

**P&T Committee Meeting Minutes
GHP Family
September 18, 2018**

<p>Present: Bret Yarczower, MD, MBA – Chair Kenneth Bertka, MD – via phone Holly Bones, PharmD – via phone Kim Castelnovo, RPh – via phone Rajneel Chohan Pharm.D. Kimberly Clark, PharmD Kristi Clarke, PharmD, MHA – via phone Tricia Heitzman, Pharm.D. Jason Howay, Pharm.D. – via phone Keith Hunsicker, Pharm.D. Kelli Hunsicker, Pharm.D. – via phone Steven Kheloussi, PharmD – via phone Perry Meadows, MD – via phone Aubrielle Prater Pharm.D. Kristen Scheib, Pharm. D. – via phone William Seavey, Pharm.D. – via phone Richard Silbert, MD – via phone Kelly Sones, pharmacy student Michael Spishock, RPh – via phone Todd Sponenberg, Pharm.D. Jill Stone, Pharm.D. Kevin Szczecina, RPh Lori Zaleski, RPh – via phone</p>	<p>Absent: Kristen Bender, PharmD Beverly Blaisure, MD Dean Christian, MD Alyssa Cilia, RPh Michael Evans, RPh Patrick Ferguson, RPh, MBA Sandra Garrett, RPh, MBA Phillip Krebs, R.EEG T. Jamie Miller, RPh Stephen Moscello, RPh Jonas Pearson, RPh Ginnetta Reed</p>
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Call to Order:

Dr. Bret Yarczower called the meeting to order at 1:03 p.m., Tuesday, September 18, 2018.

Review and Approval of Minutes:

Dr. Bret Yarczower asked for a motion or approval to accept the July 17, 2018 minutes as written. Tricia Heitzman accepted the motion and Kevin Szczecina seconded the motion. None were opposed.

DRUG REVIEWS

LUCEMYRA (lofexidine)

Review: Lucemyra (lofexidine) is a central alpha-2 adrenergic agonist and is the first FDA-approved non-opioid for the treatment of opioid withdrawal symptoms in adults who need to rapidly discontinue an opioid. It is approved for use for up to 14 days. Lucemyra is available as a 0.18 mg tablet. The recommended Lucemyra starting dosage is three 0.18 mg tablets taken orally four times daily during the period of peak withdrawal symptoms (generally the first 5 to 7 days following last use of opioid) with dosing guided by symptoms and side effects. The maximum daily dose is 16 tablets (4 tablets four times daily). The most common adverse effects seen are orthostatic hypotension, bradycardia, and hypotension. Lucemyra is currently only approved for adults and has not yet been studied in pediatrics. Through clinical studies it has been determined that lofexidine demonstrated efficacy for some opioid withdrawal symptoms but may not alleviate all symptoms and was commonly used in combination with a variety of prescription and over-the-counter medications. Less than half of the patients in the two placebo-controlled trials completed the studies. Clonidine is used off-label for this indication and has been compared head-to-head with Lucemyra. No significant difference in efficacy were noted, though patients on clonidine experienced more hypotension than those treated with Lucemyra. Guidelines and expert consensus support the use of clonidine as an adjunctive medication to treat the symptoms of withdrawal.

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. Tricia Heitzman made a motion to accept the criteria as written. Kevin Szczecina seconded the motion. None were opposed.

Financial Discussion: Dr. Silbert made a comment that he has used clonidine for this for 20 years. No questions or comments. Kim Clark made a motion to accept the criteria as written. Todd Sponenberg seconded the motion. None were opposed.

Outcome: For Medicaid, Lucemyra will be a pharmacy benefit and will not be added to the GHP Family formulary. The following prior authorization criteria should apply:

- Medical record documentation of a diagnosis of use to mitigate opioid withdrawal symptoms in patients abruptly discontinuing opioids **AND**
- Medical record documentation of a Clinical Opiate Withdrawal Scale (COWS) score greater than or equal to 5 **AND**
- Documentation that patient is at least 18 years of age **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to clonidine

Authorization duration, quantity limit: Rx count of 2, max 7 day supply, QL of 16 tabs per day

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

FIRVANQ (vancomycin hydrochloride)

Review: Firvanq is indicated in adult and pediatric patients for the treatment of *Clostridium difficile*-associated diarrhea and enterocolitis caused by *Staphylococcus aureus* (including methicillin-resistant strains). Firvanq is the only FDA-approved vancomycin hydrochloride for oral solution. CutisPharma is also the manufacturer of First Vancomycin, which was discontinued April 2, 2018. Firvanq is supplied as kits and each kit contains vancomycin powder for oral solution, equivalent to 3.75 g, 7.5 g, 10.5 g, or 15 g vancomycin, and grape flavored diluent. Firvanq powder must be reconstituted by the healthcare provider (i.e., a pharmacist) to produce an oral solution. The recommended dose for adults with *C. difficile*-associated diarrhea is 125 mg administered orally 4 times daily for 10 days. The recommended dose for adults with Staphylococcal enterocolitis is 500 mg to 2 g per day administered orally in 3 to 4 divided doses for 7 to 10 days. The recommended dose for both indications in pediatric patients is 40mg/kg/day in 3 or 4 divided doses for 7 to 10 days. The total dose should not exceed 2 g. There were no additional clinical trials for the approval of this product. Firvanq shares the same contraindications, warnings and precautions, and adverse reactions as vancomycin. Per IDSA/SHEA 2017 update, vancomycin or fidaxomicin is recommended over metronidazole for initial episode of *C. difficile* in adults. For children, either metronidazole or vancomycin is recommended for the treatment of children with an initial episode or first recurrence of nonsevere *C. difficile*. For children with an initial episode of severe *C. difficile*, oral vancomycin is recommended over metronidazole. Vancomycin is recommended for the treatment of suspected or proven intra-abdominal infection due to MRSA.

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. Kim Clark made a motion to accept the recommendations as presented. Todd Sponenberg seconded the motion. None were opposed.

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

Outcome: For Medicaid, Firvanq will be a pharmacy benefit. It is recommended that Firvanq be added to the GHP Family formulary at the Brand tier.

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

Xhance (fluticasone propionate)

Review: Xhance is indicated for the treatment of nasal polyps in patients 18 years and older. Nasal polyps require testing via rhinoscopy or nasal endoscopy in order to confirm a diagnosis. Xhance is a more potent version of Flonase, with the same active ingredient (fluticasone propionate) in a larger dose per spray. Xhance is supplied in a metered-dose manual spray pump with flexible mouthpiece (**Figure 1**), which is more cumbersome than other intranasal steroids indicated for nasal polyps which use just a metered pump spray. In patients using Xhance to treat nasal polyps, warnings are similar to those seen with other intranasal corticosteroids, and adverse events including epistaxis, nasopharyngitis, nasal septal ulceration, nasal congestion, acute sinusitis, headache, pharyngitis, nasal mucosal ulceration, nasal mucosal erythema, and nasal septal erythema were reported in greater than 3% of patients.

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

Clinical Discussion: No comments or questions. Kevin Szczecina made a motion to accept the recommendations as written. Keith Hunsicker seconded the motion. None were opposed

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

Outcome: For Medicaid, Xhance is a pharmacy benefit and should not be added to the GHP Family formulary. The criteria below should apply to requests for Xhance:

- Medical record documentation that member is at least 18 years of age **AND**
- Medical record documentation of diagnosis of nasal polyps **AND**
- Medical record documentation of failure on, contraindication to, or intolerance to mometasone furoate

Additional Formulary recommendations:

It is recommended that mometasone nasal spray is added to generic tier of the GHP Family formulary not requiring prior authorization. Additionally, the prior authorization criteria for Beconase AQ (1092.0F) should be updated to:

Medical record documentation that the member is being treated for the prevention of nasal polyps **AND** medical record documentation of a therapeutic failure on, intolerance to, or contraindication to mometasone nasal spray.

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

ZYPITAMAG (pitavastatin magnesium)

Review: Zypitamag (pitavastatin magnesium) is an HMG-CoA reductase inhibitor, approved for patients with primary hyperlipidemia or mixed dyslipidemia. Zypitamag (pitavastatin magnesium) does not differ clinically from Livalo (pitavastatin calcium). Zypitamag is available as a 1 mg, 2 mg, and 4 mg tablet. Pitavastatin 2 mg and 4 mg are considered moderate-intensity statin doses, which according to the 2013 ACC/AHA guidelines, should be used in patients who are unable to take high-intensity statin therapy. Pitavastatin does not currently carry an FDA approval for primary prevention of CV disease, unlike other drugs in its class (atorvastatin, lovastatin, pravastatin, and rosuvastatin). Pitavastatin also lacks FDA approval for secondary prevention of CV events, which all other drugs in its class have (atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, and simvastatin).

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. Todd Sponenberg made a motion to accept the recommendations as written. Keith Hunsicker seconded the motion. None were opposed

Financial Discussion: No comments or questions. Kim Clark made a motion to accept the recommendations as written. Rajneel Chohan seconded the motion. None were opposed

Outcome: For Medicaid, Zypitamag is a pharmacy benefit and it is recommended that Zypitamag not be added to the GHP Family formulary. Requests for coverage will require the following:

- Medical record documentation of intolerance to, contraindication to, or therapeutic failure (including up-to-date laboratory values) to reach goal LDL (per NCEP guidelines) after titration to tolerated doses of atorvastatin and rosuvastatin.

Additional formulary recommendation:

The following update should be made to the Livalo policy (1167.0F) – update in **bold** below:

- Medical record documentation of intolerance to, contraindication to, or therapeutic failure (including up-to-date laboratory values) to reach goal LDL (per NCEP guidelines) after titration to tolerated doses of simvastatin, **rosuvastatin**, and atorvastatin.

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

RHOPRESSA (netarsudil)

Review: Rhopressa (netarsudil ophthalmic solution) 0.02% is a Rho kinase inhibitor indicated for the reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension. Rhopressa is a rho kinase inhibitor, which is believed to reduce IOP by increasing the outflow of aqueous humor through the trabecular meshwork route. The exact mechanism is unknown. The dose is one drop into the affected eye(s) once daily in the evening. If one dose is missed, treatment should continue with the next dose in the evening. Twice a day dosing is not well tolerated and is not recommended. If Rhopressa is to be used concomitantly with other topical ophthalmic drug products to lower IOP, administer each drug product at least 5 minutes apart. The product comes as an ophthalmic solution containing 0.2 mg/mL of Rhopressa. The product contains a warning for there have been reports of bacterial keratitis associated with the use of multiple-dose containers of topical ophthalmic products. These containers had been inadvertently contaminated by patients who, in most cases, had a concurrent corneal disease or a disruption of the ocular epithelial surface. Contact lenses should be removed prior to instillation of Rhopressa and may be reinserted 15 minutes following its administration.

Rhopressa 0.02% was evaluated in three randomized and controlled clinical trials, namely AR-13324- CS301 (NCT 02207491, referred to as Study 301), AR-13324-CS302 (NCT 02207621, referred to as Study 302), and AR-13324-CS304 (NCT 02558374, referred to as Study 304), in patients with open-angle glaucoma or ocular hypertension. Studies 301 and 302 enrolled subjects with baseline IOP lower than 27. mmHg and Study 304 enrolled subjects with baseline IOP lower than 30 mmHg. The treatment duration was 3 months in Study 301, 12 months in Study 302, and 6 months in Study 304.

The three studies demonstrated up to 5 mmHg reductions in IOP for subjects treated with Rhopressa 0.02% once daily in the evening. For patients with baseline IOP < 25 mmHg, the IOP reductions with Rhopressa 0.02% dosed once daily were similar to those with timolol 0.5% dosed twice daily (see Table 1). For patients with baseline IOP equal to or above 25 mmHg, however, Rhopressa 0.02% resulted in smaller mean IOP reductions at the morning time points than timolol 0.5% for study visits on Days 43 and 90; the difference in mean IOP reduction between the two treatment groups was as high as 3 mmHg, favoring timolol.

The most common ocular adverse reaction observed in controlled clinical studies with Rhopressa dosed once daily was conjunctival hyperemia which was reported in 53% of patients. Other common (approximately 20%) ocular

adverse reactions reported were: corneal verticillata, instillation site pain, and conjunctival hemorrhage. Instillation site erythema, corneal staining, blurred vision, increased lacrimation, erythema of eyelid, and reduced visual acuity were reported in 5-10% of patients. Corneal verticillata occurred in approximately 20% of the patients in controlled clinical studies. The corneal verticillata seen in Rhopressa-treated patients were first noted at 4 weeks of daily dosing. This reaction did not result in any apparent visual functional changes in patients. Most corneal verticillata resolved upon discontinuation of 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. Keith Hunsicker made a motion to accept the recommendations as written. Tricia Heitzman seconded the motion. None were opposed

Financial Discussion: There was discussion regarding requiring failure of multiple prostaglandin analogs, or a prostaglandin analog and an agent with a different mechanism of action (i.e. Beta blocker). Keith Hunsicker make a motion to amend the recommendations to require failure on three (3) formulary alternatives, one of which must be a prostaglandin analog eye drop. Aubrielle Prater seconded the motion. None were opposed

Outcome: For Medicaid, Rhopressa will be a pharmacy benefit. It is recommended that Rhopressa not be added to the formulary at this time. Request for coverage will require the following:

- Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on three (3) formulary alternatives, one of which must be a prostaglandin analog eye drop.

Quantity Limit: 0.17 mLs per day (5 mLs-2 bottles for a 30-day supply) – set at max dose

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

CRYSVITA (burosumab-twza)

Review: Crysvida is the only drug in its class and the first biologic treatment approved for X-linked hypophosphatemia (XLH) in patients 1 year of age and older. XLH is a genetic disorder causing renal phosphorus wasting, requiring a reduced TmP/GFR ratio and a reduced plasma concentration of vitamin D for diagnosis. Reduced vitamin D levels can be seen both in reduced 25-hydroxyvitamin D [25(OH)D] and 1,25-dihydroxycholecalciferol (1,25-DHCC) levels. However, genetic testing for a mutation in the PHEX gene can also confirm a diagnosis. The only other drug indicated for XLH is ergocalciferol, which is not sufficient to treat the disease as monotherapy. In all clinical trials, Crysvida demonstrated ability to increase serum phosphorus levels in both adults and children over the age of 2. It is available as a subcutaneous injection to be administered by a health care professional. Adults should receive their dose once every 4 weeks, while pediatric patients are dosed every 2 weeks. Prior to each administration, serum phosphorus levels must be drawn to determine if receiving Crysvida is still appropriate and at what dose. Notably, while Crysvida has no known drug interactions, vitamin D analogs and phosphate supplements were to be discontinued prior to the trials. Crysvida also has no renal or hepatic toxicities associated with it. In clinical trials pediatric patients receiving Crysvida reported side effects of headache, injection site reaction, vomiting, pyrexia, pain in extremity, and vitamin D decreased. Adult patients receiving Crysvida during clinical trials reported side effects of back pain, headache, tooth infection, restless leg syndrome, vitamin D decreased, dizziness, constipation, and blood phosphorus increased.

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: Holly Bones commented that required REMS program (UltraCare program) is labor intensive. Tricia Heitzman commented that the manufacturer may be pursuing a labeling change which would not require administration of medication in a healthcare setting. Kevin Szczecina made a motion to accept the recommendations as written. Keith Hunsicker seconded the motion. None were opposed

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

Outcome: For Medicaid, Crysvida will be a medical benefit. It will not be added to the pharmacy formulary. Requests for coverage will require the following:

- Medical record documentation that the patient is at least 1 year of age or older **AND**
 - Medical record documentation that Crysvida is being prescribed by, or in consultation with, an endocrinologist, geneticist, or nephrologist **AND**
 - Medical record documentation of a diagnosis of X-linked hypophosphatemia as evidenced by one of the following:
 - o Reduced TmP/GFR ratio **AND** Reduced plasma concentration of 1,25-dihydroxycholecalciferol (1,25-DHCC) or 25-hydroxyvitamin D [25(OH)D] **OR**
 - o Genetic testing confirming a mutation in the PHEX (Phosphate regulating Endopeptidase on the X chromosome) gene
- AND**
- Medical record documentation that the patient is not concurrently using vitamin D analogs or phosphate supplements.

Auth duration: 6 months initially, every 12 months thereafter

Reauthorization Criteria:

- Medical record documentation that patient is being followed regularly by and receiving medication from an endocrinologist or nephrologist **AND**
- Medical record documentation that Crysvida is improving patient's disease as evidenced by normalized or improved serum phosphorus levels **AND**
- Medical record documentation that the patient is not concurrently using Vitamin D analogs or phosphate supplements.

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

TAVALISSE (fostamatinib)

Review: Tavalisse is indicated for the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia (cITP) who have had an insufficient response to a previous treatment. Unlike many hematologic conditions, the treatment of the average cITP patient is generally not targeted at reaching a particular platelet count, but rather, at determining if the patient is stable at current platelet levels with regards to bleeding. Like many

autoimmune conditions, ITP is prone to both disease flares and spontaneous remission, with or without treatment. Platelets for ITP tend to be functional and bleeding is rare even in patients with severe thrombocytopenia. Tavalisse inhibits spleen tyrosine kinase (SYK). SYK is a protein implicated in macrophage recognition and antibody-bound platelet phagocytosis. Macrophages in the spleen are the primary route of platelet destruction, although macrophages throughout the body may also utilize this pathway. A number of first-line treatments exist for cITP, including corticosteroids, IVIG, and anti-D factor. Tavalisse provides a treatment option for patients who have failed to garner a sufficient therapeutic response to previous treatments. At this time, it is unclear if patients who have had a splenectomy will be more or less responsive to treatment with Tavalisse.

The starting dose of Tavalisse is 100 mg taken orally twice daily. After one month, if platelet count has not increased to at least $50 \times 10^9/L$, Tavalisse can be increased to 150 mg twice daily. The lowest dose of Tavalisse should be used to achieve and maintain a platelet count at least $50 \times 10^9/L$ as necessary to reduce the risk of bleeding. Tavalisse should be discontinued if the platelet count does not increase to a level sufficient to avoid clinically important bleeding after 12 weeks of treatment. Tavalisse is supplied in 100 mg and 150 mg tablets.

Tavalisse was studied in two double-blind placebo-controlled efficacy and safety studies (FIT-1 and FIT-2), and in an open-label extension study (FIT-3). In FIT-1 and 2, a total of 150 patients with persistent or cITP who had an insufficient response to previous treatment (corticosteroids, immunoglobulins, splenectomy, and/or a thrombopoietin receptor agonists) were randomized to Tavalisse or placebo for 24 weeks. Stable concurrent ITP therapy (glucocorticoids [< 20 mg prednisone equivalent per day], azathioprine, or danazol) was allowed, and rescue therapy was permitted, if needed. Most patients were treated corticosteroids (93%), immunoglobulins (53%), and thrombopoietin receptor agonists (48%). Most patients had chronic ITP (93%) and 35% had a splenectomy. At baseline, the median platelet count was $16 \times 10^9/L$ (with almost half [45%] less than $15 \times 10^9/L$). In order to be included in the clinical trial, the average platelet count was $< 30,000/\text{microL}$ and not greater than 35,000 unless as a result of rescue therapy from at least 3 qualifying counts. In the FIT-1 study, a significantly larger proportion of patients in the Tavalisse group had stable platelet response (at least $50 \times 10^9/L$ on at least 4 of the 6 visits between Weeks 14 to 24) compared to placebo. This was also the case for the FIT-2 trial, however this trial did not achieve statistical significance. The rate of bleeding events in both arms was also addressed, all severe events led to hospitalizations and no qualifier for statistical significance, however there was a trend towards less bleeds with Tavalisse use. Of those who achieved a stable response in FIT-1, FIT-2, and FIT-3, 64% maintained a platelet count of at least $50 \times 10^9/L$ for 12 months or longer.

There are no black box warnings or contraindications associated with the use of Tavalisse. The most common adverse reactions (incidence $\geq 5\%$) are diarrhea, hypertension, nausea, respiratory infection, dizziness, ALT/AST increased, rash, abdominal pain, fatigue, chest pain and neutropenia. Tavalisse also has warnings and precautions for hypertension (including hypertensive crisis), hepatotoxicity, diarrhea, neutropenia, and embryo-fetal toxicity. Tavalisse can cause fetal harm when administered to a pregnant woman. Women should use effective contraception during treatment and for at least 1 month after the last dose of Tavalisse. Due to animal studies, women should not breastfeed during treatment and for at least 1 month after the last dose. The safety and effectiveness have not been established in pediatric patients.

For patients with new diagnosis of ITP and platelet count $< 20,000/\text{microL}$, ITP-specific therapy is recommended, even in the absence of bleeds. Some patients with platelet counts between 20,000 and 30,000/ microL may be managed with just observation and close monitoring. If severe bleeding occurs, therapy can be administered. Patients with platelet count $> 30,000/\text{microL}$ may require treatment if they have an increased risk of bleeds (e.g. peptic ulcer disease, high fall risk, use of anticoagulants, surgery). Per UpToDate, for patients who continue to have platelet counts $< 20,000/\text{microL}$ or bleeding symptoms despite treatment, additional therapies can be tried. Once treatment(s) have been tried, patients can be observed with platelet counts $> 20,000/\text{microL}$ and no bleeding.

When observation is not merited (due to frank bleeding or when prophylaxis is required), first-line therapies for cITP include corticosteroids, intravenous immune globulin (IVIG), and anti-D factor (in Rh-positive patients who are not already asplenic). Once first-line therapies have been exhausted or ruled out, second-line therapies may be considered. Splenectomy is considered one of the strongest treatment modalities in terms of strength and durability of response, though the palatability of surgery and potential immune deficiency is often a strong detractor for patients and physicians evaluating options. Furthermore, it is still not a guaranteed cure, and septicemia is a distinct

hazard of the procedure. Other options include the use of thrombopoietin analogs/mimetics, such as (Promacta and Nplate), as well as Rituxan (rituximab) separately or concurrently (for patients who have failed to respond to splenectomy). IVIG can raise platelet count more rapidly than glucocorticoids, with effects lasting 2-6 weeks, and is most useful for those unable to tolerate glucocorticoids or waiting second line therapy. Promacta and Nplate are maintenance therapy and do not induce remission. Tavalisse is expected to also be a maintenance treatment.

Jenna Carmichael, BCOP, mentioned that it is very difficult to get patients to agree to a splenectomy. Usually providers reserve splenectomy after Promacta/Nplate. Patients with cITP are commonly treated when their platelet counts are 20,000/microL or less. However, when to treat and re-treat is very patient specific. For example, she has a patient with platelets persistently < 50,000/microL despite Promacta and the team is recommending a splenectomy. She has not seen much in practice in terms of clinically significant bleeds, typically, patients have a history of bleeds or never bled. The most common treatment algorithm at Geisinger includes corticosteroids/IVIG, Rituxan, Promacta/Nplate, then splenectomy (in that order).

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: A comment was made that although splenectomy appears in the guidelines, it does not appear to be routinely utilized in clinical practice. Rajneel Chohan made a motion to accept the recommendations as written. Kevin Szczecina seconded the motion. None were opposed.

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

Outcome: For Medicaid, Tavalisse will be a pharmacy benefit. It is recommended that Tavalisse not be added to the GHP Family formulary. The following prior authorization criteria should apply.

- Medical record documentation that Tavalisse is prescribed by or in consultation with a hematologist AND
- Medical record documentation of patient age greater than or equal to 18 years AND
- Medical record documentation of a diagnosis of chronic immune thrombocytopenia (cITP) AND
- Medical record documentation symptomatic ITP with bleeding symptoms and platelet count <30,000/microL OR a platelet count of < 20,000/microL and an increased risk of bleeding AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to two (2) of the following:
 - Corticosteroids
 - IVIG*
 - Rhogam (if RhD-positive and spleen intact)
 - Rituxan*
 - Splenectomy
 - Promacta*/Nplate*

Authorization Duration: Initial approval will be for three (3) months and subsequent approvals will be for twelve (12) months.

Reauthorization Criteria:

- Medical record documentation of platelet count \geq 50,000/microL and continued or sustained reduction in bleeding events.

Quantity Limit: 60 tablets per 30 days

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

BRAFTOVI (encorafenib)

Review: Braftovi is a BRAF kinase inhibitor indicated for use in combination with binimetinib (Mektovi) for metastatic or nonresectable melanoma with a BRAF V600E or V600K mutation. Braftovi is dosed 6 tablets once as day without regards to meals, as compared to dabrafenib (Tafinlar) and vemurafenib (Zelboraf), which are drugs in the same class that are dosed two times per day. Vemurafenib and dabrafenib are currently FDA-approved for use in multiple types of cancer while Braftovi is only approved for use in melanoma. Braftovi in combination with Mektovi has been shown to improve progression-free disease as compared to vemurafenib alone with slightly reduced severe adverse events. The combination of Braftovi with Mektovi is recommended by NCCN as a category 1 first-line option and as a category 2A second-line option, in line with the other BRAF/MEK inhibitor combinations. The most common adverse events seen in combination therapy were fatigue and nausea, whereas in monotherapy with Braftovi they were found to be alopecia and palmoplantar erythrodysesthesia syndrome. Finally, Braftovi is not indicated for monotherapy use while dabrafenib and vemurafenib may be used alone if monotherapy is required due to patient specific factors.

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 written. Keith Hunsicker seconded the motion. None were opposed.

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

Outcome: For Medicaid, Braftovi is a pharmacy benefit and should be added to the brand tier of GHP Family Formulary requiring prior authorization. Requests for coverage will require the following:

- Prescription written by a hematologist, oncologist, or dermatologist **AND**
- Medical record documentation of a diagnosis of unresectable or metastatic melanoma **AND**
- Medical record documentation of a BRAF V600E or V600K mutation as detected by a Food and Drug Administration (FDA)-approved test **AND**
- Medical record documentation that Braftovi is being prescribed in combination with Mektovi*

*Braftovi may be temporarily used as monotherapy if Mektovi must be held for any reason. If Mektovi is to be discontinued permanently, Braftovi should also be discontinued.

- **Quantity Limit:** 180 tablets/30 days for the 75 mg tablets; 120 tablets/30 days for the 50 mg tablets.

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.

Additional formulary recommendations: The policy for Cotellic should be updated to the following:

1. Prescription written by a hematologist, oncologist, or dermatologist **AND**
2. Medical record documentation of unresectable or metastatic melanoma **AND**
3. Medical record documentation of BRAF V600E or V600K mutation as detected by an FDA-approved test **AND**
4. Medical record documentation of concomitant use with Zelboraf (vemurafenib)

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

MEKTOVI (binimetinib)

Review: Mektovi (binimetinib) is a reversible inhibitor of mitogen-activated extracellular signal regulated kinase 1 (MEK1) and MEK2 activity indicated for use in combination with encorafenib (Braftovi) for metastatic or nonresectable melanoma with a BRAF V600E or V600K mutation. Mektovi is the third MEK inhibitor available on the market, following trametinib (Mekinist) and cobimetinib (Cotellic). Unlike Mekinist, Mektovi is not indicated for monotherapy use in melanoma. Still, NCCN guidelines state that MEK inhibitor monotherapy is not recommended given limited efficacy compared to BRAF/MEK combination therapy and BRAF monotherapy. Mektovi in combination with Braftovi has been shown to improve progression-free disease as compared to vemurafenib alone with slightly reduced severe adverse events. The combination of Braftovi with Mektovi is recommended by NCCN as a category 1 first-line option and as a category 2A second-line option, in line with the other BRAF/MEK inhibitor combinations. Mektovi is dosed two times daily without regard to meals unlike trametinib that is dosed one time daily 1 hour before or 2 hours after a meal and cobimetinib, which is dosed once daily on days 1 to 21 of a 28-day cycle. Adverse event profiles between the MEK-inhibitors are very similar. Interestingly, when given in combination with encorafenib, Mektovi decreases the likelihood of alopecia and palmoplantar erythrodysesthesia (side effects seen with encorafenib monotherapy) but increases the risk of nausea and fatigue. There are currently no studies comparing Mektovi to other MEK inhibitors due to the fact they must be used in combination with an FDA approved BRAF inhibitor.

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 written. Todd Spenberg seconded the motion. None were opposed.

Financial Discussion: No comments or questions. Keith Hunsicker made a motion to accept the recommendations as written. Rajneel Chohan seconded the motion. None were opposed.

Outcome: For Medicaid, Mektovi is a pharmacy benefit and should be added to the brand tier of GHP Family Formulary requiring a prior authorization. Requests for coverage will require the following:

- Prescription written by a hematologist, oncologist, or dermatologist **AND**
- Medical record documentation of a diagnosis of unresectable or metastatic melanoma **AND**
- Medical record documentation of a BRAF V600E or V600K mutation as detected by a Food and Drug Administration (FDA)-approved test **AND**
- Medical record documentation that Mektovi will be used in combination with Braftovi

Quantity Limit: 180 tablets/30 days

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.

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

JYNARQUE (tolvaptan)

Review: Jynarque is indicated to slow kidney function decline in adults at risk of rapidly progressing autosomal dominant polycystic kidney disease (ADPKD). Polycystic kidney disease (PKD) includes inherited diseases that cause an irreversible decline in kidney function. It is characterized by growth of cysts causing progressive kidney enlargement associated with hypertension, abdominal fullness/pain, cyst hemorrhage, hematuria, nephrolithiasis, cyst infections, and reduced quality of life. ADPKD is caused by two known genetic mutations *PKD1* and *PKD2*. Diagnosis of ADPKD relies upon imaging of kidney with typical findings of large kidneys with extensive cysts throughout both kidneys. Ultrasound is the most common type of imaging used for diagnosis. Presence or absence of family history, the number of renal cysts, and the age of the patient can help with diagnosis too. Genetic testing if available to identify causative mutation in ADPKD, however it is not commonly performed.

Tolvaptan is a selective vasopressin V₂ receptor antagonist. In human ADPKD cyst epithelial cells, tolvaptan inhibited *in vitro* cyst growth and chloride-dependent secretion into cysts. In animal models, decreased cAMP were associated with decreases in the rate of growth of total kidney volume and the rate of formation and enlargement of kidney cysts. The recommended initial dose is 60 mg orally per day, taken as 45 mg on waking and 15 mg 8 hours later. The dose should be titrated (at least weekly) to 60 mg plus 30 mg then to 90 mg plus 30 mg per day, if tolerated.

Jynarque was shown to slow the rate of decline in renal function patients at risk of rapidly progressing ADPKD in two trials; TEMPO 3:4 (earlier stages of disease) and REPRISÉ (later stages of disease). In TEMPO 3:4, 1,145 adult patients (mean age: 39 years) with creatine clearance ≥ 60 mL/min, rapidly progressing (total kidney volume ≥ 750 mL and age < 51 years) ADPKD (diagnosed by modified Ravine criteria) were randomized 2:1 to receive treatment with tolvaptan or placebo for up to 3 years. The primary endpoint was the intergroup difference for the rate of change of total kidney volume normalized as a percentage. The key secondary composite endpoint was time to multiple clinical progression events of worsening kidney function, medically significant kidney pain, worsening hypertension, and worsening albuminuria. The trial met its prespecified primary endpoint of 3-year change in total kidney volume ($p < 0.0001$). The difference in total kidney volume occurred at the greatest extent in the first year, with less difference in years two and three. The relative rate of ADPKD-related events (composite secondary endpoint) was decreased by 13.5% in tolvaptan-treated patients, which met statistical significance. This composite outcome was driven by effects on worsening kidney function and kidney pain events. There was no effect on tolvaptan on progression or hypertension or albuminuria. REPRISÉ was a double-blind, placebo-controlled randomized withdrawal trial in adult patients ($n=1519$) (age 18-65, mean:47 years) with chronic kidney disease with an average eGFR 41 mL/min/1.73m². Only patients who could tolerate 60mg/30 mg or 90 mg/30 mg of tolvaptan (after single-blind run-in periods) were randomized ($n=1370$) 1:1 to treatment with tolvaptan or placebo. Patients were treated for 12 months. The primary endpoint was the treatment difference in the change of eGFR from pre-treatment baseline to post-treatment follow-up. This was annualized by dividing each subject's treatment duration. The change of eGFR from pretreatment baseline to post-treatment follow-up was -2.3 mL/min/1.73m²/year with tolvaptan as compared with -3.6 mL/min/1.73m²/year with placebo, with a treatment effect of 1.3 mL/min/1.73m²/year ($p < 0.0001$).

Jynarque has a boxed warning for risk of serious liver injury. Jynarque (tolvaptan) can cause serious and potentially fatal liver injury. Acute liver failure requiring liver transplantation has been reported. Measure ALT, AST and bilirubin before initiating treatment, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months and every 3 months thereafter. Because of the risks of serious liver injury, Jynarque is available only through a restricted distribution program under a Risk Evaluation and Mitigation Strategy (REMS) called the JYNARQUE REMS Program. Jynarque is contraindicated in patients: with a history of or signs/symptoms of significant liver impairment of injury (not polycystic liver disease), taking strong CYP3A inhibitors, uncorrected abnormal blood sodium concentrations, unable to sense of respond to thirst, with hypovolemia, with hypersensitivity to tolvaptan or any component of the product, uncorrected urinary outflow obstruction, and anuria. Jynarque has warnings for serious and potentially fatal liver injury and hypernatremia, dehydration, and hypovolemia (increases free water clearance). The most common adverse reactions (>10% and at least twice that for placebo) were polyuria, nocturia, pollakiuria and polydipsia. The safety and effectiveness of Jynarque in pediatric patients have not been established. Clinical trials did not include a sufficient number of subjects aged 65 years and over. However, dose selection should be cautious, given the greater frequency of decreased hepatic, renal, or cardiac function in elderly patients.

There are no widely accepted practice guidelines for this disease, However, the treatment of patients with ADPKD includes, strict blood pressure control, dietary protein restriction, low-salt diet, and statins. Carefully selected patients may be treated with tolvaptan. The major clinical challenge is to define patients at risk for rapid progression who are most likely to benefit from tolvaptan. The method used to identify high-risk patients varies based on treatment center. The preferred method is by CT or MRI-determined total kidney volume, other options include Mayo classification and PROPKO score. Patients below 55 years with CKD stage 3, could be considered high risk for progression regardless of total kidney volume and should be considered for treatment with tolvaptan. However, most providers also use imaging and GFR. UpToDate, does not recommend tolvaptan in patients < 18 years and > 55 years and those with GFR < 25 mL/min.

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: There was discussion around defining high risk for rapidly progressing ADPKD. IT was decided to leave suggested criteria as is until further discussed with specialist. No other comments or questions. Tricia Heitzman made a motion to accept the recommendations as written. Keith Hunsicker seconded the motion. None were opposed.

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

Outcome: For Medicaid, Jynarque will be a pharmacy benefit. It is recommended that Jynarque be added to the GHP Family formulary at Brand tier requiring prior authorization. Requests for coverage will require the following:

- Prescription written by a nephrologist AND
- Medical record documentation of the member being \geq 18 years AND
- Medical record documentation of a diagnosis of Autosomal Dominant Polycystic Kidney Disease (ADPKD) AND
- Medical record documentation the member is at high risk for rapidly progressing ADPKD AND
- Medical record documentation that the member does not have end-stage renal disease (ESRD)

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 end-stage renal disease (ESRD).

Quantity Limit: 56 tablets per 28 days

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

GIAPREZA (Angiotensin II Acetate)

Review: Giapreza (angiotensin II) is a vasoconstrictor used to increase blood pressure in septic or other distributive shock. Giapreza is available as a 2.5 mg/mL and 5 mg/2 mL injection in a vial. Giapreza should be initiated at 20 ng/kg/min as a continuous intravenous infusion and should be titrated as frequently as every 5 minutes by increments of 15 ng/kg/min while not exceeding 80 ng/kg/min in the first 3 hours. The maintenance dose should not exceed 40 ng/kg/min. In a clinical trial, Giapreza showed an increase in mean arterial pressure (MAP) during treatment without an increase to background vasopressor therapy and a decrease in mean background vasopressor doses through 48 hours. However, no difference in mortality was seen at 28 days versus placebo. Guidelines have not yet been updated to include Giapreza, though its role in therapy will likely be as add-on therapy to other vasopressors (norepinephrine, epinephrine, etc.) when vasopressor monotherapy does not produce an adequate increase in MAP. The only warning for this medication is related to an increased risk of thrombosis.

A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, and Other Considerations and a Financial Review Based on Cost Analysis were presented. For geriatric members, no specific dose adjustment is required.

Clinical Discussion: No comments or questions. Kevin Szczecina made a motion to accept the recommendations as written. Keith Hunsicker seconded the motion. None were opposed.

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

Outcome: Giapreza, if given outpatient, would be considered a medical benefit. However, this medication is only utilized in emergency settings and would never be given outpatient. Therefore, Giapreza should not be included in the pharmacy formulary.

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

TIBSOVO (ivosidenib)

Review: Tibsovo is Indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (R/R AML) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test (Abbott RealTime IDH1). Tibsovo is the first approved oral agent to target IDH1 mutations. Tibsovo joins Idhifa (enasidenib) as the second approved, oral inhibitor targeting isocitrate-dehydrogenase (IDH) mutations in relapsed or refractory AML patients. IDH mutations have been reported in about 20% of patients with AML, of which IDH1 mutations occur in approximately 6% to 10% of AML cases, while IDH2 mutations occur in 9% to 13% of all AML patients. Mutations in IDH1 and IDH2 genes block normal blood stem cell differentiation, which can result in accumulation of myeloid blasts. Targeted therapies against IDH mutations, promote cell differentiation and maturation.

Both Idhifa and Tibsovo offer an alternative to intense chemotherapy in patients with R/R AML in patients with an IDH mutation. Given the limited treatment options for those with R/R AML, Tibsovo will fill the gap in therapy

and offer an additional option for those with R/R AML. Current options remain limited for patients with R/R AML with the recommendations for treatment including: enrollment in a clinical trial, systemic chemotherapy, or allogeneic hematopoietic stem cell transplantation (HSCT). The National Comprehensive Cancer Network (NCCN) guidelines to treat AML patients divides treatments into two phases: induction chemotherapy and post-remission (e.g., consolidation) therapy. The goal of induction therapy is to induce complete remission (CR), while the goal of post-remission therapy is to maintain the disease-free state and prolong remission. NCCN recommends a combination of cytarabine and an anthracycline (eg, daunorubicin, doxorubicin, or idarubicin) for induction therapy in most patients. Patients who achieve CR with induction therapy will continue onto post-remission therapy, which may include three to four cycles of high dose cytarabine (HiDAC) or a stem cell transplant. In addition to conventional therapy, patients will continue to receive supportive care measures (e.g. blood products for transfusion support, tumor lysis prophylaxis, anti-infective prophylaxis, and growth factor support).

The recommended dose for Tibsovo is a 500 mg (two 250 mg tablets) taken orally once daily until disease progression or unacceptable toxicity. For patients without disease progression or unacceptable toxicity, it is recommended that patient be treated for at least 6 months to allow time for clinical response.

The efficacy of Tibsovo was evaluated in an open-labeled, single arm, multicenter phase I clinical trial completed in 174 adult patients with R/R AML with an IDH1 mutation. Patients received 500 mg of Tibsovo daily until disease progression, development of unacceptable toxicity, or underwent HSCT. Overall, 33% of patients achieved complete response or complete response with partial hematologic recovery. The median time to response was 2 months and all of the responders achieved a response within 6 months of Tibsovo initiation. About 25% percent of patients on Tibsovo achieved complete remission with a median duration of response of 10 months. Tibsovo also reduced the need for red cell and platelet transfusion in patients. Similar to Idhifa, Tibsovo carries a black box warning for differentiation syndrome. Tibsovo and Idhifa have no contraindications. Tibsovo does not carry the warning the precautions for embryo-fetal toxicity that Idhifa carries. However, based on limited animal embryo-fetal toxicity studies, there may be risk to the fetus if Tibsovo is taken during pregnancy and is not recommended. Tibsovo carries other warnings and precautions including risk of QTc interval prolongation and Guillain-Barré Syndrome which are not seen with Idhifa. Other common adverse reactions ($\geq 20\%$) noted in the clinical trial include fatigue, leukocytosis, arthralgia, diarrhea, dyspnea, edema, nausea, mucositis, electrocardiogram QT prolongation, rash, pyrexia, cough, and constipation. Women should not breastfeed during treatment with Tibsovo and for at least 1 month after the last dose. Tibsovo's safety and effectiveness has not been evaluation in pediatric patients. Per NCCN, Tibsovo is recommended for use as a single agent in patients ≥ 60 years with IDH-1 mutated AML for treatment induction when not a candidate for intensive remission induction therapy or declines intensive therapy OR post-remission therapy following response to previous lower intensity therapy. Also, Tibsovo is recommended in relapsed/refractory disease in patients with IDH-1 mutated AML as a component of repeating the initial successful induction regimen if late relapse (≥ 12 months) OR as a single agent.

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 written. Todd Sponenberg seconded the motion. None were opposed.

Financial Discussion: No comments or questions. Tricia Heitzman made a motion to accept the recommendations as written. Todd Sponenberg seconded the motion. None were opposed.

Outcome: For Medicaid, Tibsovo will be a pharmacy benefit. It is recommended that Tibsovo be added to the GHP Family formulary on the Brand Tier. The following prior authorization criteria should apply.

- Prescription written by an oncologist/hematologist AND
- Medical record documentation of the member being ≥ 18 years AND
- Medical record documentation of relapsed or refractory acute myeloid leukemia AND

- Medical record documentation of an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA approved test
- OR
- Prescription written by an oncologist/hematologist

Note: The FDA approved test is Abbott RealTime IDH1 Assay

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: 60 tablets per 30 days

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

ANDEXXA (andexanet alfa)

Review: Andexxa is a specific, rapidly acting antidote that is approved for urgent reversal of factor Xa inhibitor anticoagulant activity for apixaban and rivaroxaban only. Andexxa is administered through an IV bolus followed by continuous infusion. Andexxa received both U.S. Orphan Drug and FDA Breakthrough Therapy designations and was approved under the FDA's Accelerated Approval pathway based on the change from baseline in anti-Factor Xa activity in healthy volunteers. Andexxa has black box warnings for: arterial and venous thromboembolic events, ischemic events, including myocardial infarction and ischemic stroke, cardiac arrest, and sudden deaths. Continued approval for this indication may be contingent upon post-marketing study results to demonstrate an improvement in hemostasis in patients which is expected to begin in 2019 and end in 2023. Distribution is currently limited, but Portola expects a broader commercial launch in early 2019, once the FDA approves the Generation 2 manufacturing process.

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 written. Tricia Heitzman seconded the motion. None were opposed.

Financial Discussion: No comments or questions. Keith Hunsicker made a motion to accept the recommendations as written. Rajneel Chohan seconded the motion. None were opposed.

Outcome: Andexxa is covered under the medical benefit and should not be added to the GHP Family formulary at this time. The following prior authorization criteria should apply to medical requests.

- Medical record documentation that Andexxa is being used for the reversal of anticoagulation due to life-threatening or uncontrolled bleeding in patients treated with rivaroxaban and apixaban.

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

FAST FACTS

KEYTRUDA (pembrolizumab)

Updated Indication: Keytruda is now indicated under accelerated approval for the treatment of:

- Patients with locally advanced or metastatic urothelial carcinoma who are not eligible for cisplatin-containing chemotherapy and whose tumors express PD-L1 [Combined Positive Score (CPS) ≥ 10] as determined by an FDA-approved test, or in patients who are not eligible for any platinum-containing chemotherapy regardless of PD-L1 status
- Adult and pediatric patients with refractory primary mediastinal large B-cell lymphoma (PMBCL), or who have relapsed after 2 or more prior lines of therapy

Limitation of Use: Keytruda is not recommended for treatment of patients with PMBCL who require urgent cytoreductive therapy.

The following NSCLC indication was also updated:

- Keytruda, in combination with pemetrexed and platinum chemotherapy, is indicated for the first-line treatment of patients with metastatic nonsquamous NSCLC, with no EGFR or ALK genomic tumor aberrations.

Previously, this indication specified in combination with pemetrexed and carboplatin and did not have specifications surrounding EGFR or ALK status.

Recommendations: No changes are recommended to the formulary status of Keytruda at this time. It is recommended that the current policies are updated to account for the new indications as outlined below.

PMBCL

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

Urothelial Carcinoma

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation of locally advanced or metastatic urothelial carcinoma **AND**
- Medical record documentation of one of the following:
 - Disease progression during or following platinum-containing chemotherapy
OR
 - Disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy
OR
 - Patient is not eligible for cisplatin-containing chemotherapy* **AND**
 - Tumors express PD-L1 (combined positive score [CPS] greater than or equal to 10) as determined by an FDA-approved test
OR
 - Patient is not eligible for any platinum-containing chemotherapy (regardless of PD-L1 status)

*Note to reviewer: In clinical trials, patients who were not considered cisplatin-eligible had the following characteristics: baseline creatinine clearance of <60 mL/min, ECOG performance status of 2, ECOG 2 and baseline creatinine clearance of <60 mL/min, other reasons (Class III heart failure, Grade 2 or greater peripheral neuropathy, and Grade 2 or greater hearing loss).

Metastatic Non-Small Cell Lung Cancer

- Prescription written by a hematologist/oncologist **AND**

- Medical record documentation that patient is ≥ 18 years of age **AND**
 - Medical record documentation of a diagnosis of metastatic NSCLC meeting one of the following situations:
 - Medical record documentation that Keytruda is being given as monotherapy **AND**
 - Medical record documentation that tumors have high PD-L1 expression (Tumor Proportion Score (TPS) $\geq 50\%$ as determined by an FDA-approved test **AND**
 - Medical record documentation that tumors do not have EGFR or ALK genomic tumor aberrations
- OR**
- Medical record documentation that Keytruda is being given as monotherapy **AND**
 - Medical record documentation that tumors express PD-L1 (TPS) $\geq 1\%$ as determined by an FDA-approved test **AND**
 - Medical record documentation of disease progression on or after platinum-containing chemotherapy **AND**
 - For patients with EGFR or ALK genomic tumor aberrations: medical record documentation of disease progression on FDA-approved therapy for these aberrations prior to receiving Keytruda.
- OR**
- Medical record documentation of metastatic nonsquamous NSCLC **AND**
 - Medical record documentation that Keytruda will be given in combination with pemetrexed **AND** either carboplatin or cisplatin **AND**
 - Medical record documentation that tumors do not have EGFR or ALK genomic tumor aberrations

Discussion: No comments or questions

Outcome: Aubrielle Prater made a motion to accept the recommendations as written. 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.

ARNUITY ELLIPTA (fluticasone furoate)

Updated Indication: Arnuity Ellipta is a corticosteroid indicated for once-daily maintenance treatment of asthma as prophylactic therapy in patients aged 5 years and older.

Recommendation: Arnuity Ellipta is a pharmacy benefit currently residing on the Brand Tier without Prior Authorization.

Recommendations: There are no changes to formulary status recommended at this time.

Discussion: No comments or questions.

Outcome: Tricia Heitzman made a motion to accept the recommendations as written. 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.

EMEND IV (fosaprepitant)

Updated Indication¹: Emend (for injection) is now approved, in combination with other antiemetic agents, in adults and pediatric patients 6 months of age and older for the prevention of:

- acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin.
- delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy (MEC).

Limitations of Use: Emend has not been studied for the treatment of established nausea and vomiting.

Previously, Emend, (for injection) was only approved for use in adults.

Recommendation: Patient age is not addressed in the current Emend policy; therefore, no changes are recommended to MBP 104.0 at this time.

Discussion: No comments or questions.

Outcome: Kim Clark made a motion to accept the recommendations as written. 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.

LEUKINE (sargramostim)

Updated Indication:

Leukine is now indicated:

- For the treatment of adult and pediatric patients 2 years and older who have undergone allogeneic or autologous bone marrow transplantation in whom neutrophil recovery is delayed or failed.
Previously, Leukine was indicated in patients who have undergone allogeneic or autologous bone marrow transplantation in whom engraftment is delayed or has failed.
- To increase survival in adult and pediatric patients from birth to 17 years of age acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS])

Note: Engraftment is the process by which collected stem cells received during transplant produce new blood cells. Engraftment relates to a neutrophil and platelet count recovery. Neutrophil engraftment is defined as the first day of three consecutive days where the absolute neutrophil count (ANC) is 500 cells/mm³ or greater. Platelet engraftment is defined as 20,000/mm³ (unsupported by a platelet transfusion).

Recommendation: It is not recommended to update the formulary status at this time. However, it is recommended to add the following to the current policy.

NEUPOGEN, NEULASTA, LEUKINE, ZARXIO, GRANIX

- Medical record documentation of a diagnosis of cancer, and when any of the following FDA labeled indications or uses supposed 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)

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 greater than 2.0)
- Renal dysfunction (CrCl less than 50)

NEUPOGEN, NEULASTA, ZARXIO, OR LEUKINE:

- Medical record documentation of any of the following FDA labeled indications or uses supposed by clinical guidelines:

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

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 leukapheresis)

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

NEUPOGEN, ZARXIO

- Medical record documentation of any of the following FDA labeled indications or uses supposed by clinical guidelines:

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 clinical 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.

Discussion: No comments or questions.

Outcome: Kevin Szczecina made a motion to accept the recommendations as written. 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.

AVASTIN (bevacizumab)

Updated Indication: Avastin is now indicated for the treatment of patients with stage III or IV epithelial ovarian, fallopian tube, or primary peritoneal cancer following initial surgical resection (in combination with carboplatin and paclitaxel, followed by Avastin as a single agent).

Previously, Avastin was approved in this setting in combination with paclitaxel, doxorubicin, or topotecan for treatment of platinum-resistant recurrent disease with no more than 2 prior chemotherapy regimens OR in combination with carboplatin and paclitaxel (or carboplatin and gemcitabine) followed by Avastin as a single agent for treatment of platinum-sensitive disease.

Recommendation: Avastin is currently a medical benefit for GHP Family members. Avastin does not require prior authorization for either benefit. Because Avastin processes freely and there is not strong rationale to require prior authorization, no changes are recommended at this time despite the updated indication.

Discussion: No comments or questions.

Outcome: Todd Sponenberg made a motion to accept the recommendations as written. 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.

PROLIA (denosumab)

Updated Indication: Treatment of glucocorticoid-induced osteoporosis in men and women at high risk for fracture who are either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and expected to remain on glucocorticoids for at least 6 months. High risk of fracture is defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy.

Prolia was previously indicated for:

- Treatment of postmenopausal women with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy.
- Treatment to increase bone mass in men with osteoporosis, defined as a history of osteoporotic fracture, or multiple risk factors for fracture; or patients who have failed or are intolerant to other available osteoporosis therapy;
- Treatment of bone loss in men receiving androgen deprivation therapy for prostate cancer; and
- Treatment of bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer.

Recommendation:

The current policy should be updated as follows:

1. For post-menopausal women at high risk for fractures:
 - Physician provided documentation of a diagnosis of post-menopausal osteoporosis; **AND**
 - Physician provided documentation of previous osteoporotic fracture or high risk of fracture (defined as a spine or hip DXA T-score of less than or equal to -2.5, supporting clinical factors, and/or FRAX calculation showing a $\geq 3\%$ probability of hip fracture OR $\geq 20\%$ probability of major osteoporosis-related fracture); **OR**
 - Physician provided documentation of a failed attempt of therapy with or contraindication to one oral bisphosphonate
2. For increasing bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer:
 - Physician provided documentation of a failed attempt of therapy with or contraindication to one oral bisphosphonate
3. For increasing bone mass in men at high risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer:
 - Physician provided documentation of a failed attempt of therapy with or contraindication to one oral bisphosphonate

4. For the treatment of men at high risk for fractures:
 - Physician provided documentation of a diagnosis of osteoporosis; and
 - Physician provided documentation of previous osteoporotic fracture or high risk of fracture (defined as spine or hip DXA T-score of less than or equal to -2.0, supporting clinical factors, and/or FRAX calculation showing a $\geq 3\%$ probability of hip fracture OR $\geq 20\%$ probability of major osteoporosis-related fracture);
OR
 - Physician provided documentation of a failed attempt of therapy with or contraindication to one oral bisphosphonate

5. For the treatment of glucocorticoid-induced osteoporosis
 - Medical record documentation of a diagnosis of glucocorticoid-induced osteoporosis **AND**
 - Medical record documentation that the patient is initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone **AND**
 - Medical record documentation that the patient is going to remain on systemic glucocorticoid therapy for at least 6 months **AND**
 - Medical record documentation of previous osteoporotic fracture or high risk of fracture defined as DXA T-score of less than or equal to -2.0 at the lumbar spine, total hip, or femoral neck, supporting clinical factors and/or FRAX calculation showing a $\geq 3\%$ probability of hip fracture OR $\geq 20\%$ probability of major osteoporosis-related fracture **OR**
 - Medical record documentation of a failure on, intolerance to, or contraindication to one oral bisphosphonate

Discussion: No comments or questions.

Outcome: Tricia Heitzman made a motion to accept the recommendations as written. Kim 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.

JADENU AND EXJADE (deferasirox)

Updated Indication: Jadenu and Exjade are indicated for the treatment of chronic iron overload due to blood transfusions in patients 2 years of age and older.

Previous indications: Jadenu and Exjade were previously indicated for the treatment of chronic iron overload due to blood transfusions in patients 2 years of age and older. However, the following language was included "This indication is based on reduction in serum ferritin and liver iron concentration (LIC). An improvement in survival or disease-related symptoms has not been established." Both agents are still indicated for chronic iron overload in patients 10 years of age and older with non-transfusion-dependent thalassemia (NTDT) syndromes and with a liver iron concentration of at least 5 mg Fe per gram of dry weight and a serum ferritin greater than 300 mcg/L.

Recommendations from National Agencies or Organizations: The major cause of iron overload is due to an increased intake from RBC transfusions for chronic anemia not caused by iron deficiency (e.g. thalassemia, sickle cell disease, inherited bone marrow failure syndrome, myelodysplastic syndrome). Treatment for iron overload includes phlebotomy for those without significant anemia and chelation therapy for those with anemia.

Specialist Feedback: Jenna Carmichael, PharmD, BCOP, mentioned that she sees Exjade/Jadenu used mostly for chronic iron overload due to blood transfusions in patients with myelodysplastic syndromes (MDS). She also mentioned that thalassemia is not very common.

Note: Deferasirox limitations of use: Controlled clinical trials of Jadenu/Exjade in patients with MDS and chronic iron overload due to blood transfusions have not been performed.

Recommendation: There are no changes to formulary placement recommended at this time. Although the transfusional iron overload clinical trials for Exjade only included patients with beta-thalassemia and transfusional hemosiderosis, the FDA indication is for the treatment of chronic iron overload due to blood transfusions in patients 2 years of age and older. Our current policy does not account for other conditions that may lead to chronic iron overload due to blood transfusions (e.g. sickle cell anemia, aplastic anemia, MDS, malignancies), therefore it is recommended to update the current prior authorization criteria.

Also, based on the pooled pediatric study, there have been several updates to the PI regarding volume depletion and overchelation. There was a higher rate of renal adverse events among patients with serum ferritin was < 1,000 mcg/L. If serum ferritin falls below 1000 mcg/L a dose reduction can be considered, especially if the dose is greater than 25 mg/kg/day for Exjade (> 17.5 mg/kg/day for Jadenu). If the serum ferritin falls below 500 mcg/L, therapy should be interrupted and monitored monthly. For NTDT, therapy should still be interrupted if serum ferritin falls below 300 mcg/L. Based on this updated warning, the re-authorization criteria should be separated based on indication.

- Prescription is written by a hematologist AND
- Medical record documentation of being used for the treatment of chronic iron overload caused by blood transfusions (transfusional hemosiderosis) in patients 2 years of age and older and with a serum ferritin level > 1000 mcg/L OR
- Medical record documentation of being used for the treatment of chronic iron overload in patients 10 years of age and older with non-transfusion dependent thalassemia syndromes and with a liver iron (Fe) concentration (LIC) of at least 5 mg Fe per gram of dry weight and a serum ferritin greater than 300 mcg/L.

Authorization Duration (for Chronic Iron Overload): If approved, approval is for 6 months of therapy.

Reauthorizations will be for an additional 6 months and will require medical record documentation of a serum ferritin greater than 500 mcg/L.

Authorization Duration (for Chronic Iron Overload due to NTDT): If approved, approval is for 6 months of therapy.

Reauthorizations will be for an additional 6 months and will require medical record documentation of a serum ferritin greater than 300 mcg/L.

Discussion: No comments or questions.

Outcome: Kevin Szczecina made a motion to accept the recommendations as written. 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.

INTELENCE (etravine)

Updated Indication: Intelence, in combination with other antiretroviral agents, is now indicated for the treatment of human immunodeficiency virus type 1 (HIV-1) infection in antiretroviral treatment-experienced patients ages 2

years of age and older, who have evidence of viral replication and HIV-1 strains resistant to a non-nucleoside reverse transcriptase inhibitor (NNRTI) and other antiretroviral agents.

Intelence was previously indicated for patients 6 years of age and older for the same indication

Recommendations: No changes are recommended.

Discussion: No comments or questions.

Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Kim 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.

GILENYA (fingolimod)

Updated Indication: Gilenya is now indicated for the treatment of relapsing forms of multiple sclerosis (MS) in patients 10 years of age and older.

Previously, the safety and effectiveness of Gilenya in pediatric patients below the age of 18 years with MS have not been established.

Recommendation: Gilenya currently is a pharmacy benefit available at the Brand tier. Gilenya does not require a prior authorization. It has a QL of 30 capsules per 30 days. Since Gilenya is available without any prior authorization criteria or age restriction no changes are recommended

Discussion: No comments or questions.

Outcome: Tricia Heitzman made a motion to accept the recommendations as written. Kim 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.

YERVOY (ipilimumab) and OPDIVO (nivolumab)

Updated Indications – Opdivo:

- Opdivo is indicated under accelerated approval, in combination with ipilimumab, for the treatment of adults and pediatric patients 12 years and older with MSI-H or dMMR metastatic colorectal cancer that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan.
 - Opdivo maintains its previously approved indication for this disease state as a single agent.
- Opdivo is indicated under accelerated approval for the treatment of patients with metastatic small cell lung cancer (SCLC) with progression after platinum-based chemotherapy and at least one other line of therapy

Updated Indication – Yervoy:

- Yervoy is indicated under accelerated approval, in combination with nivolumab, for the treatment of adults and pediatric patients 12 years and older with MSI-H or dMMR metastatic colorectal cancer that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan.

Updated Dosing for New Indications^{1,2}:

- **MSI-H/dMMR CRC (Combination Regimen)** – Opdivo 3mg/kg IV over 30 minutes, followed by Yervoy 1mg/kg IV over 30 minutes on the same day, every 3 weeks for 4 doses. After completing 4 doses of the combination, administer Opdivo 240mg IV (as a single agent) every 2 weeks over 30 minutes until disease progression or unacceptable toxicity.
- **SCLC** – Opdivo 240mg IV over 30 minutes every 2 weeks until disease progression or unacceptable toxicity

Recommendations: No changes are recommended to the formulary status of Opdivo or Yervoy at this time. It is recommended that the current criteria be updated to account for the new indication(s)

MBP 91.0 – Yervoy

Colorectal Cancer

1. Prescription written by a hematologist/oncologist **AND**
2. Medical record documentation that patient is ≥ 12 years of age **AND**
3. Medical record documentation of a diagnosis of metastatic colorectal cancer **AND**
4. Medical record documentation of microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease **AND**
5. Medical record documentation of progression following treatment with a fluoropyrimidine, oxaliplatin, or irinotecan-based therapy **AND**
6. Medical record documentation that Yervoy is being given in combination with nivolumab (Opdivo).

AUTHORIZATION DURATION:

For Adjuvant melanoma:

Initial approval will be for **6 months**. Subsequent approvals will be for an additional **12 months** and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

For all other indications:

Approval will be for one (1) **6-month** authorization for the FDA-approved maximum of up to four (4) doses of Yervoy. Requests for authorization exceeding these limits will require the following:

- Medical record documentation of continued disease improvement or lack of disease progression **AND**
- Medical record documentation of peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

MBP 126.0 – Opdivo

Colorectal Cancer

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is ≥ 12 years of age **AND**
- Medical record documentation of a diagnosis of metastatic colorectal cancer **AND**
- Medical record documentation of microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease **AND**
- Medical record documentation of progression following treatment with a fluoropyrimidine, oxaliplatin, or irinotecan **AND**
- Medical record documentation that Opdivo is being used as a single agent or in combination with ipilimumab (Yervoy).

Small Cell Lung Cancer (SCLC)

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is ≥ 18 years of age **AND**
- Medical record documentation of a diagnosis of metastatic small cell lung cancer (SCLC) **AND**
- Medical record documentation of disease progression after two different lines of therapy, one of which must be a platinum-based chemotherapy.

Discussion: No comments or questions.

Outcome: Rajneel Chohan made a motion to accept the recommendations as written. 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.

ACTEMRA (tocilizumab)

Updated Dosing/Indication: Actemra is indicated for the treatment of patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis (PJIA) with subcutaneous (SC) dosage recommendations. Previously, Actemra was indicated for PJIA, however there were only dosage recommendations for intravenous (IV) administration.

Polyarticular Juvenile Idiopathic Arthritis:

- Actemra may be used alone or in combination with methotrexate. Dose should not be changed based on single visit body weight.
- Subcutaneous
 - Patients less than 30 kg weight: 162 mg once every three weeks
 - Patients at or above 30 kg weight: 162 mg once every two weeks
- When transitioning from IV to SC, administer the first SC dose instead of the next scheduled IV dose.

Recommendation: 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 polyarticular juvenile idiopathic arthritis (PJIA)

- 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 polyarticular juvenile idiopathic arthritis or juvenile rheumatoid arthritis **AND**
- Physician provided documentation of a therapeutic failure on, contraindication to or intolerance to a minimum 4 month trial of Humira*

*Requires prior authorization

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 PJIA 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 PJIA while on Actemra therapy.

Quantity Limit: 2 syringes per 28 days

Other Recommendations:

It is recommended to update the following PJIA criteria for **Actemra IV policy** to remove failure on Enbrel only require failure on Humira.

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to a minimum four month trial of Humira*

It is recommended to update the following PJIA criteria for the **Orencia policy** to remove failure on Enbrel and only require failure on Humira.

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to a minimum 4 month trial of Humira*

Discussion: No comments or questions.

Outcome: Todd Sponenberg made a motion to accept the recommendations as written. 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.

MYRBETRIQ (mirabegron)

Updated Indication: Myrbetriq, in combination with the muscarinic antagonist solifenacin succinate, is indicated for the treatment of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and urinary frequency.

Myrbetriq was previously only indicated as monotherapy.

Updated Dosing for New Indication:

- Recommended starting dose is 25 mg once daily, alone or in combination with solifenacin succinate 5 mg, once daily.
- Based on individual efficacy and tolerability after 4 to 8 weeks, may increase dose to 50 mg once daily, alone or in combination with solifenacin succinate 5 mg, once daily.
- Myrbetriq and solifenacin succinate can be taken together, with or without food.

Recommendation: Myrbetriq should be added to the Brand tier of the GHP Family formulary. A quantity limit of 30 tablets per 30 days should apply.

Discussion: No comments or questions.

Outcome: Kevin Szczecina made a motion to accept the recommendations as written. 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.

TECENTRIQ (atezolizumab)

Updated Indication: Tecentriq (atezolizumab) is now indicated for the treatment of patients with locally advanced or metastatic urothelial carcinoma who:

- are not eligible for cisplatin-containing chemotherapy and whose tumors express PD-L1 (PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5% of the tumor area), as determined by an FDA-approved test, or
- are not eligible for any platinum-containing chemotherapy regardless of PD-L1 status

Tecentriq was previously approved for locally advanced or metastatic urothelial carcinoma in patients who:

- are not eligible for cisplatin-containing chemotherapy, or
- have disease progression during or following any platinum-containing chemotherapy, or within 12 months of neoadjuvant or adjuvant chemotherapy

Tecentriq was also previously indicated only for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) who have disease progression during or following platinum-containing chemotherapy.

Recommendation: No formulary updates for any line of business are recommended at this time. It is recommended that the following updates are made to the Urothelial Carcinoma section of MBP 144.0 to account for the updated indication as outlined below.

1. Prescription written by an oncologist **AND**
2. Medical record documentation of a diagnosis of locally advanced or metastatic urothelial carcinoma **AND**
3. Medical record documentation of one of the following:
 - a. Disease progression during or following platinum-containing chemotherapy
OR
 - b. Patient is not eligible for cisplatin-containing therapy **AND**
 - c. Tumors express PD-L1 (greater than or equal to 5%) as determined by an FDA-approved test
OR
 - d. Patient is not eligible for any platinum-containing chemotherapy (regardless of PD-L1 status)

Discussion: No questions or comments.

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.

XTANDI (enzalutamide)

Updated Indication¹: Xtandi is now indicated for the treatment of patients with castration-resistant prostate cancer (CRPC).

Previous indication: Xtandi was indicated for the treatment of patients with metastatic castration-resistant prostate cancer.

Updated Dosing for New Indication: The recommended dose of Xtandi remains 160 mg (four 40 mg capsules) administered orally once daily. However, patients receiving Xtandi should also receive a gonadotropin-releasing hormone (GnRH) analog concurrently or should have had a bilateral orchiectomy.

Recommendation: It is recommended to add Xtandi to the Brand tier of the GHP Family formulary. Also, it is recommended to update the prior authorization criteria to the following.

- Medical record documentation that Xtandi is prescribed by a hematologist, oncologist, or urologist AND
- Medical record documentation of diagnosis of prostate cancer AND
- Medical record documentation that the member is no longer responding to castration or is hormone resistant AND
- Medical record documentation that a gonadotropin-releasing hormone (GnRH) analog will be used concurrently OR member has had bilateral orchiectomy

There are no updates to quantity limits or authorization duration at this time.

Discussion: No comments or questions.

Outcome: Kim Clark 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.

CLASS REVIEW

Rheumatoid arthritis update

	Ankylosing Spondylitis	Crohn's Disease	Pediatric Crohn's Disease	Hidradenitis Suppurativa	Juvenile Idiopathic Arthritis	Plaque Psoriasis	Psoriatic Arthritis	Rheumatoid Arthritis	Ulcerative Colitis	Pediatric Ulcerative Colitis	Uveitis
Abatacept (Orencia)					x		x	x			
Adalimumab (Humira)	x	x	x	x	x	x	x	x	x		x
Anakinra (Kineret)								x			
Apremilast (Otezla)						x	x				
Brodalumab (Siliq)						x					
Certolizumab (Cimzia)	x	x					x	x			
Etanercept (Enbrel)	x				x	x	x	x			
Golimumab (Simponi, Simponi Aria)	x						x	x	(Simponi Only)		
Guselkumab (Tremfya)						x					
Infliximab (Remicade)	x	x	x			x	x	x	x	x	
Infliximab-dyyb (Inflectra)	x	x	x			x	x	x	x		
Infliximab-abda (Renflexis)	x	x	x			x	x	x	x		
Ixekizumab (Taltz)						x	x				
Natalizumab (Tysabri)		x									
Rituximab (Rituxan)								x			
Sarilumab (Kevzara)								x			
Secukinumab (Cosentyx)	x					x	x				
Tocilizumab (Actemra)					x			x			
Tofacitinib (Xeljanz, Xeljanz XR)							x	x			
Ustekinumab (Stelara)		x				x	x				
Vedolizumab (Entyvio)		x							x		

Summary of Clinical Guidelines¹⁶:

The 2015 American College of Rheumatology (ACR) guidelines recommend use of a DMARD (MTX preferred) for all patients with low disease activity who have not previously received DMARD therapy.

For patients with early RA (duration of disease < 6 months) with moderate/high disease activity, DMARDs are also preferred first line therapy. If the member has continued disease activity while on a DMARD, combination DMARD therapy, TNFi +/- MTX, nonTNFi biologic +/- MTX is preferred.

For members with established RA (duration of disease > 6 months) who are on DMARD therapy and continue to have moderate/high disease activity, the following treatments maybe considered: combination DMARD therapy, addition of TNFi, nonTNFi, or tofacitinib to current DMARD therapy. If the member is not currently receiving a DMARD and continuing to experience high disease activity, the ACR guidelines recommend addition of a DMARD as the next treatment strategy. Therapy should not be discontinued in members who achieve low disease activity or remission while on therapy. ACR 2015 does not recommend use of one TNFi or nonTNFi biologic over another.

Provider Feedback/Geisinger Health System Rheumatoid Arthritis ProvenCare Pathway:

The AIM-FARTHER2 Rheumatoid Arthritis ProvenCare team has recommended SQ MTX as the preferred first line therapy for patients with RA. For members who do not respond to SQ MTX alone, triple therapy with MTX, hydroxychloroquine, and sulfasalazine is recommended. It was noted that triple therapy is a cost-effective regimen with positive outcomes and is a reasonable alternative to try prior to starting therapy on TNFi or nonTNFi biologic therapy. For members who fail triple therapy, treatment with a TNFi or nonTNFi biologic is recommended. The committee noted that there was no preference of preferred biologic treatment, as all are considered to be equally efficacious. The team did recommend that two agents with different mechanisms of action be chosen as first line, preferred therapies. This formulary design would give prescribers the opportunity to maximize their treatment options for members who do not respond to their first biologic agent. The team has stated that Humira is an appropriate first line agent due to the efficacy evidence and low cost. These recommendations were supported by the entire ProvenCare team. It was recognized that members may have contraindications to use of Humira and these members should be allowed to explore other non-preferred treatment options, when clinically appropriate.

Formulary Recommendations Based on Clinical Review

For Rheumatoid Arthritis Indication ONLY (unless otherwise specified)

Medication	Current Policy	Recommendations
Actemra	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Prescribed by a rheumatologist AND • Diagnosis of moderate to severe rheumatoid arthritis (made in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis AND • Age greater than or equal to 18 years 	<p>Add:</p> <ul style="list-style-type: none"> • Actemra is <u>not</u> being used concurrently with a TNF blocker or other biologic agent
Cimzia	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Age greater than or equal to 18 years AND • Prescribed by a rheumatologist AND • Diagnosis of moderate to severe rheumatoid arthritis (made in accordance with the American College of Rheumatology Criteria for the Classification of Diagnosis of Rheumatoid Arthritis) AND • Cimzia is <u>not</u> being used concurrently with a TNF blockers or other biologic agent 	<p>No changes to clinical criteria recommended at this time.</p>
Enbrel	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Diagnosis of moderate to severe rheumatoid arthritis (made in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis) AND • Prescribed by a rheumatologist AND • Age greater than or equal to 18 years AND • Enbrel is <u>not</u> being used concurrently with a TNF blocker or other biologic agent 	<p>No changes to clinical criteria recommended at this time.</p>

Humira	<p><u>Biweekly Dosing</u> Medical record documentation of:</p> <ul style="list-style-type: none"> • Diagnosis of moderate to severe rheumatoid arthritis (made in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis) AND • Prescribed by a rheumatologist AND • Age greater than or equal to 18 years AND • Humira is <u>not</u> being used concurrently with a TNF blocker or other biologic agent <p><u>Weekly Dosing</u> Medical record documentation of:</p> <ul style="list-style-type: none"> • Diagnosis of moderate to severe rheumatoid arthritis (made in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis) AND • Prescribed by a rheumatologist AND • Age greater than or equal to 18 years AND • Humira is <u>not</u> being used concurrently with a TNF blocker or other biologic agent AND • Contraindication to, intolerance to, or therapeutic failure on BIWEEKLY (every other week) administration of Humira 	No changes to clinical criteria recommended at this time.
Infliximab (Remicade, Inflectra, Renflexis)	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Must be 18 years of age or greater AND • Requesting provider must be a rheumatologist AND • Diagnosis of moderate to severe rheumatoid arthritis according the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis AND • Medical record documentation that the infliximab product is <u>not</u> being used concurrently with a TNF blocker or other biologic agent AND • Continuation of effective dose of methotrexate during infliximab therapy 	No changes to clinical criteria recommended at this time.
Kevzara	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Age greater than or equal to 18 years AND • Prescribed by a rheumatologist AND • Diagnosis of moderate to severe rheumatoid arthritis made in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of RA 	<p>Add:</p> <ul style="list-style-type: none"> • Kevzara is <u>not</u> being used concurrently with a TNF blocker or other biologic agent
Kineret	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Diagnosis of moderate to severe rheumatoid arthritis made in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis AND • Age greater than or equal to 18 years AND • Prescribed by a rheumatologist 	<p>Add:</p> <ul style="list-style-type: none"> • Kineret is <u>not</u> being used concurrently with a TNF blocker or other biologic agent
Orencia	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Prescribed by a rheumatologist AND • Diagnosis of moderate to severe rheumatoid arthritis (made in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis) AND • Age greater than or equal to 18 years AND • Orencia is <u>not</u> being used concurrently with a TNF blockers or other biologic agent 	No changes to clinical criteria recommended at this time.

Rituxan	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Diagnosis of moderate to severe rheumatoid arthritis in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis AND • At least 18 years of age or older AND • Prescription written by a rheumatologist AND • Medical record documentation that an effective dose of methotrexate will be continued during rituximab therapy 	<p>Add:</p> <ul style="list-style-type: none"> • Rituxan is <u>not</u> being used concurrently with a TNF blocker or other biologic agent
Simponi	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Prescribed by a rheumatologist AND • Age greater than or equal to 18 years AND • Diagnosis of moderate to severe rheumatoid arthritis (made in accordance with the American College of Rheumatology Criteria for the Classification of Diagnosis of Rheumatoid Arthritis) AND • Concomitant methotrexate use AND • Simponi is <u>not</u> being used concurrently with a TNF blocker or other biologic agent 	No changes to clinical criteria recommended at this time.
Simponi Aria	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Requesting provider must be a rheumatologist AND • Age ≥18 years AND • Diagnosis of moderate to severe rheumatoid arthritis according the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis AND • Simponi Aria will be given in combination with methotrexate AND • Simponi Aria is <u>not</u> being used concurrently with a TNF blocker or other biologic agent 	No changes to clinical criteria recommended at this time.
Xeljanz/Xeljanz XR	<p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Diagnosis of moderate to severe rheumatoid arthritis (made in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis) AND • Prescribed by a rheumatologist AND • Age greater than or equal to 18 years AND • Xeljanz or Xeljanz XR is <u>not</u> being used concurrently with a TNF blocker or other biologic agent 	No changes to clinical criteria recommended at this time.

Formulary Recommendations Based on Cost Analysis

For Rheumatoid Arthritis Indication ONLY (unless otherwise specified)

Medication	Current Policy/Formulary Status	Recommendations
Actemra	<p>Formulary Status: Non-formulary OR Medical Benefit w/ PA for IV formulation</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira* AND Enbrel* <p>Authorization Duration:</p> <ul style="list-style-type: none"> • Initial: Six (6) months • Subsequent: Twelve (12) months 	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p> <ul style="list-style-type: none"> • Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*

	Quantity Limit: 4 syringes per 28 days	
Cimzia	<p>Formulary Status: Brand Tier w/ PA OR Medical Benefit w/ PA</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to a minimum 3 month trial of Humira* AND Enbrel* <p>Authorization Duration:</p> <ul style="list-style-type: none"> • Initial: Six (6) months • Subsequent: Twelve (12) months <p>Quantity Limit:</p> <ul style="list-style-type: none"> • Initial: Three (3) kits per 28 days x 1 week, One (1) kit per 28 days remainder of 6 months • Subsequent: One (1) kit per 28 days 	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p> <ul style="list-style-type: none"> • Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*
Enbrel	<p>Formulary Status: Brand Tier w/ PA</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Inadequate response to a minimum 3 month trial of methotrexate or other DMARD if methotrexate is not tolerated or contraindicated OR medical record documentation of a therapeutic failure on or intolerance to prior biologic therapy <p>Authorization Duration:</p> <ul style="list-style-type: none"> • Initial: Six (6) months • Subsequent: Twelve (12) months <p>Quantity Limit: (by GPID)</p> <ul style="list-style-type: none"> • 50 mg syringe/pen: 3.92 mL per 28 days • 25 mg syringe: 4.08 mL per 28 days • 25 mg vial: 8 vials per 28 days 	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p> <ul style="list-style-type: none"> • Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*
Humira	<p>Formulary Status: Brand Tier w/ PA</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Medical record documentation of an inadequate response to a minimum 3 month trial of methotrexate or other DMARD if methotrexate is not tolerated or contraindicated OR medical record documentation of a therapeutic failure on or intolerance to prior biologic therapy <p>Authorization Duration:</p> <ul style="list-style-type: none"> • Initial: Six (6) months • Subsequent: Twelve (12) months <p>Quantity Limit:</p> <ul style="list-style-type: none"> • Biweekly Dosing: 2 syringes per 28 days • Weekly Dosing: 4 syringes per 28 days 	<p>Formulary Status: No changes recommended at this time</p> <p>No changes to criteria recommended at this time.</p>

<p>Infliximab (Remicade, Inflectra, Renflexis)</p>	<p>Formulary Status: Medical Benefit w/ PA</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira* AND Enbrel* <p>AND</p> <ul style="list-style-type: none"> • For new start Remicade or Renflexis requests, medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Inflectra* <p>Authorization Duration:</p> <ul style="list-style-type: none"> • Initial: Six (6) months • Subsequent: Twelve (12) months 	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p> <ul style="list-style-type: none"> • Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*
<p>Kevzara</p>	<p>Formulary Status: Non-formulary</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Therapeutic failure on, intolerance to, or contraindication to a minimum 3 month trial or Humira* AND Enbrel* <p>Authorization Duration:</p> <ul style="list-style-type: none"> • Initial: Six (6) months • Subsequent: Twelve (12) months <p>Quantity Limit: 2.28ml per 28 days</p>	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p> <ul style="list-style-type: none"> • Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*
<p>Kineret</p>	<p>Formulary Status: Brand Tier w/ PA</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira* AND Enbrel* <p>Authorization Duration:</p> <ul style="list-style-type: none"> • Initial: Six (6) months • Subsequent: Twelve (12) months 	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p> <ul style="list-style-type: none"> • Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*
<p>Orencia</p>	<p>Formulary Status: Brand Tier w/ PA OR Medical Benefit w/ PA for IV formulation</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> • Inadequate response to a minimum 3 month trial of one preferred TNF-alpha inhibitor (Humira* OR Enbrel*) <p>Authorization Duration:</p> <ul style="list-style-type: none"> • Initial: Six (6) months • Subsequent: Twelve (12) months <p>Quantity Limit (SQ Syringes): 4 syringes per 28 days</p>	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p> <ul style="list-style-type: none"> • Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*
<p>Rituxan</p>	<p>Formulary Status: Medical Benefit w/ PA</p> <p>Medical record documentation of:</p>	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p>

	<ul style="list-style-type: none"> Inadequate response to 12 weeks of therapy with etanercept (Enbrel) AND adalimumab (Humira) <p>Limitations (Authorization Duration & Quantity Limit): Approval will be limited to one course of therapy defined as two infusions, one given on day 1 and another on day 15. Additional courses may be considered medically necessary if the following criteria are met:</p> <ul style="list-style-type: none"> At least 6 months has elapsed since the previous treatment course; AND Physician documentation of improvement or lack or progression in the signs and symptoms of rheumatoid arthritis; AND Physician documentation showing previous treatment course did not result in active infection 	<ul style="list-style-type: none"> Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*
Simponi	<p>Formulary Status: Non-formulary</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> Intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira* AND Enbrel* <p>Authorization Duration:</p> <ul style="list-style-type: none"> Initial: Six (6) months Subsequent: Twelve (12) months <p>Quantity Limit: 0.5ml per 28 days (Approve Simponi 50mg/0.5ml by GPID only)</p>	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p> <ul style="list-style-type: none"> Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*
Simponi Aria	<p>Formulary Status: Medical Benefit w/ PA</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> Inadequate response to, contraindication to, or failure on 12 weeks of etanercept (Enbrel*) AND adalimumab (Humira*) therapy <p>Authorization Duration:</p> <ul style="list-style-type: none"> Initial: Six (6) months Subsequent: Twelve (12) months 	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p> <ul style="list-style-type: none"> Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*
Xeljanz (XR)	<p>Formulary Status: Non-formulary</p> <p>Medical record documentation of:</p> <ul style="list-style-type: none"> Inadequate response to or intolerance to a 3-month trial of methotrexate or other disease-modifying antirheumatic drug (DMARD) AND Intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira* AND Enbrel* <p>Authorization Duration:</p> <ul style="list-style-type: none"> Initial: Six (6) months Subsequent: Twelve (12) months 	<p>Formulary Status: No changes recommended at this time</p> <p>Change current criteria to:</p> <ul style="list-style-type: none"> Intolerance to, contraindication to, or therapeutic failure on a minimum 3 month trial of Humira*

	Quantity Limits: <ul style="list-style-type: none"> • Xeljanz: 2 tablets per day, 30 day supply per fill • Xeljanz XR: 1 tablet per day, 30 day supply per fill 	
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Discussion: No comments or questions.

Outcome: Kim Clark 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.

UPDATES

DUPIXENT (dupilumab)

Discussion: GHP received feedback from several Geisinger dermatologists who had different interpretations of the “systemic treatment” criterion. Many providers interpreted this criterion to mean “failure of methotrexate, azathioprine, AND mycophenolate.” GHP’s intention for this criterion is to mean failure of one systemic treatment (i.e. “failure of methotrexate, azathioprine, OR mycophenolate”). The suggestion from providers is to provide clarification of this criterion.

Recommendations: Based on provider feedback, the following change is recommended to the systemic treatment criterion.

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

Discussion: No comments or questions.

Outcome: Aubrielle Prater 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.

STEP THERAPY UPDATE

Discussion: With the current and anticipated increase of prior authorization cases, a review on potential policies that can be transitioned to step therapy was completed.

Recommendations: The following policies are recommended to be switched to step therapy. The standard step therapy language below will apply to all updated policies:

- Electronic step therapy of on-line prescription drug claims history showing 15 days use of MEDICATION NAME, within the previous 180 days. If this electronic step is met, the claim will automatically adjudicate OR
- Medical record documentation of current utilization, intolerance to, or contraindication to MEDICATION NAME

Medication Name	Policy Number	Medication(s) to be tried first	Notes (if blank, no additional changes needed to policy)
Rozerem	1075.0F	zolpidem AND zaleplon	<u>Recommend removing</u> required documentation of diagnosis of insomnia
Zolpidem SL	1075.0F		
Zolpidem ER	1075.0F		
Dexilant	1080.0F	omeprazole, pantoprazole, lansoprazole, rabeprazole, AND esomeprazole	
Omeprazole/sodium bicarbonate	1080.0F	omeprazole, pantoprazole, lansoprazole, rabeprazole, Dexilant, AND esomeprazole	
Darifenacin ER	1083.0F	oxybutynin OR oxybutynin XL AND tolterodine	
Oxytrol	1083.0F		
Toviaz	1083.0F		
Trospium XR	1083.0F		
Vesicare	1083.0F		
Levalbuterol solution	1087.0F	Albuterol solution	<u>Recommend removing</u> required documentation of diagnosis of an FDA-approved indication
Levalbuterol HFA	1087.0F	Ventolin HFA	
Omnaris	1092.0F	fluticasone propionate AND triamcinolone acetonide	Also included in this policy is Beconase AQ, which should not be switched to step therapy since it has an alternative indication (nasal polyps).
Qnasl	1092.0F		
Budesonide nasal	1092.0F		
Zetonna	1092.0F		
Januvia	1136.0F	Tradjenta	
Onglyza	1136.0F		
Alogliptin	1136.0F		
Ciprodex	1222.0F	ciprofloxacin otic drops OR ofloxacin otic drops OR neomycin/polymyxin/hydrocortisone otic solution or suspension	
Cipro HC	1222.0F		
Trulicity	1288.0F	Victoza AND Ozempic	<u>Recommend removing</u> required documentation of diagnosis of type II diabetes and age \geq 18 years from current policy
Lantus	1408.0F	Basaglar OR Toujeo	

Discussion: Kevin Szczecina made the recommendation to add Levalbuterol products to the formulary on the generic tier and remove all UM and that triamcinolone be replaced with mometasone furoate in 1092.0F

Outcome: Kim Clark made a motion to accept the amended recommendations. 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.

P&T DUR UPDATE

A listing of current DUR related activities was reviewed for the committee for informational purposes:

In Progress

- Statin Use in Persons with Diabetes (SUPD)
 - This is the 3rd quarter MedImpact DUE for GHP Family
 - From this report, we selected **100 GHP Family members** whose medication history was suggestive of the presence of diabetes and who were not receiving a statin drug during the previous three-month period.
 - Brandy P. is completing the mail merge for these letters once the prescriber addresses are verified they will be mailed out.
 - Will run report on the members who we sent a letter on in December to determine the effectiveness of the letter.
- Asthma Med Ratio DUE
 - This is the 2nd quarter MedImpact DUE for GHP Family.
 - From this report, we identified **92 GHP Family members** with a ratio of controller medications to total asthma medications of greater than 0.2 (HEDIS threshold is greater than or equal to 0.5).
 - Brandy P. completed the mail merge and sent out the letters to the providers of these 92 members on 06/18/2018
 - Will run report on the members who we sent a letter on in October to determine the effectiveness of the letter.
- Adherence to Antidepressants DUE
 - This is the 1st quarter MedImpact DUE.
 - From this report, we identified **187 GHP Family members** with PDC < 50% and sent out letters to their prescribers. These letters were mailed out to providers 3/6/18
 - Adam provided us with the follow up data on these members in response to the DUE letters sent out: 41% of members (39 out of 95 members still enrolled) now compliant.
 - Adam was able to run this data again August 2018 (**100 members** now analyzed) and of those members **83%** had an increase in their PDC with **19 members** who more than doubled their PDC.
- Tobacco Cessation Program
 - Monthly meeting with Wellness/MTDM RPhs/Dr. Andrea Feinberg to create a program that identifies GHP members who may benefit from tobacco cessation interventions/medications.
 - We gathered drug utilization data to determine which medications are being prescribed and appropriate use. We also informed the group of the Chantix updates approved at the March P&T meeting: Chantix was added to the Brand Tier for GHP Family without Prior Authorization.
 - We are working with Hilary Steich from Wellness who has created an updated brochure (DHS approved) to send to members and pending DHS approval of a letter to send as well.
 - We hope to start looking into this report and sending letters/brochures to identified members as a future project.

- DUR Duplicate Anticoagulant Report
 - We are working with Sally and Krista to build a **monthly** report for **Medicaid** on members filling duplicate anticoagulant medications. We have created letters to send out to providers for both of these reports and they have been approved by Marketing and Legal. We hope to start working on this as a future project.
- FWA with MedImpact
 - We are also working with MI to see if we can implement pharmacy compliance audits and implement a policy for billing lotions/eye drops, etc. Sent a document in the beginning of July 2018 of common types of meds that are flagging on the FWA reports for further outreach/education.

Ongoing

- Duplicate Specialty Therapy
 - We run an in-house retrospective report **quarterly** for **all LOBs** with help from Adam Kelchner and Aubrielle Prater. These members are identified and written up and sent to a medical director if follow up is needed.
 - For Family 1Q2018 report, **1 intervention** resulting in **cost savings of \$3,103.30**
- Suboxone with an Opioid Report
 - We are getting this report **weekly** for **all LOBs** from Adam Kelchner. These members are being forwarded to Dr. Meadows, and he is looking into whether the opioid auths can be ended.
 - We hope to start working on the ending auth letters approved by Legal for the Medicaid LOB.
 - For Family in 2018, we have reviewed **157 members** so far, and **35 members** have been referred to Dr. Meadows.
- Medicaid Opioid Overutilization Report
 - We are getting this report **monthly** from MI and we are writing up each member that flags on the report. We have been monitoring the members that are continuously showing up on the report by any change in their MED. For those members we deem appropriate we will send a letter to their PCP.
 - For Family in 2018, we have reviewed **44 cases** so far and have not sent any prescriber letters yet.
- FWA Reports
 - We are getting this report **weekly** for **all LOBs** from Marie Strausser. We prepare this report by determining which claims need to be verified, and the Wilkes pharmacy students/GHP technicians have been making the calls to pharmacies.
 - We review claims for anti-hypertensives, statins, 1-day supply, and inhalers.
 - For Family in 2018, we have **reviewed 425 cases** so far and have **corrected 192 claims**, resulting in a **cost savings of \$19,072.92**
- Stent Antiplatelet Adherence Program
 - We continue to identify new stent patients at GMC/GWV/CMC/Susq and follow members with **all LOBs** for 1 year after discharge.
 - For Family in 2018, we have identified and outreached to **65 new stent patients** so far.
- Severity Report

- This is a **monthly** report for **all LOBs** on members who have filled a medication that has a level one interaction with another medication they are on.
- For Family in 2018, we have sent letters to providers on **73 GHP Family members** so far.
- Duplicate Antipsychotics
 - Adam Kelchner runs this report **quarterly**, and we send letters to the PCPs to address potential duplicate therapy issues.
 - 1Q2018 report was received on 4/17/18 included **133 members** with multiple antipsychotics. We sent these members to Brandy Powell who completed the mail merge and sent letters to providers 4/18/18.
 - 2Q2018 report received on 07/18/18 included **147 members** with multiple antipsychotic claims. We sent these members to Brandy Powell who completed the mail merge and sent letters to providers the week of 7/23/18.
- Enbrel Overutilization for Treating Plaque Psoriasis
 - A report was created to determine members who have been using Enbrel Twice weekly dosing over the FDA approved dosing (3 months).
 - For Family on the March report, **1 intervention** resulting in **cost savings of \$4,751.36**

Glatiramer Acetate

Glatiramer acetate is a pharmacy benefit and will be added to formulary for all lines of business.

Medicaid: It is recommended that glatiramer acetate be added to the GHP Family formulary at the Generic Tier. No prior authorization criteria will apply.

Quantity Limit:

glatiramer acetate 20 mg/mL: 30mL per 30 days

glatiramer acetate 40 mg/mL: 12mL per 28 days

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.

TRELEGY ELLIPTA

Background: Trelegy Ellipta (fluticasone/umeclidinium/vilanterol) is a 3-in-1 combination inhaler that is indicated for the maintenance treatment of airflow obstruction in patients with COPD, including chronic bronchitis and/or emphysema, and to reduce COPD exacerbations in patients with a history of exacerbations.

Trelegy Ellipta offers the benefit of once daily dosing with the added benefit of combining three medication classes in one device (inhaled corticosteroid [ICS], long-acting muscarinic agent [LAMA], and a long-acting beta agonist [LABA]). This can potentially improve patient adherence, which may subsequently reduce long-term costs associated with COPD.

Current Formulary Status/Prior Authorization Criteria: NF, PA required, QL

Recommendations: It is recommended that the following updates be made:

- Move Trelegy to Brand Tier for GHP Family
- Remove PA requirement

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.

NUPLAZID QL UPDATE

Nuplazid was previously only available as 17 mg tablets. Nuplazid is also now available as 34 mg capsules and 10 mg tablets.

Dosage schedule¹:

Recommended Dose:

- 34 mg taken orally once daily, without titration (administration of one 34 mg capsule once daily results in plasma concentrations similar to exposure with two, 17 mg tablets once daily)

Coadministration with Strong CYP3A4 Inhibitors

- 10 mg orally as one tablet once daily

Medicaid:

Quantity Limit:

Nuplazid 10 mg tablets: 30 tablets per 30 days

Nuplazid 17 mg tablets: 60 tablets per 30 days

Nuplazid 34 mg capsules: 30 capsules per 30 days

Recommendations: Apply quantity limits as presented.

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.

GHP FAMILY FORMULARY UPDATE

Recommendations: It is recommended that the following formulary changes be approved:

Medication	Tier/UM	Rationale
Defetilide	Generic	Formulary for all other LOBs
Tolterodine ER	Generic	AWP of \$1.79 (MAC)

Estradiol Patch	Generic	Formulary for all other LOBs
Estradiol Cream	Generic	Formulary for all other LOBs
Isotretinoin	Remove PA	No PA required for other LOBs
Ciclopirox Gel	Generic	Formulary for all other LOBs
Ciclopirox Shampoo	Generic	Formulary for all other LOBs
Ciclopirox Susp	Generic	Formulary for all other LOBs
Esomeprazole	Generic	AWP of \$0.59 (MAC)
Quetiapine ER	Generic w/QL	Formulary for all other LOBs
Bunavail 2.1/0.3 mg	2 daily	Reduce excessive doses
Bunavail 4.2/0.7 mg	2 daily	Reduce excessive doses
Bunavail 6.3/1 mg	1 daily	Reduce excessive doses
Buprenorphine 2 mg	3 daily	Reduce excessive doses
Buprenorphine 8 mg	2 daily	Reduce excessive doses
Buprenorphine/Naloxone 2/0.5 mg	3 daily	Reduce excessive doses
Buprenorphine/Naloxone 8/2 mg	2 daily	Reduce excessive doses
Suboxone 2/0.5 mg	3 daily	Reduce excessive doses
Suboxone 4/1 mg	2 daily	Reduce excessive doses
Suboxone 8/2 mg	2 daily	Reduce excessive doses
Suboxone 12/3 mg	1 daily	Reduce excessive doses
Zubsolv 0.7/0.18 mg	3 daily	Reduce excessive doses
Zubsolv 1.4/0.36 mg	3 daily	Reduce excessive doses
Zubsolv 2.9/0.71 mg	3 daily	Reduce excessive doses
Zubsolv 5.7/1.4 mg	2 daily	Reduce excessive doses
Zubsolv 8.6/2.1 mg	1 daily	Reduce excessive doses
Zubsolv 11.4/2.9 mg	1 daily	Reduce excessive doses

Discussion: No comments or questions.

Outcome: Keith Hunsicker 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.

TESTOSTERONE UPDATE

Recommendations: It is recommended generic Fortesta, generic Testim, generic Androgel 1% (pump and packets) and generic Vogelxo (packets and pump) be placed on the Generic Tier

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.

GHP FAMILY POLICY UPDATE

Recommendations: During review of the policies developed during the July P&T Committee meeting, DHS requested several updates and clarifications. It is recommended the Committee approve the changes noted below:

Policy 1447.0F Agents for Hemophilia A– it was noted that Tretten is indicated for routine prophylaxis of bleeding in patients with congenital factor XIII A-subunit deficiency, not hemophilia A. It is recommended that Tretten not be reviewed using policy 1447.0F and that a separate policy be developed at a later time.

Policy 1449.0F Feiba – DHS noted that Feiba is indicated for use in hemophilia A and B patients with inhibitors for control and prevention of bleeding episodes, perioperative management and routine prophylaxis to prevent or reduce the frequency of bleeding episodes. However, our policy addressed only Feiba’s use for hemophilia A. As a result, it is recommended the following underlined changes be approved by the committee:

- Medical record documentation of a diagnosis of hemophilia A (a documented Factor VIII deficiency) or hemophilia B AND
- Medical record documentation that the antihemophilic agent will be for outpatient use AND
- Medical record documentation that the member has factor inhibitors (neutralizing antibodies), confirmed by laboratory testing (ie. Bethesda assay) AND
- Medical record documentation that the antihemophilic agent will be used for on-demand treatment or perioperative management of bleeds
OR
- Medical record documentation that the antihemophilic agent will be used for routine prophylaxis AND If being used for routine prophylaxis of hemophilia A: medical record documentation of therapeutic failure on, intolerance to, or contraindication to Hemlibra

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

PRIOR AUTHORIZATION/ STEP THERAPY REMOVAL

It is recommended that the step therapy requirement is removed from the below diabetes medications due to a high approval percentage:

- Diabetic therapies stepped through metformin:
 - Jardiance
 - Synjardy/Synjardy XR
 - Invokana
 - Invokamet/Invokamet XR
 - Glyxambi
 - Tradjenta
 - Jentadueto/Jentadueto XR
 - Ozempic
 - Victoza

Brilinta: It is recommended that the prior authorization requirement be removed from Brilinta due to a high approval percentage

Esomeprazole: It is recommended that the step therapy requirement is removed from esomeprazole capsules due to similar efficacy and cost as formulary alternatives.

Recommendations: Remove PA or Step therapy as presented

Discussion: No comments or questions.

Outcome: Tricia Heitzman 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.

Medical Benefit Policy Updates

The following policy updates were made to the following Medical Benefit Policies based on recommendations from the Department of Health (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 176.0 Sublocade (buprenorphine ER subcutaneous injection)- The following changes were required by DHS for policy approval. GHP expressed concerns over the requirements imposed by DHS for approval of the submitted policy specifically noting that criteria included in the FDA approved indication of the drug were not permitted by DHS as they indicated the proposed criteria would impose stricter criteria than the fee for service policy. The following criteria were removed from MBP 176.0 to allow approval from DHS.

Sublocade (buprenorphine ER subcutaneous injection) will be considered medically necessary when ALL of the following criteria are met:

- Medical record documentation that the patient is 18 years of age or older **AND**
- Medical record documentation of a diagnosis of opioid use disorder (opioid dependence) **AND**
- ~~Medical record documentation that Sublocade will be used as part of a complete treatment program that includes counseling and psychosocial support~~ **AND**
- Medical record documentation that member has been initiated into treatment with a transmucosal buprenorphine-containing product (e.g. Suboxone, buprenorphine/naloxone, buprenorphine), followed by dose adjustment for a minimum of 7 days **AND** until cravings and withdrawal symptoms are clinically controlled **AND**
- Medical record documentation that the member will not be receiving supplemental sublingual buprenorphine concurrently with Sublocade **AND**
- ~~Medical record documentation of a history of poor adherence to oral medications AND documentation that education to improve adherence has been attempted~~ **AND**
- If the member has previously been established on Sublocade and the 300mg maintenance dose is requested: Medical record documentation that the member has tried and failed the 100mg maintenance dose **AND** that the benefits outweigh the risks of increasing to the 300mg maintenance dose **AND**
- Confirmation that the prescriber or prescriber's delegate has conducted a review of Pennsylvania's Prescription Drug Monitoring Program (PA PDMP) prior to administering Sublocade.

AUTHORIZATION DURATION: If approved, initial authorization duration will be for 3 months. After the initial 3-month authorization, subsequent approval will be for 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of the following:

- ~~Medical record documentation that the member is adherent to buprenorphine and is not using opiates. This must be verified by all urine drug screens from the time of last authorization, one of which must be dated within 28 days of the request date for opiates and buprenorphine. All drug screens must be positive for buprenorphine and norbuprenorphine, and negative for opiates. The presence of other non-opiate controlled substances must be consistent with prescribed controlled substances and documentation that their use is medically necessary and the benefit outweighs any risks associated with their use in the member must be provided~~ **AND**
 - ~~Medical record documentation that Sublocade continues to be used as part of a complete treatment program that includes counseling and psychosocial support~~ **AND**
 - Medical record documentation that the member will not be receiving supplemental sublingual buprenorphine concurrently with Sublocade **AND**
 - Medical record documentation of one of the following:
 - That the member will continue to receive the 100mg monthly maintenance dose **OR**
 - If 300mg maintenance dose is requested, the member has tried and failed the 100mg monthly maintenance dose **AND** the benefits outweigh the risks of receiving the 300mg monthly dose
- AND**
- Confirmation that the prescriber or prescriber's delegate has conducted a review of Pennsylvania's Prescription Drug Monitoring Program (PA PDMP) prior to administering Sublocade.

MBP 146.0 Probuphine (buprenorphine)- Submission of Probuphine for annual review prompted new questions from DHS of the previously approved policy. DHS noted that the policy was more strict than the fee for service policy and specific criteria would need to be removed for approval. The following changes were made to allow for continued approval of the policy by DHS.

Probuphine (buprenorphine) will be considered medically necessary when ALL of the following criteria are met:

- Prescriber must have a unique identification number issued by the Drug Enforcement Agency (DEA) certifying prescribing authority for buprenorphine agents **AND**
- Prescriber must have enrolled, trained, and demonstrated competency in Probuphine procedures as described by the Probuphine REMS Program **AND**
- ~~Probuphine must be prescribed by a participating provider or a provider who participates in the plan's designated behavioral health benefit program~~ **AND**
- Medical record documentation of a diagnosis of opioid dependence **AND**
- Medical record documentation that patient is clinically stable by verifying **ALL** of the following:
 - No reports of significant withdrawal symptoms
 - Reports of low to no desire/need to use illicit opioids
 - No episodes of hospitalizations (for addiction or mental health issues), emergency room visits, or crisis interventions in the past 90 days
 - Consistent compliance with clinic visit requirements as evidenced by documentation of attendance to all scheduled appointments **at least** 6 months prior to the ordering of Probuphine **AND**
- Medical record documentation that patient is stable for at least the last 6 months on low-to-moderate doses of a transmucosal buprenorphine containing product (i.e., doses of no more than 8 mg per day of Subutex or Suboxone sublingual tablets or generic equivalent) **AND**
- Medical record documentation that the member is compliant with oral buprenorphine therapy, documented by all urine drug screens within 90 days of the request, one of which must be dated within 28 days of request date, for opiates and buprenorphine. The drug screen must be positive for buprenorphine and norbuprenorphine and negative for opiates. The presence of other non-opiate controlled substances must be consistent with prescribed controlled substances and documentation that their use is medically necessary and the benefit outweighs any risks associated with their use in the member must be provided.

AND

- ~~Medical record documentation of member abstinence from alcohol~~ **AND**
- Medical record documentation that the member will not be receiving supplemental sublingual buprenorphine after implant insertion **AND**
- ~~Member must be actively involved in formal counseling with a licensed behavioral health provider. Must provide the name of counselor and/or facility or rationale for non-participation~~ **AND**
- There is confirmation that the prescriber or the prescriber's delegate has conducted a review of Pennsylvania's Prescription Drug Monitoring Program (PDMP) prior to prescribing Probuphine.

For re-authorization:

- ~~Member must be adherent to buprenorphine and must not be using opiates. Must be verified by all urine drug screens within the past 6 months, one of which must be dated within 28 days of request date for opiates and buprenorphine. All drug screens must be positive for buprenorphine and norbuprenorphine, and negative for opiates. The presence of other non-opiate controlled substances must be consistent with prescribed controlled substances and documentation that their use is medically necessary and the benefit outweighs any risks associated with their use in the member must be provided.~~ **AND**
- ~~Medical record documentation that member continues to be actively involved in formal counseling with a licensed behavioral health provider. Must provide the name of counselor and/or facility or rationale for non-participation~~ **AND**
- ~~Medical record documentation of continued member abstinence from alcohol~~ **AND**
 - Medical record documentation that Probuphine has **NOT** been used for greater than one year **AND**
 - Medical record documentation that the new implants will be inserted into the contralateral arm **AND**
 - Medical record documentation that member will not be receiving supplemental sublingual buprenorphine after implant insertion **AND**

There is confirmation that the prescriber or the prescriber's delegate has conducted a review of Pennsylvania's Prescription Drug Monitoring Program (PDMP) prior to prescribing Probuphine

MBP 173.0 Fasenra (benralizumab)- DHS noted that in the clinical trials for approval of Fasenra, in trials 1 and 2 while patients with a baseline blood eosinophil count ≥ 300 cells/ μ L showed a numerically greater response than those with counts < 300 cells/ μ L reductions in exacerbation rates were observed irrespective of baseline peripheral eosinophil counts. Additionally, patients in trial 3 were required to have blood eosinophil counts ≥ 150 cells/ μ L. GHP updated our clinical policy to be more reflective of the eosinophil counts used in clinical trials as noted below.

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

Fasenra (benralizumab) will be considered medically necessary when ALL of the following criteria are met:

- Prescribed by an allergist/immunologist or pulmonologist **AND**
- Patient is 12 years of age or older **AND**
- Medical record documentation of a diagnosis of severe eosinophilic asthma **AND** that Fasenra is being used as add-on maintenance treatment **AND**
- Medical record documentation of blood eosinophil count ≥ 150 cells/ μ L ($0.15 \times 10^3/\mu$ L) ~~≥ 300 cells/ μ L ($0.3 \times 10^3/\mu$ L)~~ within the past 3 months **AND**
- Medical record documentation of:
 - Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3-month trial of high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR**
 - Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist

AND

- Medical record documentation that individual is adherent to current therapeutic regimen and must demonstrate appropriate inhaler technique **AND**
- Medical record documentation that known environmental triggers within the member's control have been eliminated **AND**
- Medical record documentation that Fasenra is not being used in combination with Xolair (omalizumab), Nucala (mepolizumab), or Cinqair (reslizumab)

Recommendations: Apply criteria to appropriate medical policies

Discussion: No comments or questions.

Outcome: Kim Clark 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.

RITUXAN UPDATE

Chronic Lymphoid Leukemia (CLL)- Current authorization requirements for Rituxan under the medical benefit do not require Prior Authorization of Rituxan when it is being used for the diagnosis of Non-Hodgkins lymphoma and any subsequent diagnosis that falls under that disease state. After review of our policy we would like to remove the requirements for Prior Authorization for the diagnosis of Chronic Lymphoid Leukemia (CLL) as well. CLL is often grouped with SLL which is a form of Non-Hodgkins Lymphoma and the requirement to Prior Authorize CLL and not NHL has caused confusion with providers and members. Rituxan is a mainstay of treatment in CLL and removal of the Prior Authorization requirement for this population would improve access to treatment.

Multiple Sclerosis- In addition we would like to remove the Prior Authorization requirement for Rituxan when used to treat Multiple Sclerosis. Our current prior authorization requirements require failure of higher cost treatment alternatives, creating a barrier to less costly alternatives such as Rituxan. To help decrease the prior authorization burden and allow easier access to less costly treatment alternatives for the treatment of Multiple Sclerosis we would like to remove the Prior Authorization requirement for a diagnosis of Multiple Sclerosis.

Current Medical Policy:

MBP 48.0 Rituxan (rituximab)

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

1. **For Rheumatoid Arthritis:**

All of the following criteria must be met:

- Physician documentation of a diagnosis of moderate to severe rheumatoid arthritis in accordance with the American College of Rheumatology Criteria for the Classification and Diagnosis of Rheumatoid Arthritis; **AND**
- At least 18 years of age or older; **AND**
- Prescription written by a rheumatologist; **AND**
- Medical record documentation that an effective dose of methotrexate will be continued during rituximab therapy; **AND**
- Physician documentation of an inadequate response to 12 weeks of therapy with etanercept (Enbrel) **AND** adalimumab (Humira); **AND**

LIMITATIONS:

If criteria are met, approval will be limited to one course of therapy defined as two infusions, one given on day 1 and another on day 15.

Additional courses may be considered medically necessary if the following criteria are met:

- At least 6 months has elapsed since the previous treatment course; **AND**
- Physician documentation of improvement or lack of progression in the signs and symptoms of rheumatoid arthritis; **AND**
- Physician documentation showing previous treatment course did not result in active infection.

2. For Chronic Immunothrombocytopenia (ITP):

All of the following criteria must be met:

- Diagnosis of primary chronic ITP **AND**
- Platelet count of $< 30,000/\text{mm}^3$ with active bleeding or $< 20,000/\text{mm}^3$ with increased risk of bleeding **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to corticosteroids **AND** IVIg* **AND** splenectomy (*prior authorization required)

Authorization Duration*: If patient meets criteria for coverage, authorization will be given for one month of treatment with rituximab.

3. For Chronic Lymphoid Leukemia:

- Medical record documentation of a diagnosis of chronic lymphoid leukemia used in combination with fludarabine and cyclophosphamide

4. For Microscopic Polyarteritis Nodosa

- Medical record documentation of a diagnosis of microscopic polyarteritis nodosa used in combination with glucocorticoids

5. For Wegner's Granulomatosis

- Medical record documentation of a diagnosis of Wegner's granulomatosis used in combination with glucocorticoids

6. For Non-Hodgkin Lymphoma

Note: *Prior authorization is not required for diagnosis codes C82.00 through C85.99 and C86.0 through C88.9. In the event a requestor would like a medical necessity review completed the following criteria would apply:*

- Medical record documentation of a diagnosis of Non-Hodgkin Lymphoma

7. For Multiple Sclerosis (MS)

○ **For Primary Progressive MS (PPMS):**

All of the following criteria must be met:

- Medical record documentation of prescription written by a neurologist **AND**
- Medical record documentation of a diagnosis of PPMS

○ **For Secondary Progressive MS (SPMS)/Relapsing Progressive MS (RPMS):**

All of the following criteria must be met:

- Medical record documentation of prescription written by a neurologist **AND**
- Medical record documentation of a diagnosis of SPMS or relapsing progressive MS **AND**
 - Medical record documentation of rapidly progressing disease (ex. EDSS score increase of >1 in 1 year) **OR**

- Medical record documentation of slowly progressing disease (ex. EDSS score change of < 1 in 1 year) and therapeutic failure on, contraindication to, or intolerance to Aubagio ^
- **For Relapsing/Remitting MS (RRMS):**
All of the following criteria must be met:
 - Medical record documentation of prescription written by a neurologist **AND**
 - Medical record documentation of a diagnosis of Relapsing/Remitting MS (RRMS) **AND**
 - Medical record documentation of therapeutic failure on, contraindication to, or intolerance to three alternatives one of which must be Tysabri* **OR**
 - Medical record documentation of poor prognosis and therapeutic failure on, contraindication to, or intolerance to Tysabri*

*NOTE: According to the American Academy of Neurology recommendation, Tysabri may be considered as a first line therapy in individuals with relapsing remitting multiple sclerosis who exhibit particularly aggressive initial course of disease and in whom the potential benefit is felt to outweigh the risk. Patients with a poor prognosis/aggressive disease include those with a heavy T2 lesion load, lesions in brain stem, cerebellum, and spinal cord. **Patients who are anti-JCV antibody positive should avoid Tysabri use.***

(* requires prior authorization, ^QL apply)

(**NOTE to reviewer: Studied dose for MS is 1gm given on day 1 and 15, repeated every 6 months**)

8. **For Refractory Chronic Debilitating Myasthenia Gravis**

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

*Note: Corticosteroids: betamethasone, dexamethasone, methylprednisolone, prednisone
Cholinesterase inhibitors: pyridostigmine, neostigmine
Immunosuppressants: azathioprine, mycophenolate, cyclosporine, Rituxan*

9. **For Pemphigus Vulgaris (PV)**

- Prescription written by a dermatologist **AND**
- Member is 18 years of age or older **AND**
- Medical record documentation of a diagnosis of moderate to severe pemphigus vulgaris **AND**
- Medical record documentation of a contraindication to, intolerance to, or therapeutic failure on corticosteroids **AND** a 12-week trial of at least one (1) nonsteroidal immunomodulatory medication (e.g. azathioprine, cyclophosphamide, or mycophenolate).

AUTHORIZATION DURATION:

For Multiple Sclerosis: 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.

For all other indications: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate (*except for the diagnosis for ITP). Subsequent approvals will be for an additional 6 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.

Recommendations: Apply criteria to appropriate medical policy

Discussion: No comments or questions.

Outcome: Kim Clark 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.

QUARTERLY CASE AUDIT RESULTS

The Quarterly Case Audit was held on September 6th. No changes to formulary are recommended at this time. Considering creating a policy for non-preferred skeletal muscle relaxants, non-preferred eye drops, and non-preferred inhaled corticosteroids to allow for consistency among reviewers and to ensure appropriateness. Will continue to look for opportunities to create more drug specific policies at future quarterly case audit meetings.

Meeting adjourned at 4:36 pm.

Future Scheduled Meetings

Tuesday, November 20, 2018 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.