in consultation with a neurologist, geneticist, or specialist with experience in the treatment of hereditary transthyretin-mediated amyloidosis (hATTR) **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of diagnosis of hereditary transthyretin-mediated amyloidosis as confirmed by genetic testing to confirm a pathogenic mutation in TTR AND one of the following:
    - Biopsy of tissue/organ to confirm amyloid presence **OR**
    - A clinical manifestation typical of hATTR (Neuropathy and/or CHF) without a better alternative explanation **AND**
- Medical record documentation of Onpattro being used to treat polyneuropathy **AND**
- Medical record documentation of familial amyloid polyneuropathy (FAP) stage 1-2 and/or polyneuropathy disability score (PND) indicating the patient is not wheelchair bound or bedridden **AND**
- Medical record documentation that Onpattro will not be used in combination with other RNA interference treatment

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 an additional 12 months or less if the reviewing provider feels it is medically appropriate. The medication will no longer be covered if the member progresses to FAP stage 3 and/or polyneuropathy disability score indicating the patient is wheelchair-bound or bedridden.

NOTE:

FAP stage:

1-unimpairmend ambulation
2- assistance with ambulation
3- wheelchair-bound or bedridden

Polyneuropathy disability score:

I- preserved walking, sensory disturbances
II- impaired walking without need for stick/crutches
IIIa- walking with 1 stick/crutch
IIIb- walking with 2 sticks/crutches
IV-wheelchair-bound or bedridden

Polyneuropathy disability score (used in Neuro-TTR trial):

I- preserved walking, sensory disturbances
II- impaired walking without need for stick/crutches
III- walking with 1 stick/crutch
IV- walking with 2 sticks/crutches
V-wheelchair-bound or bedridden

There are no updates to the quantity limits.

No comments or questions. Kimberly Clark made a motion to accept the recommendations as presented. Keith Hunsicker seconded the motion. None were opposed.

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

DUROLANE (sodium hyaluronate)

Review: Durolane is a single-injection, high molecular-weight hyaluronic acid supplement indicated for the treatment of pain in osteoarthritis (OA) of the knee in patients who have failed to respond adequately to conservative non-pharmacological therapy or simple analgesics, e.g. acetaminophen. Durolane is one of many hyaluronic acid supplementation products on the market. Durolane is injected directly into the knee joint and aims to increase lubrication and cushioning, which may relieve related osteoarthritic pain.

In clinical trials, Durolane failed to demonstrate superiority compared to placebo (in two trials) and methylprednisolone injections (in one trial). The pivotal clinical trial demonstrated that Durolane was non-inferior to a commercially available 5-injection HA product based on the WOMAC 20-point Likert-scale (primary endpoint) and based on the WOMAC physical function change from baseline (CFB), subject global assessment CFB, and WOMAC knee stiffness CFB (secondary endpoints).

The safety profile of Durolane is relatively benign and similar to other HA products. Durolane does not maintain any black box warnings; however, is contraindicated in patients with a known hypersensitivity to hyaluronic acid preparations and in patients with knee joint infections, infections, or skin disease in the area of the injection site. Durolane's warnings are significant for the concomitant use of disinfectants containing quaternary ammonium salts and the injection of Durolane intra-vascularly, extra-articularly, or in the synovial tissues or capsule. Precautions include administration in joints other than the knee, repeated injections, joint effusion, treatment pain/swelling, aseptic administration technique, administration route, local anesthetics, pre-existing chondrocalcinosis, and strenuous activity or prolonged weight bearing activity within 48 hours of injection. Listed adverse reactions include: aggravated osteoarthritis, arthralgia (knee pain), arthropathy, arthrosis, baker's cyst, bursitis, immune

response, infection, injection site erythema, edema, pain, and reaction, joint (knee) disorder, effusion, stiffness, and swelling, pain in limb, paraesthesia, phlebitis, pruritus, and tendonitis.

The current clinical practice guidelines do not favor hyaluronic acid products due to their lack of proven efficacy. The 2013 American Academy of Orthopaedic Surgeons' guidelines for the Treatment of Osteoarthritis of the Knee (2nd edition) noted that despite statistically significant functional benefit was seen in meta-analysis, there was a low likelihood that an appreciable number of patients achieved clinically important benefits. There are new ACR guidelines currently in development for the treatment of osteoarthritis. These updated guidelines are planned to be released in the Spring of 2019 (delayed from 2018).

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

Clinical Discussion: No comments or questions. Kevin Szczecina made a motion to accept the recommendations as presented. Kimberly Clark seconded the motion. None were opposed.

Financial Discussion: No comments or questions. Rajneel Chohan made a motion to accept the recommendations as presented. Kevin Szczecina seconded the motion. None were opposed.

Outcome: Durolane will be covered as a medical benefit which does not require prior authorization.

Additional Recommendations: Based on new contracting opportunities, Geisinger Health Plan has the ability to expand its preferred product list to include six preferred products without compromising manufacturer rebates. To increase hyaluronic acid product access to patients and prescribers, lower prior authorization burden, increase timeliness of patient care, and increase savings opportunities, it is recommended that Supartz FX and Euflexxa be added to MBP 13.0 as preferred agents, not requiring prior authorization.

The following changes are recommended to MBP 13.0 to account for the above recommendations.

NOTE: Durolane, Euflexxa, Gelsyn-3, Supartz FX, Synvisc, and Synvisc One are preferred agents and DO NOT Require Prior Authorization

~~**Euflexxa,**~~ **Gel-One, GenVisc 850, Hyalgan, Hymovis, Monovisc, Orthovisc,** ~~**Supartz FX,**~~ and **Visco-3** require prior authorization and will be considered medically necessary when all of the following criteria are met:

- Physician documented symptomatic osteoarthritis of the knee, defined as knee pain associated with radiographic evidence of osteophytes in the knee joint provided the clinical presentation is not that of "bone-on-bone", morning stiffness of less than or equal to 30 minutes in duration, crepitus on range of motion; **AND**
- Physician documented knee joint pain sufficient to interfere with ambulatory functional activities; **AND**
- Physician documentation of non-pharmacologic modalities, e.g., weight loss, quadriceps muscle strengthening, other physical therapy modalities, or exercises that have not promoted satisfactory symptomatic relief; **AND**
- Physician documentation that there has been no significant improvement following pharmacologic therapy with a full-dose nonsteroidal anti-inflammatory drug (NSAID) regimen, with or without supplemental acetaminophen, over a 10-12 week period of time or if

NSAID's are contraindicated, a failure of daily acetaminophen regimen over a 4 to 6 week period; **AND**

- Physician documentation that there has been no significant improvement following standard dose intra-articular corticosteroid injection(s) e.g., a satisfactory clinical response of greater than or equal to 3 months; this requirement does not apply if the use of corticosteroids might increase the risk of local or systemic bacterial infection, e.g., diabetes mellitus; **AND**
- Physician documentation of failure on, intolerance to or contraindication to three (3) of the following: Durolane, Euflexxa, Gelsyn-3, Synvisc, and/or Synvisc One

AUTHORIZATION DURATION/QUANTITY LIMIT: Initial approval will be for six (6) months and will be limited to one (1) treatment course to the affected knee(s) (bilateral injections may be allowed if both knees meet the required coverage criteria). Subsequent approvals will be for six (6) months and will be limited to one (1) treatment course to the affected knee(s) when members meet the following criteria:

- Repeat treatment cycles are considered medically necessary when ALL of the following criteria are met:
    1. Medical record documentation of significant improvement in pain and function following the previous injection; AND
    2. Documented reduction of the doses of nonsteroidals or analgesics during the six month period following the last injection in the previous series as well as no need for accompanying intra-articular steroid injections; AND
    3. Six months or longer have elapsed since the last injection in the previous series.

LIMITATIONS:

- Durolane treatment course is limited to 1 injection in a 6-month period
- Euflexxa treatment course is limited to 3 injections, one week apart, in a 6-month period
- Gel-One treatment course is limited to 1 injection in a 6-month period.
- Gelsyn-3 treatment course is limited to 3 injections in a 6-month period.
- GenVisc 850 treatment course is limited to 5 injections in a 6-month period.
- Hyalgan (sodium hyaluronate) treatment course is limited to 5 injections in a 6-month period.
- Hymovis treatment course is limited to 2 injections in a 6-month period.
- Monovisc treatment course is limited to 1 injection in a 6-month period.
- Orthovisc treatment course is limited to 4 injections in a 6-month period.
- Supartz treatment course is limited to 5 injections in a 6-month period.
- Synvisc (Hylan G-F 20) treatment course is limited to 3 injections in a 6-month period.
- Synvisc One treatment is limited to 1 injection in a 6-month period.
- Visco-3 treatment course is limited to 3 injections in a 6-month period.
- Treatment requires referral to and should be rendered by a participating Orthopedic surgeon or Rheumatologist.
- Bilateral injections may be allowed if both knees meet the required coverage criteria.

CONTRAINDICATIONS:

- The use of these products for injection into any joint other than the knee.
- Injection of these products for indications other than the diagnosis of osteoarthritis.
- Documented allergy to chickens or eggs.
- Knee joint infection, skin disease or infection around the area where the injection will be given.

- The insured individual has known sensitivity or contraindication to the use of either sodium hyaluronate or hylan G-F 20, e.g., crystal synovitis or hypersensitivity to hyaluronan preparations

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

XOFLUZA (baloxavir marboxil)

Review: Xofluza (baloxavir marboxil) is indicated for the treatment of uncomplicated influenza in patients ≥ 12 years of age. It is dosed based on weight as a single oral dose of either 40 mg (40 kg to 80 kg) or 80 mg (> 80 kg). It is the only FDA approved antiviral treatment for influenza in a single oral dose formulation. According to the clinical evidence, it has been shown to reduce time to symptom resolution and decrease viral load when compared to oseltamivir or placebo. The most commonly observed (≥ 1%) adverse effects reported are: diarrhea, bronchitis, nausea, nasopharyngitis, and headache. Xofluza has a unique mechanism of action as an endonuclease inhibitor, compared to Tamiflu (oseltamivir), Rapivab (peramivir), and Relenza (zanamivir), which are all neuraminidase inhibitors. All four of these agents are indicated for the treatment of uncomplicated influenza, while oseltamivir and zanamivir are also indicated for prophylaxis. The FDA-approved ages for treatment of influenza are, Xofluza in patients ≥12 years of age; peramivir, ≥2 years; oseltamivir, ≥2 weeks; and zanamivir, ≥7 years.
A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, and Other Considerations and a Financial Review Based on Cost Analysis were presented.

Clinical Discussion: No comments or questions. Keith Hunsicker made a motion to accept the recommendations as presented. Todd Sponenberg seconded the motion. None were opposed.

Financial Discussion: No comments or questions. Kevin Szczecina made a motion to accept the recommendations as written. Aubrielle Prater seconded the motion. None were opposed.

Outcome: Xofluza will be covered as a pharmacy benefit which does not require prior authorization. Xofluza will be added to the formulary on the brand tier. The following restriction/quantity limit will apply:

- Age edit requiring patients to be 12 years or older
- A QL of 2 tablets per fill.
- A QL of 2 fills of Tamiflu, Relenza, or Xofluza per season

Additional Recommendations: Tamiflu (both brand and generic oseltamivir) and Relenza will be updated to allow coverage for up to 2 fills of Tamiflu, Relenza, or Xofluza per 180 days.

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

FAST FACTS

LYNPARZA (olaparib)

Updated Indication: Lynparza is now indicated as maintenance treatment of adult patients with deleterious or suspected deleterious germline or somatic *BRCA*-mutated (g*BRCA*m or s*BRCA*m) advanced epithelial ovarian, fallopian tube or primary peritoneal cancer who are in complete or partial response to 1st-line platinum-based chemotherapy

Updated Dosing for New Indication:
Lynparza 300mg orally twice daily, with or without food, for a total daily dose of 600mg.

Limitation of Use: Treat until disease progression, unacceptably toxicity or completion of two (2) years of treatment. Patients with complete response at two (2) years should stop treatment. Patients with evidence of disease at two (2) years, who in opinion of the treating healthcare provider can derive further benefit from continuous treatment, can be treated beyond two (2) years.

Recommendations: No formulary changes are recommended for Lynparza. The following changes are recommended to the existing policy/criteria (1289.0F):

** Remove capsule criteria and quantity limits from policy as Lynparza is no longer available in capsule form. (Discontinued 09/2018)

Prior authorization criteria as follows:

- Medical record documentation that Lynparza is prescribed by an oncologist or hematologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of deleterious or suspected deleterious germline *BRCA*-mutated advanced ovarian cancer as verified by a Food and Drug Administration (FDA) approved test **AND** Medical record documentation of therapeutic failure on, intolerance to, or contraindication to three or more prior lines of chemotherapy **OR**
- Medical record documentation of diagnosis of recurrent epithelial ovarian, primary peritoneal, or fallopian tube cancer **AND** Medical record documentation of Lynparza being used as maintenance therapy after a complete or partial response to platinum-based chemotherapy **OR**
- Medical record documentation of a diagnosis of deleterious or suspected deleterious g*BRCA*m, HER2-negative metastatic breast cancer **AND** Medical record documentation that member has been previously treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting **AND** If hormone receptor (HR)-positive, medical record documentation that prior treatment included endocrine therapy or documentation that endocrine therapy would be considered inappropriate **OR**
- Medical record documentation of a diagnosis of deleterious or suspected deleterious germline or somatic *BRCA*-mutated (g*BRCA*m or s*BRCA*m) advanced epithelial ovarian, fallopian tube or primary peritoneal cancer **AND** Medical record documentation member has had a complete or partial response to first-line platinum based chemotherapy

QUANTITY LIMITS:
100 mg tablets: 4 tablets per day, 28 day supply per fill
150 mg tablets: 4 tablets per day, 28 day supply per fill

AUTHORIZATION DURATION:

For first-line maintenance of BRCA-mutated advanced ovarian cancer (failure on first-line platinum-based chemotherapy):

Initial approval will be for 12 months or less if the reviewing provider feels it is medically appropriate. One subsequent approval for Lynparza will be granted for up to an additional 12 months (total of two years of therapy) 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

For members requesting approval of treatment beyond two (2) years, medical record documentation will be required showing patient has continued evidence of disease and treating healthcare provider believes member can derive further benefit from continuous treatment. Each additional approval will be for a period of 12 months. Members with complete response at two years, will not be granted additional treatment, per the package labeling.

For all other indications:

Initial approval will be for 12 months or less if the reviewing provider feels it is medical 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 the member experiences unacceptable toxicity or worsening of disease.

Discussion: No comments or questions

Outcome: Kevin Szczecina made a motion to accept the recommendations as presented. Tricia Heitzman seconded the motion. None were opposed.

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

LILETTA (levonorgestrel-releasing intrauterine system)

Updated Indication: Liletta is a sterile, levonorgestrel-releasing intrauterine system indicated for prevention of pregnancy for up to 5 years. The system should be replaced after 5 years if continued use is desired.

Previous Indication: Liletta is a sterile, levonorgestrel-releasing intrauterine system indicated for prevention of pregnancy for up to 4 years.

Recommendations: Litetta is currently covered as a medical benefit which does not require prior authorization. No changes are recommended at this time.

Discussion: No comments or questions.

Outcome: Kimberly Clark made a motion to accept the recommendations as presented. Aubrielle Prater seconded the motion. None were opposed.

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

DUXPIENT (pasireotide)

Updated Indication: Dupixent is now indicated as add-on maintenance treatment in patients with moderate-to-severe asthma aged 12 years and older with eosinophilic phenotype or with oral corticosteroid dependent asthma.

Limitations of Use: Not for the relief of acute bronchospasm or status asthmaticus

Previously: Dupixent was only indicated for the treatment of adult patients with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. It could be used with or without topical corticosteroids.

Updated Dosing for New Indication[1]:
Asthma for patients ≥ 12 years of age:

- Initial: 400 mg (two 200 mg injections) followed by 200 mg given every other week OR 600 mg (two 300 mg injections) followed by 300 mg given every other week
- For patients requiring concomitant oral corticosteroids-dependent asthma or with co-morbid moderate-to-severe atopic dermatitis, the initial dose of 600 mg followed by 300 mg given every other week should be started.

For Atopic Dermatitis, the recommended dose is 600 mg (two of the 300 mg injections), followed by 300 mg given every other week.

Recommendation: There are no changes to formulary status at this time. However, it is recommended to update the prior authorization criteria to the following.

Atopic Dermatitis

- Medical record documentation that Dupixent is prescribed by or in consultation with an allergist, dermatologist, or immunologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of moderate to severe atopic dermatitis **AND**
- Medical record documentation of a failure on topical therapies as evidenced by one or more of the following:
    - Documentation of contraindication to, intolerance to, or therapeutic failure* on daily treatment with at least one medium potency** topical corticosteroid **OR**
    - If topical corticosteroids are not indicated (i.e. use on sensitive areas such as face, axillae, or groin, steroid-induced atrophy, etc.), documentation of contraindication to, intolerance to, therapeutic failure* on topical calcineurin inhibitors (i.e. tacrolimus, pimecrolimus)

  AND
- Medical record documentation of a contraindication to, intolerance to, or therapeutic failure on phototherapy (UVA/UVB treatment) **AND**
- Medical record documentation of a contraindication to, intolerance to, or therapeutic failure on at least one systemic treatment(i.e. methotrexate, azathioprine, mycophenolate)

Asthma

- 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 12 years A**ND**
- Medical record documentation of one of the following:
    - A diagnosis of moderate to severe eosinophilic asthma **AND** a blood eosinophilic count ≥ 150 cells/microL O**R**
    - 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 one 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, emergency department or urgent care visits, or hospitalization) despite current therapy or intolerance to inhaled corticosteroids plus a long-acting beta agonist **AND**
- Medical record documentation that Dupixent will not be used in combination with Xolair, Fasenra, Nucala, or Cinqair.

Measures of Disease Severity

Measure	Not Well Controlled	Very Poorly Controlled
Symptoms	> 2 days per week	Throughout the day
Nighttime awakenings	1-3x/week	> 4x/week
Interference with normal activity	Some limitation	Extremely limited
SABA use for symptom control (not to prevent exercise-induced bronchospasm)	> 2 days/week	Several times per day
FEV1 (% predicted) or peak flow (% personal best)	60-80%	< 60%
Asthma Control Test (ACT) Score	16-19	< 15

Quantity Limit: *Quantity limit should be entered by GPID.*
Dupixent 300 mg/2 mL: Initial authorizations: one-week auth for QL of eight (8) mL per 42 days; remainder of the 6 month auth duration, QL of four (4) mL per 28 days
Subsequent authorizations: four (4) mL per 28 days

Dupixent 200 mg/1.14 mL: Initial authorization: one-week auth for QL 4.56 mL per 42 days; remainder of the 6 month auth duration, QL 2.28 mL per 28 days
Subsequent authorizations: 2.28 mL per 28 days

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 the member experiences unacceptable toxicity or worsening of disease.

Discussion: No comments or questions.

Outcome: Keith Hunsicker made a motion to accept the recommendations as presented. Kelly Yelenic seconded the motion. None were opposed.

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

HUMIRA (adalimumab)

Updated Indication: Humira is now approved for treatment of non-infectious intermediate, posterior, and pan-uveitis (UV) in pediatric patients 2 years of age and older and for the treatment of hidradenitis suppurativa (HS) in patients 12 years of age and older.

Updated Dosing for New Indication:
Pediatric UV:
10 kg (22 lbs) to < 15kg (33lbs): 10mg every other week
15 kg (33lbs) to < 30 kg (66 lbs): 20 mg every other week
≥ 30 kg (66 lbs): 40 mg every other week

HS:
Adolescents (12 years and older) 30 kg (66 lbs) to <60kg (132 lbs):
Initial dose (Day 1): 80mg
Second dose (Day 8) and subsequent doses: 40mg every other week
Adolescents (12 years and older) ≥60 kg (132 lbs):
Initial dose (Day 1): 160 mg (given in one day or split over two consecutive days)
Second dose (Day 15): 80 mg
Third (Day 29) and subsequent doses: 40 mg every week

Recommendation: No formulary changes are recommended at this time. The following additions/changes to the current criteria are recommended:

Non-Infectious Intermediate, Posterior and Panuveitis

- Medical record documentation that Humira is prescribed by an ophthalmologist or rheumatologist **AND**
- Medical record documentation of age greater than or equal to 2 years **AND**
- Medical record documentation of a diagnosis of non-infectious intermediate, posterior or panuveitis **AND**
- Medical record documentation of:
    i. Therapeutic failure on, intolerance to, or contraindication to local/systemic corticosteroids AND an immunosuppressant (methotrexate, azathioprine, mycophenolate, cyclosporine or tacrolimus) **OR**
    ii. For members 2-18 years, therapeutic failure on, intolerance to, or contraindication to local/systemic corticosteroids AND methotrexate **AND**
- For members 2-18 years, medical record documentation that Humira is being given in combination with methotrexate; for members who are not receiving combination therapy, medical record documentation of a contraindication to methotrexate **AND**
- Medical record documentation that member is receiving appropriate dose of Humira based on weight and age **AND**
- Medical record documentation that Humira is not being used concurrently with a tumor necrosis factor (TNF) blocker or other biologic agent

QUANTITY LIMITS:

Adult Uveitis	One-week auth for QL of 4 syringes per 28 days; Remainder of the 6 month auth duration, QL of 2 syringes per 28 days

Pediatric Uveitis	
≥ 30 kg	2 syringes per 28 days for the 40 mg/0.8 mL strength **(Approve by GPID)**
15 kg to < 30 kg	2 syringes per 28 days for the 20 mg/0.4 mL strength **(Approve by GPID)**
10 kg to < 15 kg	2 syringes per 28 days for the 10 mg/0.2 mL strength **(Approve by GPID)**

AUTHORIZATION DURATION:
Approval will be given for an initial duration of six (6) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in the signs and symptoms of uveitis on six (6) months of adalimumab therapy is required.

After the initial six (6) month approval, subsequent approvals will be for a duration of one (1) year requiring medical record documentation of continued or sustained improvement in the signs and symptoms of uveitis while on adalimumab therapy.

Hidradenitis Suppurativa

- Medical record documentation that Humira is prescribed by a dermatologist **AND**
- Medical record documentation of a diagnosis of moderate to severe hidradenitis suppurativa (HS), defined as Stage II or III on the Hurley staging system*
- Medical record documentation of at least 3 abscesses or inflammatory nodules **AND**
- Medical record documentation of concomitant use of oral or systemic antibiotics **AND**
- Medical record documentation that the member has received counseling on weight management (if overweight) and smoking cessation (if the member is an active smoker) **AND**
- Medical record documentation that Humira is not being used concurrently with a tumor necrosis factor (TNF) blocker or other biologic agent **AND**
- Medical record documentation of patient age 12 years or older **AND**
- For patients 12 to 18 years of age, weighing 30 kg (66 lbs) to <60kg (132 lbs), medical record documentation of Humira being given at a maximum dose of 40mg every other week

QUANTITY LIMITS: (approve by GPID)
For members 18 years of age and older: One-week auth for QL of 6 syringes per 28 days; Remainder of the 6 month auth duration, QL of 4 syringes per 28 days

For members 12-18 years of age, weighing ≥ 60kg (132lbs): One-week auth for QL of 6 syringes per 28 days; Remainder of the 6 month auth duration, QL of 4 syringes per 28 days

For members 12-18 years of age, weighing 30 kg (66 lbs) to <60kg (132 lbs): One week auth for QL of 3 syringes per 28 days; Remainder of the 6 month auth duration, QL of 2 syringes per 28 days

AUTHORIZATION DURATION:
Approval will be given for an initial duration of six (6) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in the signs and symptoms of hidradenitis suppurativa on six (6) months of adalimumab therapy is required.

After the initial six (6) month approval, subsequent approvals will be for a duration of one (1) year requiring medical record documentation of continued or sustained improvement in the signs and symptoms of hidradenitis suppurativa while on adalimumab therapy.

Discussion: No comments or questions.

Outcome: Tricia Heitzman made a motion to accept the recommendations as presented. Keith Hunsicker seconded the motion. None were opposed.

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

ALIMTA (pemetrexed)

Updated Indication: Alimta is now indicated in combination with pembrolizumab and platinum chemotherapy, for the initial treatment of patients with metastatic non-squamous NSCLC, with no EGFR or ALK genomic tumor aberrations. Previously, this indication specified "in combination with carboplatin" and did not specify "with no EGFR or ALK tumor aberrations."

Alimta maintains its previous indications for the initial treatment of patients with non-squamous, NSCLC in combination with cisplatin, for the treatment of non-squamous NSCLC as a single agent (after progression on first-line chemotherapy and recurrence after prior chemotherapy, and the initial treatment of unresectable mesothelioma or in patients unable to tolerate surgery.

Updated Dosing[1]: The recommended dose of Alimta when administered with pembrolizumab and platinum chemotherapy for the initial treatment of metastatic non-squamous NSCLC in patients with a creatinine clearance (calculated by Cockcroft-Gault equation) of 45 mL/min or greater is 500 mg/m^2 as an intravenous infusion over 10 minutes administered after pembrolizumab and prior to carboplatin or cisplatin on Day 1 of each 21-day cycle for 4 cycles. Following completion of platinum-based therapy, treatment with Alimta with or without pembrolizumab is administered until disease progression or unacceptable toxicity. See the full prescribing information for pembrolizumab and for carboplatin or cisplatin.

Recommendation: Alimta is currently available without restriction for all lines of business as a medical benefit. Based on the updated indication no changes are recommended at this time for any lines of business.

Discussion: No comments or questions.

Outcome: Kimberly Clark made a motion to accept the recommendations as presented. Tricia Heitzman seconded the motion. None were opposed.

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

XARELTO (rivaroxaban)

Updated Indication:

- *Coronary artery disease (chronic) or peripheral artery disease: Reduction of risk of major cardiovascular (CV) events (CV death, MI, and stroke) in patients with coronary artery disease (chronic) or peripheral artery disease*
- Indefinite anticoagulation (reduced intensity dosing against VTE recurrence): Reduction in the risk of recurrence of DVT and PE in patients at continued risk of DVT and PE following at least 6 months of initial full therapeutic anticoagulant treatment for DVT and/or PE

- Nonvalvular atrial fibrillation: Prevention of stroke and systemic embolism in patients with nonvalvular atrial fibrillation
- VTE (DVT or PE): Treatment of DVT or PE
- VTE prophylaxis in total hip or knee arthroplasty: Postoperative thromboprophylaxis of DVT, which may lead to PE in patients undergoing total hip or total knee arthroplasty

Updated Dosing for New Indication:

- Coronary artery disease (stable) or peripheral artery disease (prevention of major cardiovascular events):
    - **2.5 mg twice daily; administer in combination with daily low dose aspirin.**
    - **Note:** Some experts do not recommend substituting or adding anticoagulant therapy to aspirin for these indications due to excess risk of major bleeding. May consider rivaroxaban in carefully selected patients who are at high risk of cardiovascular events and low risk of bleeding who do not require therapeutic anticoagulation or dual antiplatelet therapy for another indication.
    - For patients receiving 2.5 mg twice daily: if a dose is missed, the patient should take a single 2.5 mg Xarelto dose as recommended at the next scheduled time

Recommendation: Xarelto is currently on the formulary at the brand tier with a quantity limit. No changes are recommended at this time.

Discussion: No comments or questions.

Outcome: Kevin Szczecina made a motion to accept the recommendations as presented. Kimberly Clark seconded the motion. None were opposed.

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

XYREM (sodium oxybate)

Updated Indication: Xyrem is now indicated for the treatment of cataplexy or excessive daytime sleepiness (EDS) in patients 7 years of age and older with narcolepsy.

Updated Dosing for New Indication:[1]

Table 1: Recommended Pediatric Xyrem Dosage for Patients 7 Years of Age and Older*

Patient Weight	Initial Dosage		Maximum Weekly Dosage Increase		Maximum Recommended Dosage	
	Take at Bedtime:	Take 2.5 to 4 Hours Later:	Take at Bedtime:	Take 2.5 to 4 Hours Later:	Take at Bedtime:	Take 2.5 to 4 Hours Later:
<20 kg**	There is insufficient information to provide specific dosing recommendations for patients who weigh less than 20 kg.					
20 kg to <30 kg	≤1 g	≤1 g	0.5 g	0.5 g	3 g	3 g
30 kg to <45 kg	≤1.5 g	≤1.5 g	0.5 g	0.5 g	3.75 g	3.75 g
≥45 kg	≤2.25 g	≤2.25 g	0.75 g	0.75 g	4.5 g	4.5 g

* For patients who sleep more than 8 hours per night, the first dose of Xyrem may be given at bedtime or after an initial period of sleep.

**If Xyrem is used in patients 7 years of age and older who weigh less than 20 kg, a lower starting dosage, lower maximum weekly dosage increases, and lower total maximum nightly dosage should be considered.
Note: Unequal dosages may be required for some patients to achieve optimal treatment.

Recommendation: No changes are recommended to formulary placement at this time. The following changes are recommended to prior authorization criteria to reflect the new indication:

Removal of criteria requiring confirmation of enrollment in Xyrem REMS program, as this is the responsibility of the prescriber/dispensing pharmacy. *(The Xyrem central pharmacy (1-866-997-3688) has verified the eligibility of the physician to prescribe the drug, and they have contacted the member by telephone to confirm their understanding of the program. This information may be furnished when Orphan Medical initiates a call to the Geisinger Health Plan for prior authorization, or the GHP Customer Service Representative may call the phone number listed to confirm)*

Discussion: It was recommended that the prior authorization criteria were updated to require failure on modafinil and to define the number of stimulants that must be tried and failed. Additionally, it was recommended that a quantity limit of 18 mL per day, 30 day supply per fill be applied. Finalized criteria are as follows:

- Diagnosis of an FDA approved indication **AND**
- For cataplexy with narcolepsy, medical record documentation of failure on, intolerance to or contraindication to venlafaxine XR **or** fluoxetine **OR**
- For excessive daytime sleepiness with narcolepsy:
    a. For patients 18 years and older, medical record documentation of failure on, intolerance to or contraindication to modafinil* **AND** methylphenidate IR **or** amphetamine/dextroamphetamine IR **OR**
    b. For patients 7-18 years, medical record documentation of failure on, intolerance to methylphenidate IR **or** amphetamine/dextroamphetamine IR

QUANTITY LIMIT: 18ml/day, max 30 days supply per fill

Outcome: Kimberly Clark made a motion to accept the recommendations as amended. Keith Hunsicker seconded the motion. None were opposed.

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

PROMACTA (eltrombopag)

Updated Indication: Promacta is now indicated in combination with standard immunosuppressive therapy for the first-line treatment of adult and pediatric patients 2 years and older with severe aplastic anemia.

Promacta was previously only indicated for thrombocytopenia in patients with cITP, thrombocytopenia in patients with HCV on interferon therapy, and for patients with severe aplastic anemia who have had an insufficient response to immunosuppressive therapy.

Updated Dosing for New Indication:
First-Line Severe Aplastic Anemia:

- Promacta should be initiated concurrently with standard immunosuppressive therapy.
- The total duration of Promacta treatment is 6 months.
- Recommended initial dose is as follows:
    - Patients 12 years and older: 150 mg once daily for 6 months
    - Pediatric patients 6 to 11 years: 75 mg once daily for 6 months
    - Pediatric patients 2 to 5 years: 2.5 mg/kg once daily for 6 months
- Recommended initial dose for patients of Asian Ancestry or those with hepatic impairment is as follows:
    - Patients 12 years and older: 75 mg once daily for 6 months
    - Pediatric patients 6 to 11 years: 37.5 mg once daily for 6 months
    - Pediatric patients 2 to 5 years: 1.25 mg/kg once daily for 6 months

Recommendations: There is no changes recommended to formulary status at this time. However, it is recommended to update the current Promacta policy (specifically the Severe Aplastic Anemia section) to the following (updates highlighted in yellow).

For Severe Aplastic Anemia

- Medical record documentation of a diagnosis of severe aplastic anemia AND
- Prescription is written by a hematologist AND
- Medical record documentation of platelet count ≤ 30,000/μL AND
- Medical record documentation of one of the following:
    - Medical record documentation of an inadequate response to at least one prior immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil, sirolimus, Atgam® [lymphocyte immune globulin, anti-thymocyte globulin [equine] sterile solution for intravenous use only]) OR
    - Medical record documentation that Promacta will be used as first line treatment in combination with standard immunosuppressive therapy (e.g. antithymocyte globulin [equine] and cyclosporine)

AUTHORIZATION DURATION: If an exception is made, Promacta will be authorized for an initial period of six (6) months and continued coverage will require medical record documentation of improvement in symptoms and a hematological response. Subsequent authorizations will be for a period of six (6) months and will then require medical record documentation of continued hematological response.

Note to reviewer: Per UpToDate, hematologic response is defined as independence from transfusion, no need for additional immunosuppressive therapy, and/or improvement of peripheral blood counts to the point that they no longer meet criteria for severe aplastic anemia.

Note to reviewer: For **first line** severe aplastic anemia, Promacta is only approved for 6 month treatment duration.

Discussion: No comments or questions.

Outcome: Kevin Szczecina made a motion to accept the recommendations as presented. Kelly Yelenic seconded the motion. None were opposed.

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

INVOKANA (canagliflozin) & INVOKAMET/INVOKAMET XR (cangliflozin, metformin hydrochloride)

Updated Indication:

- Invokana is a sodium-glucose co-transporter 2 (SGLT2) inhibitor
- Invokamet and Invokamet XR are a combination of canagliflozin, an SGLT2 inhibitor, and metformin HCl, a biguanide
- Both are now indicated to reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus and established cardiovascular disease
    - Invokana, Invokamet, and Invokamet XR were historically only indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus

Recommendation: Invokana, Invokamet, and Invokamet XR are currently on the formulary at the brand tier with a quantity limit. No changes are recommended at this time.

Discussion: No comments or questions.
Outcome: Aubrielle Prater made a motion to accept the recommendations as presented. Kimberly Clark seconded the motion. None were opposed.

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

SPRYCEL (dasatinib)

Updated Indication: Sprycel is now indicated for the treatment of pediatric patients 1 year of age and older with newly diagnosed Ph+ ALL in combination with chemotherapy.

Updated Dosing for New Indication:
Table 1: Dosage of Sprycel for Pediatric Patients[a]

Body Weight (kg)[b]	Daily Starting Dose (mg)
10 to less than 20kg	40mg

20 to less than 30kg	60mg
30 to less than 45kg	70mg
At least 45kg	100mg

[a] For pediatric patients with Ph+ ALL, begin Sprycel therapy on or before day 15 of induction chemotherapy, when diagnosis is confirmed and continue for 2 years.
[b] Tablet dosing is not recommended for patients weighing less than 10kg

In clinical studies, treatment with SPRYCEL in pediatric patients with Ph+ ALL was administered for a maximum duration of 2 years.

Do not crush, cut or chew tablets. Swallow tablets whole. The exposure for dispersed tablets in a clinical trial was 36% lower as compared to intact tablets in pediatric patients. Due to the limited available clinical data, it is unclear whether dispersing SPRYCEL tablets significantly alters the safety and/or efficacy of SPRYCEL.

Recommendation: No formulary changes are recommended for Sprycel at this time. It is recommended the prior authorization criteria be updated to reflect the new indication:

- Medical record documentation that Sprycel is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of the use of Sprycel to treat newly diagnosed chronic phase Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) **OR**
- Medical record documentation of the use of Sprycel to treat chronic, accelerated, or myeloid/lymphoid blast phase Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) with resistance or intolerance to prior therapy including imatinib **OR**
- Medical record documentation of use of Sprycel to treat Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL) with resistance or intolerance to prior therapy **OR**
- Medical record documentation of use of Sprycel to treat newly diagnosed Philadelphia chromosome positive (Ph+) acute lymphoblastic leukemia (ALL) in pediatric patients 1 year and older in combination with chemotherapy.

AUTHORIZATION DURATION:
Treatment period will be defined as 12 months. Re-review will be every 12 months. Sprycel will no longer be covered if there is medical record documentation of disease progression.

QUANTITY LIMIT:
Pharmacist note to CSR: *Authorization should be entered by HICL and only checking the Formulary PA required box (no QLs need to be entered within the authorization).*

- 20 mg tablet: 3 tablets per day, 30 day supply per fill
- 50 mg, 70 mg, 80 mg, 100 mg, and 140 mg tablets: 1 tablet per day, 30 day supply per fill

Discussion: No comments or questions.

Outcome: Tricia Heitzman made a motion to accept the recommendations as presented. Kevin Szczecina seconded the motion. None were opposed.

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

CABOMETYX (cabozantinib)

Indication: Cabometyx is a kinase inhibitor now indicated for the treatment of patients with hepatocellular carcinoma (HCC) who have previously treated with sorafenib.

Cabometyx was previously only approved for patients with advanced renal cell carcinoma.

Updated Dosing for New Indication[1]:
Hepatocellular Carcinoma: The recommended dose of Cabometyx is 60 mg once daily without food until disease progression or unacceptable toxicity.

Note: This dose is also recommended for patients with advanced renal cell carcinoma.

There was an update to the dose modifications for patients with moderate and severe hepatic impairment. In patients with moderate hepatic impairment (Child-Pugh B), the starting dose is 40 mg once daily. Cabometyx should be avoided in patients with severe hepatic impairment (Child-Pugh C). *Previously, the 40 mg was also recommended for patients with mild hepatic impairment.*

Recommendation: There is no change recommended to formulary placement at this time. However, it is recommended to add the following criteria to the current Cabometyx policy:

Hepatocellular Carcinoma:
- Prescription written by an oncologist AND
- Medical record documentation of hepatocellular carcinoma (HCC) AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to sorafenib (Nexavar) AND
- If the requested dose is 80 mg daily: Medical record documentation that the patient is using Cabometyx in combination with a strong CYP3A4 inducer, including but not limited to, rifampin, phenytoin, carbamazepine, phenobarbital, rifabutin, rifapentine, and St. John's Wort OR
- Medical record documentation of a medically accepted indication

There are no updates to authorization durations and quantity limits.

Discussion: No comments or questions.

Outcome: Kelly Yelenic made a motion to accept the recommendations as presented. Tricia Heitzman seconded the motion. None were opposed.

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

HEMLIBRA (emicizumab-kxwh)

Updated Indication: Hemlibra is now indicated for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adult and pediatric patients ages newborn and older with hemophilia A (congenital factor VIII deficiency) without factor VIII inhibitors.

Updated Dosing for New Indication:

The recommended loading dose is 3 mg/kg by subcutaneous injection once weekly for the first 4 weeks, followed by a maintenance dose of: 1.5 mg/kg once every week, or 3 mg/kg once every two weeks, or 6 mg/kg once every four weeks.

Recommendation: No changes to formulary placement are recommended at this time. Prior authorization criteria should be updated to the following:

Pharmacy Benefit

- Medical record documentation of a diagnosis of hemophilia A (a documented Factor VIII deficiency) **AND**
- Medical record documentation that Hemlibra is being used for routine prophylaxis **AND**
- Medical record documentation that Hemlibra will be for outpatient use
- ~~Medical record documentation that member has clotting factor inhibitors (neutralizing antibodies), confirmed by laboratory testing (i.e., Bethesda assay)~~

Medical Benefit

- Medical record documentation of a diagnosis of hemophilia A (a documented Factor VIII deficiency) **AND**
- Medical record documentation that Hemlibra is being used for routine prophylaxis
- ~~Medical record documentation that member has clotting factor inhibitors (neutralizing antibodies), confirmed by laboratory testing (i.e., Bethesda assay)~~

Discussion: No comments or questions.

Outcome: Kevin Szczecina made a motion to accept the recommendations as presented. Todd Sponenberg seconded the motion. None were opposed.

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

UPDATES

VITRAKVI POLICY UPDATE

Recommendations: In order to clarify the policy criteria for the reviewer, the following updated language is recommended:

- Prescription written by or in consultation with an oncologist or hematologist AND
- Medical record documentation of unresectable or metastatic solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND
- One of the following:
    - *Medical record documentation that the member must have progressed following treatment OR*
    - *Member must have no satisfactory alternative treatments*

No changes to note, quantity limits, or authorization duration.

Discussion: No comments or questions.

Outcome: Kimberly Clark made a motion to accept the recommendations as presented. Tricia Heitzman seconded the motion. None were opposed.

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

ORILISSA POLICY UPDATE

Summary: At the September 2018 P&T meeting, the following criteria was approved for Orilissa:

- **For requests for the 200 mg strength:** Medical record documentation of a diagnosis of dyspareunia **AND**

After further review, the 200 mg strength can be used in patients with endometriosis-associated pain both with and without dyspareunia. However, if dyspareunia is present, only the 200 mg strength should be used.

Recommendations: It is recommended that the following changes be made to the current policy language for Orilissa:

Current:

- **For requests for the 200 mg strength:** Medical record documentation of a diagnosis of dyspareunia **AND**

Updated Language:

- **For patients with a diagnosis of dyspareunia:** Documentation that the request is for the 200 mg strength **AND**

Discussion: It was noted that the 150 mg strength did not demonstrate clinically significant effectiveness for patients with endometriosis associated pain with dyspareunia, but this dose is recommended for patients with moderate hepatic impairment. After a great deal of discussion, it was determined that it would be inappropriate to include this criterion as it would not allow for the use of the 150 mg strength

for patients with moderate hepatic impairment. Ultimately, this criterion in its entirety was struck from the policy.

Outcome: Tricia Heitzman made a motion to accept the recommendations as amended. Kevin Szczecina seconded the motion. None were opposed.

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

LUZU POLICY UPDATE

Recommendations: It is recommended that policy 1261.0F be updated to be used for Luliconazole (the generic) as it is currently created around brand Luzu. Additionally, it is recommended that luliconazole and Luza both be removed from the formulary.

The current policy (1261.0F) should be updated to be used for Luliconazole (the generic) and updated to mirror the FDA indication:

For Tinea corporis:

- Medical record documentation of a diagnosis of tinea corporis **AND**
- Medical record documentation of age greater than or equal to 2 years **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to clotrimazole, econazole, ketoconazole, over the counter terbinafine, over the counter tolnaftate, **AND** over the counter miconazole

OR

- If the member is between the ages of 2 and less than 18 years: Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to clotrimazole, OTC tolnaftate, **AND** OTC miconazole**.**

For Tinea pedis or Tinea cruris:

- Medical record documentation of a diagnosis or tinea pedis or tinea cruris **AND**
- Medical record documentation of age greater than or equal to 12 years **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to clotrimazole, econazole, ketoconazole, over the counter terbinafine, over the counter tolnaftate, **AND** over the counter miconazole

OR

- If member is between the ages of 12 and less than 18 years: Medical record documentation of therapeutic failure on, intolerance to, or contraindication to clotrimazole, over the counter terbinafine, over the counter tolnaftate, **AND** over the counter miconazole

AUTHORIZATION DURATION**:** 2 weeks

Discussion: No comments or questions.

Outcome: Tricia Heitzman made a motion to accept the recommendations as presented. Aubrielle Prater seconded the motion. None were opposed.

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

LOKELMA POLICY UPDATE

Summary: At the January P&T committee meeting, it was brought up that it is difficult to justify denying an agent for the treatment of chronic hyperkalemia in patients who present with a serum potassium level ≥6.5 mEq/L. Prior authorization language for Lokelma was instituted that states (amongst other criteria):

- Medical record documentation of a diagnosis of mild to moderate hyperkalemia (serum potassium greater than or equal to 5.1 mEq/L and less than 6.5 mEq/L).

Therefore, it was requested that an evidence review was completed that investigated the use of Lokelma in patients with serum potassium levels ≥6.5 mEq/L.

According to the Lokelma product label, patients in the HARMONIZE trial had serum potassium levels ranging from 5.1-7.4. However, these values, or the effects of Lokelma in patients with potassium levels ≥6.5 mEq/L could not be verified via the manufacturer, the manufacturer's dossier, or the published data from that trial. The HARMONIZE trial studied patients with potassium ≥5.1 mEq/L and treatment with Lokelma was halted if potassium levels >6.2 were observed at any time during the study.

A letter to the editor in the New England Journal of Medicine discussed a combined analysis that cited the HARMONIZE trial and one additional trial that included patients with potassium levels 5.0-6.5 mEq/L. From these two studies, a combined 45 patients were treated who had a baseline serum potassium level of ≥6.0 mEq/L (range, 6.1 to 7.2). However, the specific number of patients that were treated above 6.5 mEq/L was not specified and the mean serum potassium level at baseline was 6.3 mEq/L.

Finally, the Lokelma dossier also cites a poster presented at a 2016 conference that included patients with a serum potassium range of 4.3-7.6. However, the poster or even the abstract itself is not available.

Therefore, while an unknown number of patients in trials were treated with Lokelma who had a baseline serum potassium level ≥6.5 mEq/L, there is an absence of specifics from the trials, including results. Additionally, while there theoretically may be a therapeutic benefit in adding Lokelma to these patients' regimens, these patients are a high risk of cardiovascular complications and therefore should not be treated with chronic hyperkalemia agents, like Lokelma.

On the other hand, per the manufacturer, Lokelma is currently being investigated for use in conjunction with standard emergency treatment for patients with hyperkalemia. Additionally, Lokelma has a faster onset of action compared to Veltassa and can lower serum potassium levels by 0.4 mEq/L within 1 hour and by 0.8 mEq/L within 4 hours. Veltassa on the other hand, begins working after 7 hours and peaks at about 48 hours.

Recommendations: Given that Lokelma may be a better alternative to use in patients with more severe hyperkalemia (serum potassium levels above 6.5 mEq/L) compared to Veltassa, it is recommended that the following updates be made to existing criteria:

> **Current Language (GHP Family):** Medical record documentation of a diagnosis of mild to moderate hyperkalemia (serum potassium greater than or equal to 5.1 mEq/L and less than 6.5 mEq/L) **AND**
>
> **Recommended updated language:** Medical record documentation of a diagnosis of hyperkalemia **AND**

Discussion: No comments or questions.

Outcome: Tricia Heitzman made a motion to accept the recommendations as presented. Kevin Szczecina seconded the motion. None were opposed.

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

MEDICAL BENEFIT POLICY UPDATES

Recommendations: The following policy updates were made to the following Medical Benefit Policies based on recommendations from the Department of Human Services (DHS) during policy review submissions. The recommended policy changes were suggested and/or required for further policy approval from DHS. Additions to the policies are noted in bold italics, and removals of prior criteria are noted via strikethrough.

MBP 119.0 Keytruda (pembrolizumab)

It was noted that the indication for Keytruda for PMBCL is treatment of primary mediastinal large B-cell lymphoma (PMBCL) in adult and pediatric patients with refractory disease or who have relapsed after 2 or more prior lines of therapy. Criteria was corrected to reflect the correct indication.

Primary Mediastinal Large B-cell Lymphoma (PMBCL)

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation of refractory primary mediastinal large B-cell lymphoma (PMBCL) **OR** ~~**AND**~~
- Medical record documentation of relapse following two (2) prior lines of therapy

MBP 85.0 Cinryze (C1 esterase inhibitor, human)

Cinryze received an updated indication to include pediatric patients age 6 years and older. Criteria have been updated to reflect these changes. In addition, DHS noted that Hereditary Angioedema (HAE) is a fee for service grandfathered class. Grandfather language was added to this policy to reflect this.

DESCRIPTION:
Cinryze (C1 esterase inhibitor, human) is indicated for routine prophylaxis against angioedema attacks in ~~adult and adolescent~~ patients with Hereditary Angioedema.

CRITERIA FOR USE: Requires Prior Authorization by Medical Director or Designee

GRANDFATHER PROVISION – Members already established on therapy are eligible for approval as long as there is medical record documentation that the safety and effectiveness of use for the prescribed indication is supported by Food and Drug Administration (FDA) approval or adequate medical and scientific evidence in the medical literature

Cinryze (C1 esterase inhibitor, human) will be considered medically necessary for prophylaxis against attacks of hereditary angioedema ~~in adults and adolescents~~ when the following criteria are met:

- Member is **6** ~~13~~ years of age or older; **AND**
- Prescription is written by an allergist, immunologist, hematologist or dermatologist; **AND**
- Medication is being used as prophylactic therapy for HAE attacks; **AND**
- Diagnosis of hereditary angioedema has been established and supported by physician provided documentation of:
    - Recurrent, self-limiting non-inflammatory subcutaneous angioedema without urticaria, lasting more than 12 hours; or
    - Laryngeal edema; or
    - Recurrent, self-remitting abdominal pain lasting more than 6 hours, without clear organic etiology

AND

- the presence of specific abnormalities in complement proteins, in the setting of a suggestive clinical history of episodic angioedema without urticaria; supported by
    - Medical record documentation of 2 or more sets of complement studies, separated by one month or more, showing consistent results of
        - Low C4 levels and
        - Less than 50% of the lower limit of normal C1-INH antigenic protein levels OR
        - Less than 50% of the lower limit of normal C1-INH function levels

AND

- Physician provided documentation of failure on, intolerance to, or contraindication to danazol **AND**
- Physician provided documentation of history of more than one (1) severe event per month OR a history of laryngeal attacks

The following Medical Benefit policy changes were made during GHP annual policy review to better align with other similar polices of drugs in the same categories.

MBP 95.0 Erwinaze (asparaginase)

Erwinaze (asparaginase) will be considered medically necessary when all of the following criteria are met:

1. Diagnosis of acute lymphoblastic leukemia (ALL), in combination with other chemotherapeutic agents who have developed hypersensitivity to *E. coli*-derived asparaginase and pegaspargase. **AND**
2. Prescribed by a hematologist or oncologist.

MBP 102.0 Synribo (omacetaxine mepesuccinate)

Synribo (omacetaxine mepesuccinate) will be considered medically necessary when all of the following criteria are met:

1. Chronic Myeloid Leukemia (CML)
    - Prescribed by a hematologist/oncologist; and

- Physician documentation of chronic or accelerated phase chronic myeloid leukemia (CML); and
- Physician documentation of therapeutic failure on, intolerance to, or contraindication to two or more tyrosine kinase inhibitors (eg., Gleevec, Iclusig, Sprycel, Tasigna, or Bosulif)

AUTHORIZATION DURATION: Initial approval will be for ~~6~~ 12 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional ~~6~~ 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

Discussion: No comments or questions

Outcome: Keith Hunsicker made a motion to accept the recommendations as presented. Aubrielle Prater seconded the motion. None were opposed.

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

AIMOVIG, AJOVY, EMGALITY, AND BOTOX POLICY UPDATES

Summary: The current Aimovig, Emgality, and Ajovy policies have the following criteria:

- *"…Medical record documentation that (medication) will not be used in combination with botulinum toxin AND…"*

Reauthorization Criteria:

- *"…Medical record documentation that (medication) is not being used concurrently with botulinum toxin"*

Specialist Feedback: Sana Ghafoor, neurologist at Geisinger, feels that it would be clinically appropriate for patients to try CGRP antagonists and Botox individually prior to using them in combination. She feels that an appropriate treatment duration prior to considering failure on therapy would be 3 months for CGRP antagonists and 6 months for Botox. Mechanistically, she believes that the combination of the two products may increase efficacy.

Recommendations:

Aimovig, Emgality, Ajovy: Based on the specialist's feedback, it is recommended to update all the current CGRP antagonist policies for all lines of business to the following:

Prior Authorization:

- Prescription written by or in consultation with a neurologist or headache specialist **AND**
- Medical record documentation of patient age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of migraine with or without aura, based on the ICHD-III diagnostic criteria **AND**
- Medical record documentation of number of baseline migraine or headache days per month **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least three (3) of the following:
    - One (1) beta blocker (metoprolol, propranolol, timolol, atenolol, nadolol)
    - Topiramate
    - Divalproex/Sodium Valproate

- Amitriptyline
- Venlafaxine

AND

- Medical record documentation that (medication) will not be used in combination with botulinum toxin **OR**
- If the request is for use in combination with Botox, 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

Re-authorization Criteria:

- 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 (medication) is not being used concurrently with botulinum toxin **OR**
- If the request is for use in combination with Botox, 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

There will be no updates to authorization durations or quantity limits.

Botox: Based on the specialist's feedback, it is recommended to add the following criteria to the current Botox policies for "chronic migraine headache" for all lines of business.

- 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

Re-authorization Criteria:

- 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

Discussion: It was recommended to add "without the concomitant use" to the newly added criteria.

Outcome: Keith Hunsicker made a motion to accept the recommendations as amended. Tricia Heitzman seconded the motion. None were opposed.

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

GHP FAMILY FORMULARY UPDATE

Recommendations: It is recommended that Azelaic Acid 15% gel be added to the generic tier and Clenpiq be added to the brand tier.

Discussion: No comments or questions.

Outcome: Tricia Heitzman made a motion to accept the recommendations as presented. Rajneel Chohan seconded the motion. None were opposed.

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

GHP FAMILY POLICY UPDATE

Recommendations: It is recommended that following changes requested by DHS be approved by the Committee (additions underlined):

Hepatitis C Policies:

- Medical record documentation of a hepatitis C negative recipient receiving a transplant from a hepatitis C positive donor **AND**
- Medical record documentation of an appropriate dosing regimen and duration as determined through consultation with the prescriber.

Jynarque:

- Medical record documentation the member is at risk for rapidly progressing ADPKD as documented by one of the following:
    - Mayo classification class 1C, 1D, or 1E
    - Total Kidney Volume greater than or equal to 750 mL based on the inclusion criteria of the TEMPO 3:4 Trial
    - PROPKD score > 6
    - Kidney length > 16.5 cm as measured by ultrasound (if CT and MRI contraindicated)
    - Or other indicators of rapid disease progression supported by medical literature

Orkambi/Kalydeco:

Initial approval will be for four (4) months and subsequent approvals will be for twelve (12) months. Additional authorizations will require medical record documentation of improvement or stabilization in the signs and symptoms of cystic fibrosis or, based on the prescriber's assessment, the member continues to benefit from Orkambi/Kalydeco.

Discussion: No comments or questions.

Outcome: Rajneel Chohan made a motion to accept the recommendations as presented. Tricia Heitzman seconded the motion. None were opposed.

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

METAXALONE POLICY UPDATE

Recommendations: Metaxalone has no evidence of head-to-head trials to other medications. Four old trials against placebo exist, and are summarized by a 2004 review article, "The data on metaxalone…was mixed. The best fair-quality trial found no differences compared to placebo, but a poor-quality trial and two lesser quality trials reported some benefits compared to placebo using unvalidated outcome measures." Justin Troutman, Pain Pharmacist with Geisinger Health System, offered that spasticity and spasms have distinct etiologies (CNS origin versus acute/chronic trauma or muscle strain, respectively) and respond to different medications. NSAIDs and skeletal muscle relaxants are appropriate options depending on the patient's etiology. He reiterated that metaxalone has a limited role and a lack of evidence supporting its use aside from anecdotal evidence in specific patients. He reports never having used metaxalone because he has never found himself in a situation where all cheaper options have been exhausted. It is recommended that metaxalone be added to the generic tier of the GHP Family formulary requiring a prior authorization. The following criteria should be implemented:

- Documentation of patient age ≥ 13 years **AND**
- Medical record documentation of a diagnosis of an acute, painful musculoskeletal condition **AND**
- Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on three formulary NSAIDs and/or muscle relaxants

Authorization duration: 2 weeks

Quantity limit: 4 tablets per day

Discussion: No comments or questions.

Outcome: Tricia Heitzman made a motion to accept the recommendations as presented. Kevin Szczecina seconded the motion. None were opposed.

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

RESULTS OF ELECTRONIC VOTE

The following products were presented to the committee as an electronic vote in February of 2019. The below recommendations were approved by the P&T Committee on February 28, 2019 with 22 votes of approval.

Akynzeo for Injection

Akynzeo for Injection will be covered as a medical benefit requiring prior authorization. The following prior authorization criteria will apply:

- Medical record documentation that Akynzeo is being used for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy **AND**
- Medical record documentation of a treatment failure or contraindication to at least one NK-1 antagonist (e.g. fosaprepitant (Emend), aprepitant (Cinvanti), etc.). Treatment failure is defined as allergy, intolerable side-effects, significant drug-drug interaction, or lack of efficacy.

OR

- Medical record documentation that Akynzeo is being used for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy AND
- Medical record documentation of a treatment failure or contraindication to palonosetron (Aloxi) **AND** either ondansetron (Zofran) or granisetron (Kytril). Treatment failure is defined as allergy, intolerable side-effects, significant drug-drug interaction, or lack of efficacy.

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 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.

Note: The following antineoplastic agents are considered highly emetogenic (refer to NCCN for complete list):

- AC combination defined as any chemotherapy regimen that contains an anthracycline and cyclophosphamide
- Carboplatin
- Carmustine
- Cisplatin
- Cyclophosphamide at doses >1500 mg/m^2
- Dacarbazine
- Dactinomycin
- Daunorubicin
- Doxorubicin
- Epirubicin
- Ifosfamide
- Irinotecan
- Mechlorethamine
- Methotrexate at doses > 250mg/m^2
- Oxaliplatin
- Streptozocin
- Trabectedin

Cinvanti for Injection

Cinvanti for Injection will be covered as a medical benefit requiring prior authorization. The following prior authorization criteria will apply:

- Medical record documentation that Cinvanti is being used for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy; **OR**

- Medical record documentation that Cinvanti is being used for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy for insured individuals who have a treatment failure or contraindication to ondansetron (Zofran) or granisetron (Kytril). Treatment failure is defined as allergy, intolerable side-effects, significant drug-drug interaction, or lack of efficacy.

Note: The following antineoplastic agents are considered highly emetogenic (refer to NCCN for complete list):

- AC combination defined as any chemotherapy regimen that contains an anthracycline and cyclophosphamide
- Carboplatin
- Carmustine
- Cisplatin
- Cyclophosphamide at doses >1500 mg/m^2
- Dacarbazine
- Dactinomycin
- Daunorubicin
- Doxorubicin
- Epirubicin
- Ifosfamide
- Irinotecan
- Mechlorethamine
- Methotrexate at doses > 250mg/m^2
- Oxaliplatin
- Streptozocin
- Trabectedin

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 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.

Daurismo

Daurismo will be covered as a pharmacy benefit. Daurismo will be added to the Brand tier requiring prior authorization. The following prior authorization criteria will apply:

- Medical record documentation that Daurismo is prescribed by a hematologist/oncologist **AND**
- Medical record documentation of newly-diagnosed acute myeloid leukemia (AML) **AND**
- Medical record documentation of patient age 75 years or older **OR** medical record documentation of the presence of comorbidities that preclude use of intensive induction chemotherapy **AND**
- Medical record documentation that Daurismo is being used in combination with low-dose cytarabine

QUANTITY LIMIT: 100 mg – 1 tablet/day; 25 mg – 2 tablets/day

AUTHORIZATION DURATION: Initial approval will be for twelve (12) months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional twelve (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 the member experiences unacceptable toxicity or worsening of disease.

Venclexta

The Venclexta policy was updated as part of the Daurismo review as follows:

Current:

- Medical record documentation of age 75 years or older **AND**
- Medical record documentation of a comorbidity that precludes patient from receiving intensive induction chemotherapy

Updated:

- Medical record documentation of age 75 years or older **OR** medical record documentation of a comorbidity that precludes patient from receiving intensive induction chemotherapy

Nivestym
Nivestym will be a medical benefit or a pharmacy benefit on the brand tier requiring prior authorization. It is recommended that Nivestym be added to the existing Neupogen policies (Policy 902.0F and MBP 59.0) as outlined below:

Policy 902.0F
Neupogen, Neulasta, Fulphila, Nivestym, Zarxio, Granix and Leukine:

- **Medical record documentation of a diagnosis of cancer, and when any of the following FDA labeled indications or uses supported by clinical guidelines are present:**

Primary Prophylaxis: For the prevention of febrile neutropenia (FN) when the risk of FN due to the myelosuppressive chemotherapy regimen is 20% or greater. Those regimens include but are not limited to:

- TC (paclitaxel/cisplatin, or cyclophosphamide/docetaxel or docetaxel/cisplatin or paclitaxel/carboplatin)
- MVAC (methotrexate, vinblastine, doxorubicin, cisplatin)
- AC (doxorubicin, cyclophosphamide, docetaxel)
- AT (doxorubicin, paclitaxel)
- TIC (paclitaxel, ifosfamide, mesna, cisplatin)
- VAPEC-B (vincristine, doxorubicin, prednisolone, etoposide, cyclophosphamide, bleomycin)
- A(N)CVB (doxorubicin or mitoxantrone, cyclophosphamide, vindesine, bleomycin)
- DHAP (dexamethasone, cisplatin, cytarabine)

NOTE: Regimens not specified in this document must be listed on a nationally recognized guideline stating risk of FN of greater than 20%.

OR

For the prevention of FN when the risk of developing FN is less than 20%, but **any** other risk factor listed below is present:

- Age 65 years or greater
- Poor performance status
- Previous history of FN
- Extensive prior radiation or chemotherapy treatment
- Poor nutritional status
- Recent surgery or open wounds or active infection
- Advanced cancer
- Persistent neutropenia
- Bone marrow involvement by tumor
- Liver dysfunction (bilirubin >2.0)
- Renal dysfunction (CrCl <50)

Neupogen, Neulasta, Fulphila, Nivestym, Zarxio and Leukine: May also be considered medically necessary for any of the following:

Secondary Prophylaxis – prevention of FN when a previous cycle of chemotherapy resulted in a neutropenic complication and for which primary prophylaxis was not received, and a dose reduction will compromise disease-free or overall survival or treatment outcome.

Treatment of Febrile Neutropenia - as an adjunct to antibiotics in high-risk individuals with FN who are at high risk for infection related complications or when **any** of the following prognostic factors are documented:

- Age 65 years or greater

- Anticipated prolonged and profound neutropenia
- Uncontrolled primary disease
- Pneumonia
- Invasive fungal infection
- Hypotension
- Multi-organ dysfunction
- Hospitalized at the time of development of the fever

Dose Dense Therapy – specifically in the treatment of node positive breast cancer, small cell lung cancer, and diffuse aggressive non-Hodgkin's lymphoma.

Leukemia or Myelodysplastic Syndromes – insured individuals with:
- Acute myeloid leukemia (AML) receiving induction or consolidation chemotherapy
- Acute lymphoblastic leukemia (ALL) after completion of the first few days of chemotherapy of the initial induction or the first post-remission course
- Myelodysplastic syndrome with less than 15% blasts in the bone marrow, or recurrent neutropenic infections are experienced.

Lymphoma – Age 65 years or greater treated with curative chemotherapy, e.g., CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)

Radiation therapy –
- If prolonged delays secondary to neutropenia are anticipated.
- As treatment for radiation injury secondary to doses of 3-10 Grays (Gy) or greater
  Note: Fulphila is not indicated for Radiation Injury Syndrome

Stem Cell Transplantation- when one of the following is met:
- Bone Marrow Transplant (BMT)-
  - Documentation of a non-myeloid malignancy undergoing myeloablative chemotherapy followed by autologous or allogenic bone marrow transplant (G-CSF is given after BMT)

OR
- Peripheral Blood Progenitor Cell (Mobilization)Transplant (PBPC)
  - Used for mobilization of autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis. (G-CSF is given prior to and throughout leukaphersis)

Note: Neulasta is considered off-label for PBPC mobilization
Note: Fulphila is not indicated for PBPC mobilization

Neupogen, Nivestym, and Zarxio: May also be considered medically necessary for the following:

Severe Chronic Neutropenia – when the following criteria are met
- Diagnosis of Congenital, Cyclic, or Idiopathic Neutropenia AND
- Documentation of an Absolute Neutrophil Count (ANC) <500 cells/mm3 on three separate occasions during a 6 month period (for Congenital or Idiopathic Neutropenia) OR five consecutive days of ANC <500 cells/mm3 per cycle (for Cyclic Neutropenia) AND
- Documentation that the member experienced a clinically significant infection, fever, or oropharyngeal ulcer during the past 12 months.

Leukine:
Delayed Neutrophil Recovery or Graft Failure
- Medical record documentation that the member has had an allogeneic or autologous bone marrow transplant and neutrophil recovery* has not occurred.

*Note to reviewer: Neutrophil engraftment is defined as the first day of three consecutive days where the neutrophil count (ANC) is 500 cells/mm3 or greater.

EXCLUSIONS: There is insufficient evidence in the published, peer reviewed medical literature to clearly establish that the use of colony stimulating factors (CSF) improves the health outcomes in any of the following indications. The use of CSF's for the following indications is considered not medically necessary and are **NOT COVERED:**

- Routine use as prophylaxis on most chemotherapy regimens; or
- Use as prophylaxis during chemotherapy regimens with a febrile neutropenia risk of less than 20% and no high risk for complications; or
- Use in insured members who are neutropenic but afebrile and not meeting any of the above criteria; or
- Use as an adjunct to antibiotics in uncomplicated febrile neutropenia; or use in relapsed or refractory myeloid leukemia; or
- Use in chemo-sensitization of myeloid leukemias; or
- Use prior to or concurrent with chemotherapy for acute myeloid leukemia; or
- Use prior to or concurrently with chemotherapy for "priming" effect; or
- Use to allow an increase in the dose-intensity of cytotoxic chemotherapy beyond the established dose ranges for these regimens; or
- Use during concomitant chemotherapy and radiation therapy; or
- Continued use if no response is seen within 45 days.

Treatment period will be defined as 6 months, re-review will be required after that time.

Neulasta/Fulphila Quantity Limit: One (1) 6 mg dose per chemotherapy cycle

Perseris

Perseris will be covered as a medical benefit requiring prior authorization. Perseris will be added to the existing medical benefit Injectable Antipsychotics Policy, MBP 106.0:

- 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 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
- 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.

GRANDFATHER PROVISION – Members already established on therapy are eligible for approval as long as there is medical record documentation that the safety and effectiveness of use for the prescribed indication is supported by Food and Drug Administration (FDA) approval or adequate medical and scientific evidence in the medical literature.

LIMITATIONS:

The following quantity limits should apply (please enter claims payment note, when entering authorization)

- Abilify Maintena – One syringe or vial per 28 days
- Aristada – One syringe per 28 days (441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml strength), one syringe per 56 days (1064mg/3.9ml strength)
- Aristada Initio – Enter claims payment note as follows:
    - Aristada Initio – Rx Count of 1, quantity limit of 2.4mL (one syringe) per 28 days
    - Aristada – Open-ended authorization with quantity limit: One syringe per 28 days (441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml strength), one syringe per 56 days (1064mg/3.9ml strength)
- Invega Sustenna –two syringes per 1 week, then one syringe per 28 days thereafter
  Enter claims payment note as follows to account for loading dose in the first week:
  - Rx Count of 1 approved by GPID for 234 mg, quantity limit 1
  - Rx Count of 1 approved by GPID for 156 mg, quantity limit 1
  - Open-ended authorization for quantity limit 1 syringe per month, request to be approved by GPID for the prescribed strength.
- Invega Trinza – One syringe per 84 days (3 months)
- Perseris- One syringe kit per 28 days
- Risperdal Consta – Two vials per 28 days
- Zyprexa Relprevv – Two vials per 28 days

Note: PA is not required for inpatient or ER use for any of these medications.

Note: Only members with documented adherence issues will be eligible for medications delivered via injection

Note: The FDA approved dosing of induction into treatment with Aristada includes oral aripiprazole, Aristada Initio and Aristada (outlined below) and it is appropriate for the member to receive all the mentioned products over the course of one month for treatment initiation.

- One 30mg dose of oral aripiprazole (given on Day 1)
- One 675mg dose of Aristada Initio (given on Day 1)
- One (first) dose of Aristada (441mg, 662mg, 882mg, or 1064mg) (given on Day 1 or up to 10 days after the dose of Aristada Initio)

AUTHORIZATION DURATION:
For Aristada Initio: Approval will be for a one-time fill/visit (authorization duration of 1 month) of Aristada Initio AND a lifetime authorization of Aristada will also be entered.

All other approvals will be made for a lifetime authorization of the specific approved injectable.

Vitrakvi

Vitrakvi will be covered as a pharmacy benefit. Vitrakvi will be added to the brand tier requiring prior authorization. The following prior authorization criteria will apply:

- Prescription written by or in consultation with an oncologist or hematologist AND
- Medical record documentation of unresectable or metastatic solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation AND
- Medical record documentation that the member must have progressed following treatment or have no satisfactory alternative treatments

NOTE: There is currently no FDA-approved test for the detection of NTRK gene fusions. Testing can currently be completed via next-generation sequencing (NGS) assay and fluorescence in situ hybridization (FISH).

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 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 the member experiences unacceptable toxicity or worsening of disease.

QUANTITY LIMIT: Pharmacist note to CSR: Authorization should be entered by HICL and only checking the Formulary PA required box (no QLs need to be entered within the authorization).

25 mg capsule: 6 capsules per day
100 mg capsule: 2 capsules per day
20 mg/mL solution: 10 mL per day

Xospata

Xospata will be covered as a pharmacy benefit. Xospata will be added to the brand tier requiring prior authorization. The following prior authorization criteria will apply:

- Medical record documentation that Xospata is prescribed by a hematologist/oncologist **AND**
- Medical record documentation of a diagnosis of relapsed or refractory acute myeloid leukemia (AML) **AND**
- Medical record documentation of a FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA-approved test **AND**
- Medical record documentation that the patient is 18 years of age or older

AUTHORIZATION DURATION: Initial approval will be for twelve (12) months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional twelve (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 the member experiences unacceptable toxicity or worsening of disease.

NOTE: Information regarding the FDA approved test for FLT3 mutations can be found at: https://www.accessdata.fda.gov/cdrh_docs/pdf16/P160040C.pdf

Actemra SC for SJIA

There are no changes to formulary status at this time. However, it is recommended that the following prior authorization criteria be added to the Actemra subcutaneous policy.

Active systemic juvenile idiopathic arthritis (SJIA)

- Medical record documentation that member is 2 years of age or greater **AND**
- Prescription is written by a rheumatologist **AND**
- Medical record documentation of a diagnosis active systemic juvenile idiopathic arthritis **AND**
- Medical record documentation that medication is not being used concurrently with a TNF blocker or other biologic agent.

AUTHORIZATION DURATION:

Approval will be given for an initial duration of six (6) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in signs and symptoms of SJIA on six (6) months of Actemra is required.

After the initial six (6) month approval, subsequent approvals for coverage will be for a duration of one (1) year. Reevaluation of coverage will be every one (1) year requiring medical record documentation of continued or sustained improvement in the signs and symptoms of SJIA while on Actemra therapy.

QUANTITY LIMIT: 3.6 mL per 28 days

Other Recommendations

Per the labeling, Actemra has not been studied in combination with biological DMARDs such as TNF antagonists, IL-1R antagonists, anti-CD20 monoclonal antibodies and selective co-stimulation modulators because of the possibility of increased immunosuppression and increased risk of infection. Actemra should be avoided with biological DMARDs. Therefore, it is recommended to add the following language as indicated:

- GHP Family Policy 1251.0F - PJIA and Giant Cell Arteritis Indications:
    - Medical record documentation that medication is not being used concurrently with a TNF blocker or other biologic agent.

Actemra is available as 162 mg/0.9 mL syringe and billed per mL, so it is recommended to update the quantity limits to the following for GHP Family:

- **RA:** 3.6 mL per 28 days
- **PJIA:** 1.8 mL per 28 days
- **GCA:** 3.6 mL per 28 days

Envarsus XR for *de novo* Kidney Transplant

No changes to formulary placement of Envarsus XR are recommended, however, the prior authorization criteria should be updated as follows to include the new indication for *de novo* kidney transplant:

- Medical record documentation that Envarsus XR is prescribed by a physician experienced in immunosuppressive therapy and management of transplant patients **AND**
- Medical record documentation of kidney transplant **AND**
- Medical record documentation of age greater than or equal to 16 years **AND**
- Medical record documentation of one of the following:
    - Appropriate conversion from immediate-release tacrolimus (using 80% of pre-conversion daily dose of tacrolimus immediate release) **OR**
    - Use for *de novo* kidney transplant

  AND
- Medical record documentation of rationale for not using Astagraf XL if clinically appropriate

Mulpleta/Doptelet Policy Update

It is recommended that the criterion pertaining to specialist prescribing be updated to:

- Medical record documentation that the prescription for Doptelet is written by or in consultation with a hematologist, gastroenterologist, hepatologist, immunologist, transplant specialist, interventional radiologist or endocrinologist

Zortress Policy Update

Kidney Transplant:

- Medical record documentation that Zortress is prescribed by a physician experienced in immunosuppressive therapy and management of transplant patients **AND**
- Medical record documentation that member received a kidney transplant **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of one of the following:
    - Zortress is being administered in combination with basiliximab (Simulect) induction and concurrently with reduced doses of cyclosporine and corticosteroids **OR**
    - Member has had therapeutic failure on, contraindication to, or intolerance to calcineurin inhibitors

OR

Liver Transplant:

- Medical record documentation that Zortress is prescribed by a physician experienced in immunosuppressive therapy and management of transplant patients **AND**
- Medical record documentation that member received a liver transplant **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Zortress is being administered no earlier than 30 days post-transplant **AND**
- Medical record documentation of one of the following:
    - Zortress is being administered in combination with low-dose tacrolimus and corticosteroids **OR**
    - Medical record documentation that member has had a prior therapeutic failure on, intolerance to, or contraindication to calcineurin inhibitors

Notes to Reviewer:

- Zortress (and other mTOR inhibitors) should not be administered any sooner than 30 days after liver transplant due to risk of hepatic artery thrombosis in the early post-transplantation period.
- The use of corticosteroids beyond the first week post-transplant is controversial and varies between treatment centers. The 2009 KDIGO guidelines recommend for kidney transplant patients at low immunogenic risk and who receive induction therapy, to discontinue prednisone during the first week post-transplant.

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

Meeting adjourned at 4:22 pm.

Future Scheduled Meetings

The next bi-monthly scheduled meeting will be held on Tuesday, May 21, 2019 at 1:00 HCN3A & 3B Conference room

All of these meetings are scheduled to be held at Geisinger Health Plan, Hughes Center North and South Buildings; 108 Woodbine Lane; Danville, PA 17821.