P&T Committee Meeting Minutes
Commercial/GHP Kids/Marketplace
November 19, 2019

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

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

Review and Approval of Minutes:
Dr. Bret Yarczower asked for a motion or approval to accept the September 17, 2019 minutes as written. Keith Hunsicker accepted the motion and Tricia Heitzman seconded the motion. None were opposed.

DRUG REVIEWS

SUNOSI (solriamfetol)

Review: Sunosi is indicated to improve wakefulness in adult patients with excessive daytime sleepiness (EDS) associated with narcolepsy or obstructive sleep apnea (OSA). Sunosi is not indicated to treat the underlying airway obstruction in OSA. Ensure that the underlying airway obstruction is treated (e.g. CPAP) for at least one month prior to initiating Sunosi for excessive daytime sleepiness. Sunosi is the first dopamine-norepinephrine reuptake inhibitor (DNRI) indicated for EDS.

Sunosi is available as 75 mg and 150 mg oral tablets. The 75 mg tablets are scored and can be split in half (37.5 mg). It is to be dosed once daily upon awakening, with a minimum of 9 hours' time before planned bedtime, due to its potential to interfere with sleep.

Patients with narcolepsy EDS are recommended to begin therapy with a dose of 75 mg once daily, while those with OSA EDS are recommended to begin at 37.5 mg daily. The dose of Sunosi may be doubled at intervals of at least 3 days and the maximum recommended dose is 150 mg daily.

Dose adjustments for Sunosi are recommended in patients with moderate to severe renal dysfunction, with both indications recommended to initiate treatment at 37.5 mg once daily; an increase to 75 mg once daily is possible after 7 days of treatment.

The efficacy and safety of Sunosi was evaluated in 4 clinical trials. The efficacy endpoints in the clinical trials evaluated Maintenance of Wakefulness Test (MWT) mean sleep latency and Epworth Sleepiness Scale (ESS) scores. The MWT measures an individual's ability to remain awake during the daytime in a darkened, quiet environment. Patients are instructed to remain awake for as long as possible during 40-minute test sessions, and sleep latency was determined as the mean number of minutes patients could remain awake in the first four test sessions. The ESS is an 8-item questionnaire by which patients rate their perceived likelihood of falling asleep during usual daily life activities (a higher score represents an increased severity).

Study 1 was a double-blind, randomized, placebo-controlled, parallel-group study to determine the efficacy and safety of solriamfetol for EDS in narcolepsy. Patients (n= 239) were randomized to receive placebo or 75, 150, or 300 mg of solriamfetol once daily. Compared to placebo, patients randomized to 150 mg showed statistically significant improvements on the MWT and the ESS at Week 12. These effects were apparent at Week 1 and consistent with the results at Week 12. There were trends toward improvement in the 75 mg treatment group, however these were not statistically significant. There was no difference in efficacy between patients with cataplexy and without cataplexy.

Study 2 was a double-blind, randomized, placebo-controlled, parallel design study in which adult patients (n=476) were randomized to placebo or solriamfetol 37.5 mg, 75 mg, 150 mg, or 300 mg, respectively, to evaluate safety and efficacy of solriamfetol in treatment of EDS in OSA patients. Compared to placebo, patients randomized to 37.5 mg, 75 mg, and 150 mg showed statistically significant improvements on the MWT and the ESS at Week 12. These effects were apparent at Week 1 and consistent with the results at Week 12.

Study 3 was a 6-week, multicenter, double-blind, placebo-controlled, randomized-withdrawal study in 174 adult patients with OSA. During a 2-week, open-label titration phase, patients were started on Sunosi 75 mg once daily and were titrated to the maximum tolerable dose. At the end of the stable-dose phase, patients who reported "much" or "very much" improvement and showed improvements on the MWT and ESS entered a double-blind withdrawal phase and were randomized 1:1 to either continue Sunosi or switch to placebo. Compared to patients who remained

on Sunosi, patients randomized to placebo experienced statistically significant worsening of sleepiness as measured by MWT and ESS.

Study 4 was a 52-week, open-label study in 638 patients with either narcolepsy or OSA who had completed a prior trial. During a 2-week, open-label titration phase, patients were started on Sunosi 75 mg once daily and were titrated to the maximum tolerable dose. Patients remained on this dose during a subsequent open-label treatment period of either 38 or 50 weeks. After 6 months of stable-dose treatment, 282 patients (79 with narcolepsy; 203 with OSA) entered a 2-week randomized-withdrawal period. Patients were randomized 1:1 to either continue to receive Sunosi or switch to placebo. Compared to patients who remained on Sunosi, patients randomized to placebo experienced a statistically significant worsening in sleepiness as measured by ESS.

Sunosi is contraindicated in patients receiving concomitant treatment with MAOI, or within 14 days following discontinuation MAOI, because of the risk of hypertensive reaction. Sunosi has warnings/precautions for increases in systolic blood pressure, diastolic blood pressure, and heart rate in a dose-dependent fashion. Psychiatric adverse reactions have been observed in clinical trials, including anxiety, insomnia, and irritability. The most common adverse reactions (≥ 5% and greater than placebo) include headache, nausea, decreased appetite, insomnia, and anxiety. Sunosi has potential for abuse and is considered a controlled substance (CIV). Sunosi has not been evaluated for use in pregnant, lactating, or pediatric patients.

Nonpharmacological interventions such as (napping, sleep hygiene, avoiding certain medications, psychosocial support) may help patients with narcolepsy. However, many patients require medications. Modafinil has become a first-line agent for narcolepsy. Per UpToDate, Sunosi's side effects are similar to modafinil and may become a first-line option as clinical experience increases. Wakix just received approval in August 2019 for excessive daytime sleepiness associated with narcolepsy. Other options for narcolepsy include methylphenidate and amphetamines. Sodium oxybate reduces cataplexy and therefore is a good option for patients with severe cataplexy.

For patients with OSA, positive airway pressure therapy is the mainstay of therapy. For patients with mild to moderate OSA or those who fail to adhere to positive airway pressure therapy, oral appliances (e.g. mandibular advancement devices, tongue retaining devices) are an alternative. For patients who fail both positive airway/oral appliances and have severe obstructions of the upper airway, surgery can be tried. For OSA, modafinil and armodafinil may be beneficial as adjunctive therapy for excessive daytime sleepiness despite conventional therapy (e.g. positive airway pressure, oral appliances).

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

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

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

Outcome: Sunosi will be a pharmacy benefit that will not be added to the pharmacy formularies at this time. Sunosi will require a prior authorization with the following criteria.

<u>Narcolepsy:</u>

- Medical record documentation of diagnosis of excessive daytime sleepiness associated with narcolepsy AND
- Medical record documentation of the member being ≥ 18 years of age AND

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to: modafinil* or armodafinil* AND methylphenidate IR or amphetamine/dextroamphetamine IR

Obstructive Sleep Apnea:

- Medical record documentation of diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea AND
- Medical record documentation of the member being ≥ 18 years of age AND
- Medical record documentation that the patient's underlying airway obstruction has been treated (e.g. with a continuous positive airway pressure (CPAP)) for at least one month prior to the initiation of Sunosi AND
- Medical record documentation that the patient will continue to use this treatment modality (e.g. CPAP) while receiving Sunosi AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to modafinil* or armodafinil*

Quantity Limit: Note to CSR: Authorization should be entered by HICL and only checking the Formulary PA required box (no QLs need to be entered within the authorization). Quantity Limit: **1 tablet per day**

Other Recommendations *Armodafinil*

Currently, for all lines of business, the armodafinil policies require failure on modafinil. Since the cost of armodafinil is very similar to modafinil, the failure of modafinil will be removed from all the armodafinil policies (199.0, 1138.0F, 32.0D):

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

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

ROZLYTREK (entrectinib)

Review: Rozlytrek is a kinase inhibitor indicated for the treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1- positive or for adult and pediatric patients 12 years of age or greater with solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is liked to result in severe morbidity, and have progressed following treatment or have no satisfactory alternative therapy. It inhibits tropomyosin receptor tyrosine kinases (which are encoded by NTRK genes), the proto-oncogene tyrosine-protein kinase ROS1, and anaplastic lymphoma kinase (ALK). Rozlytrek is the third FDA approved medication which targets a biomarker across different types of tumors, rather than the specific location where the tumor originated.

Rozlytrek joins Vitrakvi in targeting NTRK fusion-positive solid tumors and current guidelines do not appear to prefer one over the other. For the treatment of ROS1-positive non-small cell lung cancer, Rozlytrek joins Xalkori as a preferred agent over Zykadia. Rozlytrek may offer some advantage in patients with CNS involvement due to better intracranial penetration.

The efficacy of Rozlytrek in unresectable or metastatic NTRK fusion positive solid tumors was evaluated in a subgroup analysis of 54 patients from the pooled data from three single-arm, open-label clinical trials- ALKA, STARTRK-1, and STARTRK-2. The major efficacy outcome measuring overall response rate according to

RECIST (v1.1) was 57% of patients, with 7.4 % of patients having a complete response and 50% of patients having a partial response. The duration of response ranged from 2.8 months to 26 months, with 68% of patients having a response lasting at least 6 months. Eleven patients included in the analysis had CNS metastases at baseline and with 57.1% achieved an intracranial response with treatment with a median intracranial duration of response that was not estimable.

The efficacy of Rozlytrek in ROS-1 positive metastatic non-small cell lung cancer was evaluated in a subgroup analysis of 51 patients from the pooled data from three single-arm, open-label clinical trials- ALKA, STARTRK-1, and STARTRK-2. The major efficacy outcome measuring overall response rate according to RECIST (v1.1) was 78% of patients, with 6% of patients having a complete response and 73% having a partial response. The duration of response ranged from 1.8 months to 36.8+ months, with 70% of patients have a response lasting at least 6 months. Twenty patients included in the analysis had CNS metastases at baseline and 55% of patients achieved an intracranial response with a median intracranial duration of response of 12.9 months and a median intracranial progression free survival of 7.7 months.

The STARTRK-NG study was a Phase 1/1b ongoing, single-arm, open-label dose escalation and expansion study investigated the safety and efficacy of Rozlytrek in 29 children and adolescents up to age 21 with recurrent or refractory solid tumors and primary CNS tumors with or without ROS1, NTRK, or ALK gene fusions. The primary endpoint was to determine the maximally tolerated phase 2 dosage, while secondary endpoints investigated safety, tolerability, pharmacokinetics, overall response rate, and progression free survival. It was found that Rozlytrek was generally well tolerated at a dose of 550 mg/m^2 daily and produced rapid and durable responses in patients with refractory CNS involvement and tumors harboring NTRK, ROS1, or ALK gene fusions.

Serious adverse reactions occurred in 39% of patients. The most frequently report serious adverse reactions were pneumonia, dyspnea, pleural effusion, sepsis, pulmonary embolism, respiratory failure, and pyrexia. Adverse reactions led to permanent discontinuation in 9% of patients, most frequently resulting from pneumonia, cardio-respiratory arrest, dyspnea, and fatigue. Dose interruptions and reductions due to adverse reactions occurred in 46% and 29% of patients, respectively. The most common adverse reactions (≥ 20%) were fatigue, constipation, dysgeusia, edema, dizziness, diarrhea, nausea, dysesthesia, dyspnea, myalgia, cognitive impairment, increased weight, cough, vomiting, pyrexia, arthralgia and vision disorders.

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

Clinical Discussion: Bret Yarczower questioned if the trials specified which NTRK genes were identified. Kim stated that the trials looked at them collectively. Bret suggested looking into via oncology to see if this product is included within it. Keith Hunsicker made a motion to accept the recommendations as presented. Aubrielle Prater seconded the motion. None were opposed.

Financial Discussion: Bret Yarczower questioned if we should prefer this over Vitrakvi for NTRK positive tumors, since they can be used interchangeably. NCCN does not prefer one over the other, so we didn't prefer one over the other at this time, and we would usually approve either medication via medical necessity. It was suggested to ask for oncology feedback if there would be other reasons to prefer one product over the other. No further comments or questions. Tricia Heitzman made a motion to accept the recommendations as presented. Keith Hunsicker seconded the motion. None were opposed.

Outcome: Rozlytrek is a pharmacy benefit that will be added to the pharmacy formulary at the Oral Oncology Brand Non-preferred tier ($0 copay). The following prior authorization criteria will apply:

For NTRK-fusion positive solid tumors:

- Prescription written by oncologist or hematologist
- Medical record documentation of age 12 years or greater.
- Medical record documentation of unresectable or metastatic solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation **AND**
- One of the following:
    - Medical record documentation that the member must have progressed following treatment **OR**
    - have no satisfactory alternative treatments

For ROS1-positive Non-Small Cell Lung Cancer:

- Prescription written by an oncologist
- Medical record documentation of age 18 years or older
- Medical record documentation of a diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors are *ROS1*-positive.

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 LIMITS: 100 mg capsules: 1 capsule per day; 200 mg capsules: 3 capsules per day

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

INREBIC (fedratinib)

Review: Inrebic is an oral kinase inhibitor with activity against wild type and mutationally activated Janus Associated Kinase 2 (JAK2) and FMS-like tyrosine kinase 3 (FLT-3) indicated for the treatment of adult patients with intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF). It is the second JAK inhibitor indicated for the treatment of myelofibrosis and is more selective than Jakafi which inhibits both JAK1 and JAK2. It is not clear whether the selectivity of Inrebic offers any improvement in the safety and efficacy profile over Jakafi, which has a high rate of discontinuation due to adverse events.

The efficacy of Inrebic was investigated in the JAKARTA trial, a phase 3, double-blind, placebo-controlled trial in patients with intermediate-2 or high-risk primary myelofibrosis, post polycythemia vera myelofibrosis and post essential thrombocytopenia myelofibrosis. Patients were randomized 1:1:1 to receive Inrebic 400 mg (n=96), Inrebic 500 mg (n=97), or placebo daily for at least 6 consecutive 28-day cycles. The primary endpoint of a 35% reduction in baseline spleen volume at 24 weeks was achieved by a statistically significant higher proportion of patients in both Inrebic treatment groups compared to placebo. All but 5 patients in the Inrebic treatment groups experienced some degree of spleen volume reduction while a majority of patients in the placebo treatment group had an increase in spleen volume. A secondary endpoint of a 50% or more reduction in total symptoms score at 24 weeks was also achieved in a significantly higher proportion of patients in both Inrebic treatment groups compared

to placebo. Results from the JAKARTA trial showed that there was a greater risk, but no significant benefit of Inrebic 500 mg compared to Inrebic 400 mg.

The efficacy findings in the JAKARTA trial were supported by the JAKARTA-2 trial, a phase 2 single-arm, open-label trial investigating the efficacy of Inrebic in patients with symptomatic intermediate-1, intermediate-2, and high-risk primary myelofibrosis, post-PV myelofibrosis, and post-EV myelofibrosis who had been previously exposed to Jakafi for at least 14 days prior to enrollment. The primary endpoint of at least 35% reduction in spleen volume at 24 weeks was achieved by 30/97 patients with a duration of response that was not reached at the time of analysis. A secondary endpoint of at least 50% reduction from baseline in total symptoms score was achieved by 23 patients.

Inrebic has a black box warning for encephalopathy, including Wernicke's encephalopathy. During the JAKARTA trial, Wernicke's encephalopathy was reported by 7 patients, all of which were receiving Inrebic 500 mg. During the JAKARTA trial and the JAKARTA-2 trial, 99% and 100% of patients reported at least one adverse event. Gastrointestinal toxic effects, including diarrhea, nausea, and vomiting, were the most frequently reported adverse reactions with the highest incidence during the first cycle of treatment. Other adverse events that led to treatment discontinuation or dosage reduction or interruption were cardiac failure, anemia, thrombocytopenia, myocardial ischemia, and increased blood creatinine.

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

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

Outcome: Inrebic is a pharmacy benefit that will be added to the pharmacy formularies at the Oral Oncology Brand Non-preferred tier ($0 copay). The following prior authorization criteria will apply.

- Medical record documentation that Inrebic is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of intermediate-2 (INT-2) or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis **AND**
- Medical record documentation of platelet count greater than or equal to 50 x 10^9/L **AND**
- Medical record documentation of splenomegaly as measured by computed tomography (CT), magnetic resonance imaging (MRI), or ultrasound **AND**
- Medical record documentation of a baseline Total Symptom Score as measured by the modified Myelofibrosis Symptom Assessment Form (MFSAF) **AND**
- Medical record documentation that Inrebic will not being used concurrently with Jakafi **AND**
- Medical record documentation that patient is ineligible for allogenic hematopoietic cell transplantation.

NOTE: Intermediate or High-Risk Myelofibrosis is defined by having at least 2 of the following factors:

- Age > 65 years
- WBC > 25 x 10^9/L
- Hemoglobin < 10 g/dL
- Blood Blasts ≥ 1%

- Presence of Constitutional Symptoms (weight loss, fever, excessive sweats, etc.)
- Transfusion dependency
- Platelets less than 100 X 10^9/L
- Unfavorable karyotype

QUANTITY LIMITS: 4 capsules per day

AUTHORIZATION DURATION: Each treatment period will be defined as six (6) months. Re-review with occur every six (6) months. Inrebic will no longer be covered if medical record documentation does not show:

- Medical record documentation of platelet count greater than or equal to 50 x 10^9/L **AND**
- The member has achieved a reduction from pretreatment baseline of at least 35% in spleen volume as measured by computed tomography (CT), magnetic resonance imaging (MRI), or ultrasound **OR**
- The member has achieved a 50% or greater reduction in the Total Symptom Score from baseline as measured by the modified Myelofibrosis Symptom Assessment Form (MFSAF)

Other Recommendations: Concurrent treatment with Jakafi and Inrebic is not recommended, the following criteria will be added to the Commercial Policy 250.0, the GHP Family Policy 1053.0F, and the Geisinger Gold Policy 224.0D for Jakafi.

- Medical record documentation that Jakafi will not being used concurrently with Inrebic.

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

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

ASPARLAS (calaspargase pegol- mknl)

Review: Asparlas is indicated as a component of a multi-agent chemotherapeutic regimen for the treatment of acute lymphoblastic leukemia (ALL) in pediatric and young adult patients age 1 month to 21 years. Asparlas is available as 3,750 units/ 5 mL (750 units/mL) clear, colorless solution in a single-dose vial. The recommended dose of Asparlas is 2,500 units/m^2 given intravenously no more frequently than every 21 days.

Asparlas is the 2nd pegylated asparaginase product, joining Oncaspar, specifically designed to offer an extended interval between doses. Oncaspar can be administered IV or IM every 2 weeks while Asparlas is administered IV every 3 weeks. Oncaspar has dosing recommendations for patients older than 21 and less than 21 years of age. Asparlas has dosing recommendations for patients ≥ 1 month to ≤ 21 year of age. Erwinaze is a short-acting asparaginase product specifically indicated for the treatment (in combination with other chemotherapy) of ALL in patients with hypersensitivity to *E. coli*-derived asparaginase. Erwinaze has dosing recommendations for patients 1 year and older.

The efficacy was based on a demonstration of the achievement and maintenance of nadir serum asparaginase activity (NSAA) above the level of 0.1 U/mL using Asparlas 2500 U/m^2 IV every 3 weeks. The pharmacokinetics of Asparlas were studied when used in combination with multiagent chemotherapy in 124 patients with B cell lineage ALL. The results showed that 99% of patients maintained NSAA > 0.1 U/mL at weeks 6, 12, 18, 24, and 30.

Asparlas is contraindicated in patients with history of serious hypersensitivity reactions to pegylated L-asparaginase therapy, history of serious thrombosis, history of serious pancreatitis, and history of serious hemorrhagic events (all during previous L-asparaginase therapy) and severe hepatic impairment. There are warnings and precautions for hypersensitivity reactions, pancreatitis, thrombosis, hemorrhage, and hepatotoxicity. The most common grade ≥ 3 adverse reactions were elevated transaminase, bilirubin increased, pancreatitis and abnormal clotting studies. Females should use effective contraceptive methods, including a barrier method, during treatment and for at least 3 months after the last dose of Asparlas. Lactating women should not breastfeed while receiving Asparlas and for 3 months after the last dose. The safety and effectiveness have been established in pediatric patients 1 month to < 17 years.

Several different multi-agent treatment regimens are recommended. L-asparaginase is a key component of first line treatment regimens for all ALL patients. It serves as a backbone therapy in all pediatric and most adult ALL regimens. There are three forms of asparaginase in clinical use: 1) pegaspargase (PEG), 2) Calaspargase pegol-mknl (CALPEG), 3) asparaginase Erwinia chrysanthemi (Erwinia). PEG is a common component of therapy for children, adolescents, and young adults with ALL. Per NCCN, for ALL and pediatric ALL, Asparlas can be substituted for pegaspargase in patients age 1 month to 21 years for more sustained asparaginase activity.

Amy Ellenburg, hematology/oncology clinical pharmacist for Geisinger mentioned that the role of Asparlas is unclear in terms of treating pediatric patients and adults up to 21 years. She mentioned that the FDA approval came from a phase 1 study showing similar PK/PD and has not been incorporated in standard of care treatment for pediatric-inspired ALL. In theory, Asparlas is an alternative. She also mentioned that Asparlas cannot be used if the patient has a history of reaction to pegaspargase and there is no information to say that it is safe to give pegaspargase after reaction to Asparlas. Therefore, she does not feel it would be clinically appropriate to require failure on both agents prior to Erwinaze. The system did not add Asparlas to formulary due to the unclear role in pediatric population.

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: Bret asked if this would only be used in the inpatient setting. Aubrielle stated this could be used either as inpatient or outpatient setting, but usually in the outpatient setting. No further comments or questions. Todd Sponenberg made a motion to accept the recommendations as presented. Kevin Szczecina seconded the motion. None were opposed.

Financial Discussion: Tricia Heitzman suggested looking at utilization of Oncaspar, and to consider adding UM if needed. No further comments or questions. Keith Hunsicker made a motion to accept the recommendations as presented. Todd Sponenberg seconded the motion. None were opposed.

Outcome: Asparlas will be covered as a medical benefit that will not be added to the pharmacy formularies. Asparlas will not require a prior authorization.

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

NUZYRA (omadacycline)

Review: Nuzyra is a semi-synthetic derivative of tetracycline with a broad spectrum of antibacterial activity including against Gram-positive, Gram-negative, aerobes and anaerobes, and atypical pathogens. It is indicated for the treatment of community-acquired bacterial pneumonia (CABP) caused by *Streptococcus pneumoniae*,

Staphylococcus aureus (methicillin-susceptible isolates), *Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Legionella pneumophila, Mycoplasma pneumoniae, and Chlamydophila pneumoniae* and for the treatment of acute bacterial skin and skin structure infections (ABSSSI) caused by *Staphylococcus aureus* (methicillin-susceptible and -resistant isolates), *Staphylococcus lugdunensis, Streptococcus pyogenes, Streptococcus anginosus* grp. (includes *S. anginosus, S. intermedius,* and *S. constellatus*), *Enterococcus faecalis, Enterobacter cloacae,* and *Klebsiella pneumoniae.* Nuzyra has been shown to be effective against bacterial strains with resistance specific to the tetracycline class as well as strains with resistance to other antibiotic classes used in the treatment of ABSSSI. The risk of developing drug-resistant bacteria is increased when Nuzyra is prescribed in the absence of a proven or strongly suspected bacterial infection.

The efficacy of Nuzyra for the treatment of adult patients with CABP was investigated in the OPTIC study, a double-blind, double-dummy, randomized non-inferiority trial comparing 7 to 14 days of treatment with Nuzyra to moxifloxacin. Patients received the IV loading dose of Nuzyra, following by the IV maintenance dose with the option to transition to the oral maintenance dose after 3 days of treatment. The primary efficacy endpoint evaluating early clinical response (improvement in two or more symptoms at 72 to 120 hours after initiation of treatment) showed Nuzyra was non-inferior to moxifloxacin with response rates of 81.1% and 82.7%, respectively. The clinical responses were sustained as shown by secondary endpoints assessing clinical response at the end of treatment and at a post-treatment evaluation (5-10 days after last dose of treatment). Response rates were comparable between treatment groups for all subgroups, with the exception of patients who had a Pneumonia Outcomes Research Team (PORT) risk class IV and in patients ≥ 65 years indicating that patients with a higher severity of illness may have a lower clinical response rate to Nuzyra treatment. There was also a morbidity imbalance observed in the OPTIC trial with 8 deaths occurring in the Nuzyra treatment group compared to only 4 deaths in the moxifloxacin group. All deaths occurred in patients over age 65 with various causes of death, including worsening or complications of infection and underlying conditions, but the cause of the mortality imbalance could not be determined.

The efficacy of Nuzyra in the treatment of adult patients with acute bacterial skin and skin structure infections was shown in two randomized, double-blind, double dummy trials, OASIS-1 and OASIS-2, which compared 7-14 days of Nuzyra treatment to linezolid. In OASIS-1, patients received the IV loading dose, followed by the IV maintenance dose, with the option to transition to the oral maintenance dose after 3 days of treatment. In the OASIS-2 trial, patients received the oral loading dose followed by the oral maintenance dose for the duration of treatment. The primary efficacy endpoint evaluating early clinical response (20% or greater decrease in lesion size 48 to 72 hours after the first dose) showed that Nuzyra was non-inferior to linezolid in patients who had at least one gram-positive bacterial pathogen identified at baseline (modified intention to treat population). Nuzyra had sustained efficacy as seen in secondary endpoints evaluation clinical response at a post-treatment evaluation (7 to 14 days after the last treatment dose).

The safety profile appears to be consistent with the known safety profile of the tetracycline class. The most frequently reported adverse reactions reported during clinical trials were gastrointestinal events (nausea, vomiting, and diarrhea), infusion site reactions, headache, insomnia, and increased alanine aminotransferase (ALT).

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: Tricia Heitzman recommended modifying the medical quantity limit to 1500 units. No further comments or questions. Kevin Szczecina made a motion to accept the recommendations as amended. Tricia Heitzman seconded the motion. None were opposed.

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

Outcome: Nuzyra vials will be a medical benefit that will not be added to the pharmacy formularies. Nuzyra tablets will be a pharmacy benefit that should be added to the pharmacy formularies at the Specialty tier or the Brand Non-Preferred tier for members with a three-tier benefit. The following prior authorization criteria will apply.

- Prescription is written by or in consultation with Infectious Disease **AND**
- Medical record documentation of member is greater than or equal to 18 years of age **AND**
- Medical record documentation of one of the following:
    - Diagnosis of Community-acquired bacterial pneumonia caused by *Streptococcus pneumoniae, Staphylococcus aureus* (methicillin-susceptible isolates), *Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Legionella pneumophila, Mycoplasma pneumoniae, and Chlamydophila pneumoniae* **OR**
    - Diagnosis of an acute bacterial skin and skin structure infection (including cellulitis/erysipelas, wound infection, and major cutaneous abscess) caused by *Staphylococcus aureus* (methicillin-susceptible and -resistant isolates), *Staphylococcus lugdunensis*, *Streptococcus pyogenes, Streptococcus anginosus* grp. (includes *S. anginosus*, *S. intermedius*, and *S. constellatus*), *Enterococcus faecalis*, *Enterobacter cloacae*, and *Klebsiella pneumoniae*.
- Medical record documentation of a culture and sensitivity showing the patient's infection is not susceptible to alternative antibiotic treatments **OR** a documented history of previous intolerance to or contraindication to three (3) alternative antibiotics shown to be susceptible on the culture and sensitivity **OR**
- Medical record documentation that treatment with Nuzyra was initiated during an inpatient setting

QUANTITY LIMIT: 30 tablets per 14 days

AUTHORIZATION DURATION: 14 days

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

TRIPTODUR (triptorelin)

Review: Triptodur is indicated for the treatment of pediatric patients 2 years and older with central precocious puberty (CPP). Triptorelin is a gonadotropin-releasing hormone (GnRH) agonist. It is also available as Trelstar, which is indicated for the palliative treatment of advanced prostate cancer.

Triptodur is available as 22.5 mg single-use kit. Triptodur must be administered under the supervision of a physician. The recommended dose is 22.5 mg administered as a single intramuscular injection once every 24 weeks. Triptodur should be discontinued at the appropriate age of onset of puberty at the discretion of the physician. The response to Triptodur should be monitored with LH levels after a GnRH or GnRH agonist stimulation test, basal LH, or serum concentration of sex steroid levels 1 to 2 months following initiation of therapy, during therapy, and with each subsequent dose. Height should be measured every 3-6 months and bone age should be monitored periodically. If the dose of Triptodur is not adequate switching to an alternative GnRH agonist for the treatment of CPP with the ability for dose adjustment may be necessary.

Triptodur was studied in a single-arm, open-label trial of 44 patients with CPP. All the patients were naïve to GnRH agonist treatment. Patients were administered Triptodur 22.5 mg every 24 weeks and evaluated over 2 dosing intervals for a total of 12 months. At all time points, ≥ 93% of children achieved LH suppression to prepubertal levels, ≥ 79% of girls achieved prepubertal levels of estradiol, and ≥ 80% of boys achieved prepubertal levels of

testosterone. Triptodur stopped or reversed progression of clinical signs of puberty with 95% of children showing no increase in bone age/chronological age ratio, and 89% showing stabilization of sexual maturation at Month 12. 1 out of 22 girls experienced an acute-on chronic phenomenon (increase in basal LH or estradiol levels after the second triptorelin injection).

Triptodur is contraindicated in individuals with a known hypersensitivity to triptorelin, any component of the product, or other GnRH agonists or GnRH. Triptodur is also contraindicated in pregnancy because it may cause fetal harm. Triptodur may cause an initial rise of gonadotropins and sex steroid levels. Psychiatric events have been reported. Postmarketing reports of convulsions have been observed in patients receiving GnRH agonists. The most common adverse reactions ($\geq$ 4.5%) are injection site reactions, menstrual bleeding, hot flush, headache, cough, and infections. The safety and effectiveness have not been established in pediatric patients less than 2 years old.

There have been no direct studies to compare the different sustained-release formulations of GnRH agonists. The choice of GnRH agonist depends on preference. Supprelin LA (histrelin implant) is administered once every 12 months. Lupron (leuprolide acetate) can be given monthly or every 12 weeks, depending on the strength and dosage form. Goserelin acetate 3.6 mg is given once every 28 days. Goserelin acetate 10.8 mg is given once every 12 weeks. Goserelin is not FDA approved for CPP. Triptodur is administered once every 24-weeks. Nafarelin (Synarel ©) is available as a daily intranasal spray. Typically, depot preparations are preferred because of increased compliance, however for certain situations (e.g. such as the development of sterile abscesses), daily preparations can be used as an alternative.

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: Bret asked if prescriber should be limited to endocrinologist. Nobody was opposed. No further comments or questions. Keith Hunsicker made a motion to accept the recommendations as amended. Tricia Heitzman seconded the motion. None were opposed.

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

Outcome: Triptodur will be covered as a medical benefit and will not be added to the pharmacy formularies. Triptodur will require a prior authorization with the following criteria.

- Medical record documentation that medication is prescribed by or in consultation with an endocrinologist.
- Medical record documentation of a diagnosis of central precocious puberty AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Lupron Depot-Ped

Quantity Limit: 1 vial per 168 days, minimum day supply 168 days, maximum day supply: 180

Other Recommendations – Supprelin LA

For all lines of business, the following will be added to the Supprelin LA policies (MBP 67.0 and 363.0D)

- Prescription written by or in consultation with an endocrinologist

Discussion: No comments or questions. Jamie Miller 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.

NAYZILAM (midazolam)

Review: Nayzilam, a single use nasal spray containing the benzodiazepine midazolam, is indicated for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e. seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy 12 years of age and older. Nayzilam offers an advantage in the delivery method over other currently available treatment options. The use of rectal diazepam may be limited by physical and social constraints, buccal benzodiazepine formulations offer inconsistent absorption rates, and intravenous benzodiazepines may not be easily accessed in emergencies and must be administered by a healthcare professional. Nayzilam can be administered by caregivers in an outpatient setting and is rapidly absorbed through the oral and nasal mucosa.
The efficacy of Nayzilam was investigated in the Artemis-1 trial, a randomized, double-blind, placebo-controlled trial in patients at least 12 years of age with seizure clusters. A total of 201 patients were randomized 2:1 to receive 5 mg of Nayzilam nasal spray administered by the caregiver at onset of seizure cluster. The primary efficacy endpoint, seizure termination within 10 minutes with no recurrence within 6 hours, was achieved by a significantly greater proportion of patients treated with Nayzilam compared to placebo. Results of the secondary and exploratory endpoints supported those of the primary endpoint.
During clinical trials, most treatment emergent adverse reactions were sedation-type events (sedation, somnolence, hypersomnia) and nasal discomfort. There were no treatment related serious adverse events and no discontinuations of treatment due to adverse events. Other safety concerns are related to the known safety profile of benzodiazepines, including Nayzilam, and include cardiorespiratory adverse reaction, central nervous system depression, suicidal behavior and ideation, impaired cognitive function, and glaucoma.
A Clinical Review including Clinical Information, Efficacy Evidence, Safety Evidence, and Other Considerations and a Financial Review Based on Cost Analysis were presented.

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

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

Outcome: Nayzilam is a pharmacy benefit and will be added to the Brand Preferred tier on the pharmacy formularies. No prior authorization will be required for patients 12 years of age and older, operationalized by an age-safety edit. For patients under 12 years of age, the following prior authorization criteria will apply. For all patients, the following quantity limits will apply.

- Medical record documentation age greater than or equal to 12 years.

OR

- Medical record documentation that the safety and effectiveness of use for the prescribed indication is supported by Food and Drug Administration (FDA) approval or adequate medical and scientific evidence in the medical literature AND
- For patients at least 2 years of age: medical record documentation of why diazepam rectal gel cannot be used.

QUANTITY LIMITS: 10 nasal spray units per 30 days
Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk)

Review: Herceptin Hylecta is a subcutaneous formulation of trastuzumab and hyaluronidase indicated for adults for adjuvant treatment of HER2 over expressing node positive or node negative (ER/PR negative or with one high risk feature) breast cancer or for treatment of HER2 over expressing metastatic breast cancer. Trastuzumab has been shown significant benefit in clinic trials in both early breast cancer and patients with metastatic disease. Hyaluronidase increases the permeability of subcutaneous tissue increasing the volume and absorption rate of trastuzumab into systemic circulation when administered subcutaneously. NCCN recommends that Herceptin Hylecta may be substituted for intravenous trastuzumab and used as a single agent or in combination with other systemic therapies for adjuvant treatment or treatment of metastatic breast cancer in adults (Category 2A).

The efficacy of Herceptin Hylecta was shown in a multi-center open-label non-inferiority study (HannaH study) comparing the efficacy of subcutaneous trastuzumab to intravenous traztuzumab in the neoadjuvant treatment of HER2-positive breast cancer. Patients were randomized 1:1 to receive Herceptin or Herceptin Hylecta following recommended dosing for 8 cycles with concurrent chemotherapy followed by surgery, then continued therapy for an additional 10 cycles. Primary endpoints measured were C_{trough} (pre-dose in cycle 8) before surgery and pathological complete response (pCR). At the time of primary analysis at 12 months, both primary endpoints were met, and Herceptin Hylecta was found to be non-inferior to Herceptin. Secondary endpoints were pharmacokinetic profile, total pCR, overall response, time to first clinical response, event free survival, overall survival, safety and tolerability, and immunogenicity. Event free survival and six-year overall survival rate were comparable between the two groups and were higher among patients who had achieved a total pCR at the time of first analysis compared to those with residual disease.

Patient preference for administration option was evaluated in a multi-center, two-cohort, two-arm, crossover study (PrefHer) comparing a single use injection device or hand-held syringe of Herceptin Hylecta compared to intravenous Herceptin. Patients were randomized to receive four cycles of subcutaneous trastuzumab followed by four cycles of intravenous trastuzumab or vice versa. After crossover, patients continued on IV or SC trastuzumab for a total of 18 cycles. The primary endpoint was proportion of patients indicating an overall preference for either subcutaneous or intravenous route of administration. Results showed that 89% of patients preferred the subcutaneous administration, regardless of method of subcutaneous delivery. Subcutaneous administration showed a time-saving benefit, patient reported advantages of convenience and less pain, and a reduction in infusion time, healthcare professionals' time, and other hospital resources. The safety profile and overall 3-year survival rates supported the efficacy trials of Herceptin Hylecta.

The safety of Herceptin Hylecta was evaluated in a two-cohort, non-randomized, multi center, open-label study (SafeHer) that study evaluated subcutaneous trastuzumab administered with concurrent or sequential neoadjuvant or adjuvant chemotherapy or without adjuvant chemotherapy. Primary endpoints evaluated safety and tolerability and secondary endpoints investigated disease free survival, overall survival and patient satisfaction with self-administration. Primary safety analysis was consistent with the known safety profile of intravenous trastuzumab. Adverse events varied according to the chemotherapy timing with higher rates of adverse events occur tin the patients treated with concurrent chemotherapy. Efficacy endpoints will be analyzed at the time the last patient has completed 5 years of follow-up.

The most common adverse events reported in trial were diarrhea, fatigue, arthralgia, headache, neutropenia, leukopenia, and febrile neutropenia. There are black box warnings for subcutaneous trastuzumab for cardiomyopathy (cardiac failure manifesting as CHF and decrease LVEF), pulmonary toxicity, and embryo-fatal toxicity. The highest incidence of cardiomyopathy occurred in patients receiving concomitant anthracycline regimens with a similar incidence to intravenous Herceptin. Overall in clinical trials, the safety profile of Herceptin Hylecta was found to be comparable to the known profile of intravenous Herceptin.

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. Kim Reichard proposed not requiring prior authorization to match current Herceptin formulary placement. Keith Hunsicker made a motion to accept the recommendations as amended. Tricia Heitzman seconded the motion. None were opposed.

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

Outcome: Herceptin Hylecta will be a medical benefit and will not be added to the pharmacy formularies. Herceptin Hylecta will not require a prior authorization.

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

FAST FACTS

ZERBAXA (ceftolozan/tazobactam)

Updated Indication: Zerbaxa is now indicated for the treatment of patients 18 years of age or older with hospital-acquired bacterial pneumonia and ventilator-associated bacterial pneumonia (HABP/VABP) caused by designated susceptible gram-negative microorganisms (*Enterobacter cloacae, Escherichia coli, Haemophilus influenzae, Klebsiella oxytoca, Klebsiella pneumoniae, Proteus mirabilis, Pseudomonas aeruginosa, and Serratia marcescens*).

Previously the use of Zerbaxa was limited to the treatment of adult patients with complicated intra-abdominal infections and complicated urinary tract infections (including pyelonephritis).

Current formulary status: Medical benefit without PA

Recommendations: In clinical trials, Zerbaxa was proven non-inferior to alternative antibiotics for the treatment of HABP/VABP as well as complicated intra-abdominal infections. In clinical trials, Zerbaxa was proven superior to levofloxacin for the treatment of complicated urinary tract infection; however, this was likely attributable due to 26.5% of levofloxacin treated patients having baseline organisms resistant to levofloxacin. The Johns Hopkins Antibiotics Guide does not list Zerbaxa as a first- or second-line treatment option for HABP/VABP or cIAI. Zerbaxa is listed as a second line option for cUTI by the guide. In terms of cost, there are more cost-effective regimens available compared to Zerbaxa (pending cultures and susceptibilities).

Based on the discussion above, it is recommended that a prior authorization be added to Zerbaxa for all lines of business. Zerbaxa will remain a medical benefit for Commercial, GHP Kids, and Marketplace. The following prior authorization criteria will apply.

Prior Authorization Criteria:

- Prescription is written by or in consultation with Infectious Disease **AND**
- Medical record documentation that the member is greater than or equal to 18 years of age **AND**
- Medical record documentation of one of the following:
    - Diagnosis of Complicated Intra-abdominal Infection (cIAI) caused by: *Enterobacter cloacae, Escherichia coli, Klebsiella oxytoca, Klebsiella pneumoniae, Proteus mirabilis, Pseudomonas*

aeruginosa, Bacteroides fragilis, Streptococcus anginosus, Streptococcus constellatus, or *Streptococcus salivarius* **OR**
    - Diagnosis of Complicated Urinary Tract Infection (including Pyelonephritis) (cUTI) caused by *Escherichia coli, Klebsiella pneumoniae, Proteus mirabilis,* or *Pseudomonas aeruginosa* **OR**
    - Diagnosis of Hospital-acquired Bacterial Pneumonia or Ventilator-associated Bacterial Pneumonia (HABP/VABP) caused by *Enterobacter cloacae, Escherichia coli, Haemophilus influenzae, Klebsiella oxytoca, Klebsiella pneumoniae, Proteus mirabilis, Pseudomonas aeruginosa,* or *Serratia marcescens.*
- Medical record documentation of a culture and sensitivity showing the patient's infection is not susceptible to preferred alternative antibiotic treatments **OR** a documented history of previous intolerance to or contraindication to three (3) preferred alternative antibiotics shown to be susceptible on the culture and sensitivity

Authorization Duration:
For cUTI: 7 days
For cIAI or HABP/VABP: up to 14 days

Quantity Limits (Medical):
For cUTI: MedAccess: 3 vials per day, Facets RX Count: 420 units
For cIAI: MedAccess 3 vials per day, Facets RX Count: 840 units
For HABP/VABP: 6 vials per day, Facets RX Count: 1680 units

Discussion: Aubrielle suggested adding a quantity limit to the criteria (based on max dose; 6 vials/day). No comments or questions

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

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

APTENSIO XR (methylphenidate hydrochloride extended-release)

Updated Indication: Aptensio XR is indicated for the treatment of ADHD in patients 6 years and older.

Limitations of Use: Pediatric patients younger than 6 years of age experience higher plasma exposure at the same dose and high rates of adverse reactions, most notably weight loss.

Previously, it was approved for the treatment of ADHD (without specifying an age in the indication). However, previous labeling mentioned dosing recommendations for patients 6 years and older.

Current Formulary Status/Prior Authorization Criteria: Aptensio XR is a pharmacy benefit and not on the Commercial/GHP Kids/Marketplace formularies. The following prior authorization criteria applies.

- Medical record documentation of a diagnosis of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Metadate CDAND amphetamine/dextroamphetamine SR combination

Recommendations: There will be no change to the formulary status at this time. There is no age restriction in the current Aptensio XR policy, therefore there will be no updates to the policy at this time.

Discussion: No comments or questions.

Outcome: Todd Sponenberg 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.

VICTOZA (liraglutide)

Updated Indication: Victoza is a glucagon-like peptide-1 (GLP-1) receptor agonist now indicated as an adjunct to diet and exercise to improve glycemic control in patients 10 years and older with type 2 diabetes mellitus.

Previously, Victoza was only indicated for adult patients as an adjunct to diet and exercise to improve glycemic control with type 2 diabetes mellitus. The other indication for Victoza- to reduce the risk of major cardiovascular events in adults with type 2 diabetes mellitus and established cardiovascular disease remains unchanged.

Current formulary status: Brand Preferred tier with a quantity limit of 0.3 mL per day

Recommendation: Because Victoza does not require a prior authorization or have an age restriction and there is currently no utilization in patients under the age of 18, no changes recommended to the current formulary status at this time. The current quantity limit is appropriate for the new indication, so no changes are recommended at this time.

Discussion: No comments or questions.

Outcome: Todd Sponenberg 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.

BOTOX (onabotulinumtoxin A)

Updated Indication: Botox is now indicated for the treatment of upper limb spasticity and lower limb spasticity (excluding spasticity caused by cerebral palsy) in pediatric patients 2 to 17 years of age.

Limitations of Use: Treatment with Botox is not intended to substitute for usual standard of care rehabilitation regimens.

Previously, Botox did not maintain an indication for pediatric upper limb or lower limb spasticity. Botox did maintain indications for adult upper and lower limb spasticity.

Current Formulary Status/Prior Authorization Criteria: NF medical benefit requiring PA

Recommendations: No changes are recommended to the formulary placement of Botox at this time. The MBP 11.0 Policy will be updated to account for the updated pediatric indications as follows.

MBP 11.0 Botulinum Toxin

31. Upper Limb Spasticity

Botulinum toxin A for the treatment of upper limb spasticity is considered medically necessary when the following criteria are met:

- Medical record documentation that Botox or Xeomin is being used for the treatment of upper limb spasticity **AND**
- Documentation that the patient is at least 4 years of age

1. Lower Limb Spasticity

- Medical record documentation that Botox is being used for the treatment of lower limb spasticity to decrease the severity of increased muscle tone in ankle and toe flexors (gastrocnemius, soleus, tibialis posterior, flexor hallucis longus, and flexor digitorum longus) **AND**
- Documentation that patient is at least 4 years of age **AND**
- Medical record documentation of failure to control spasticity with conventional therapies, e.g., physical therapy, splinting/bracing, or systemic antispasticity medication

Botulinum toxin is considered investigational for:

- headache or migraine other than chronic migraine
- myofascial pain syndrome
- tremors such as benign essential tremor, chronic motor tic disorder, and tics associated with Tourette syndrome
- ~~treatment of upper limb spasticity in pediatric patients~~
- ~~treatment of lower limb spasticity pediatric patients (with exception of Dysport)~~

Discussion: No comments or questions.

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

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

SOLIRIS (eculizumab)

Updated Indication: Soliris is now indicated for the treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive.

Current Formulary Status/Prior Authorization Criteria: Medical Benefit requiring prior authorization

Recommendations: There will be no changes to the current formulary placement of Soliris. The following prior authorization criteria will be added to Medical Benefit Policy 54.0 to include the new indication:

4. Neuromyelitis Optica Spectrum Disorder (NMOSD)

- Prescribed by or in consultation with a neurologist
- Medical record documentation that member is 18 years or older **AND**
- Medical record documentation of diagnosis of Neuromyelitis Optica Spectrum Disorder (NMOSD) **AND**

- Medical record documentation that member is anti-Aquaporin-4 (AQP4) antibody positive **AND**
- Medical record documentation of failure on intolerance to, or contraindication to Rituxan.

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

Discussion: No comments or questions.

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

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

TYBOST (cobicistat)

Updated Indication: Tybost is a CYP3A inhibitor now indicated to increase systemic exposure of atazanavir or darunavir in combination with other antiretroviral agents for the treatment of pediatric patients with HIV-1 infection weighing at least 35kg coadministered with atazanavir or weighing at least 40kg coadministered with darunavir.

Tybost maintains its previously approved indication in the adult population as a CYP3A inhibitor indicated to increase systemic exposure of atazanavir or darunavir in combination with other antiretroviral agents for the treatment of adult patients with HIV-1 infection.

Current Formulary Status/Prior Authorization Criteria: Pending (with QL of 1 tablet per day)

Recommendations: Tybost is an appropriate boosting product for atazanavir and darunavir containing antiretroviral regimens. The need for Tybost is limited by the presence of cobicistat combination products which contain both cobicistat and 1+ other antiretroviral drugs; however, Tybost may be required with the selected atazanavir/darunavir containing regimen if the regimen does not have a combination product that includes cobicistat.

Recommendation: Tybost will be added to the Brand Preferred Tier. The currently quantity limit of 1 tabler per day will apply.

Discussion: No comments or questions.

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

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

OTEZLA (apremilast)

Updated Indication: Otezla is now indicated for treatment of adult patients with oral ulcers associated with Behçet's Disease.

Previously, Otezla was indicated for the treatment of adult patients with psoriatic arthritis and in patients with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

Current Formulary Status: Brand Non-Preferred/Specialty tier requiring PA

Recommendations: There will be no changes to the current formulary placement and the current quantity limits. The following prior authorization criteria will be added to the current policies to incorporate the new indication.

For Behçet's Disease:

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of oral ulcers associated with Behçet's Disease

NOTE: The International Clinical Criteria for Behçet's Disease diagnostic criteria

- Recurrent oral ulcerations (apthous or herpetiform) at least three times in one year.
- Additionally, patients must present with two of the following:
    - Recurrent genital ulcerations
    - Eye lesions (uveitis and retinal vasculitis) observed by an ophthalmologist
    - Skin lesions (erythema nodosum, pseudofolliculitis, papulopustular lesions, acneiform nodules) found in adult patients not being treated with corticosteroids
    - Positive "pathergy test" read by a physician within 24-48 hours of testing

Discussion: No comments or questions.

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

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

EMFLAZA (deflazacort)

Updated Indication: Emflaza is now indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older.

Previously, Emflaza was indicated for the treatment of this condition in patients 5 years of age and older.

Current Formulary Status/Prior Authorization Criteria: Non-formulary pharmacy benefit requiring prior authorization

Recommendation: There will be no changes to the formulary placement of Emflaza at this time. The current policy will be updated to account for the new indicated ages as follows.

<u>Commercial/Marketplace Policy 446.0</u>

- Medical record documentation that Emflaza is prescribed by a neurologist or pediatric neurologist **AND**
- Medical record documentation of interdisciplinary team involvement including, but not limited to, neurology, pulmonology, and cardiology **AND**

- Medical record documentation of a diagnosis of Duchenne muscular dystrophy (DMD), confirmed by genetic testing **AND**
- Medical record documentation of age greater than or equal to ~~5~~ 2 years **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to prednisone

QUANTITY LIMIT:
- 6 mg tablet: 2 tablets per day
- 18 mg tablet: 1 tablet per day
- 30 mg tablet: 2 tablets per day
- 36 mg tablet: no quantity limit
- 22.75 mg/mL: no quantity limit

NOTE: Emflaza tablets may be crushed and served immediately after mixing with applesauce.

Discussion: No comments or questions.

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

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

SYMDEKO (tezacaftor/ivacaftor)

Updated Indication: Symdeko is indicated for the treatment of patients with cystic fibrosis (CF) age 6 years and older who are homozygous for the F508del mutation or who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence, see Table 1.

Note: Previously, Symdeko was only indicated for patients 12 years and older.

Table 1. List of CFTR Gene Mutations that Produce CFTR Protein and are Responsive to Symdeko– *(from Symdeko Prescribing Information)*[1]

P67L	*E193K*	*F508del**	*S977F*	*F1074L*	*3849+10kbC→T*
R74W	*L206W*	*D579G*	*F1052V*	*D1152H*	
D110E	*R347H*	*711+3A→G*	*K1060T*	*D1270N*	
D110H	*R352Q*	*E831X*	*A1067T*	*2789+5G→A*	

*A patient must have two copies of the F508del mutation or at least one copy of a responsive mutation presented in Table 1 to be indicated.
This list is based on a clinical FEV_1 response and/or *in vitro* data.
Note: *CFTR* gene mutations that are not responsive to ivacaftor alone are not expected to respond to Symdeko except for F508del homozygotes.

How Supplied: Symdeko is now available as tezacaftor 50 mg/ ivacaftor 75 mg fixed-dose combinations and ivacaftor 75 mg tablets. Previously, it was only available as tezacaftor 100 mg/ivacaftor 150 mg fix-dosed combination tablets and ivacaftor 150 mg tablets.

Current Formulary Status/Prior Authorization Criteria: Symdeko is a pharmacy benefit available at the Specialty tier or at the Brand Non-Preferred tier for members with a three tier benefit. Symdeko requires a prior authorization.

Recommendation: There will be no changes to the formulary status of Symdeko at this time. The prior authorization criteria will be updated as follows.

- Medical record documentation that Symdeko is prescribed by a pulmonologist or cystic fibrosis specialist AND
- Medical record documentation of patient age greater than or equal to ~~12~~ 6 years AND
- Medical record documentation of a diagnosis of cystic fibrosis (CF) AND
- One of the following, as detected by an FDA cleared CF mutation test:
    - Medical record documentation that the member is homozygous for the *F508del* CFTR mutation OR
    - Medical record documentation that the member has at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor per product labeling

Note to reviewer: List of CFTR gene mutations that are responsive to Symdeko:

E56K	*R117C*	*A455E*	*S977F*	*F1074L*	*3849+10kbC→T*
P67L	*E193K*	*D579G*	*F1052V*	*D1152H*	
R74W	*L206W*	*711+3A→G*	*K1060T*	*D1270N*	
D110E	*R347H*	*E831X*	*A1067T*	*2789+5G→A*	
D110H	*R352Q*	*S945L*	*R1070W*	*3272-26A→G*	

Quantity Limit: Pharmacist note to CSR: Authorization should be entered by HICL and only checking the Formulary PA required box (no QLs need to be entered within the authorization). 2 tablets per day, 28 day supply per fill.

Authorization Duration: Initial approval will be for four (4) months and subsequent approvals will be for twelve (12) months. Additional authorizations will require medical record documentation of improvement or stabilization in the signs and symptoms of cystic fibrosis. The medication will no longer be covered if the member experiences worsening of disease.

Discussion: No comments or questions.

Outcome: Todd Sponenberg 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.

DUPIXENT (dupilumab)

Updated Indication: Dupixent is an interleukin-4 receptor alpha agonist indicated as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).

Previously Dupixent was indicated for the treatment of patients 12 years and older with moderate to severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable and as add-on maintenance treatment in patients with moderate to severe asthma in patients aged 12 year and older with eosinophilic phenotype or with oral corticosteroid dependent asthma.

Current Formulary Status: Pharmacy benefit on the Specialty tier (or the Brand Non-preferred tier for patients with a three tier benefit) requiring prior authorization

Recommendation: There will be no changes to the formulary placement of Dupixent for all lines of business. The following prior authorization criteria will be added to Commercial Dupixent Policy 457.0:

Commercial Dupixent Policy 457.0
Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)

- Prescribed by or in consultation with otolaryngologist AND
- Medical record documentation that member is age 18 years or older AND
- Medical record documentation of diagnosis of chronic rhinosinusitis with nasal polyposis (CRwNP) AND
- Medical record documentation that Dupixent will be used as add-on maintenance treatment AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to three (3) intranasal corticosteroids

QUANTITY LIMIT: 4 ml per 28 days, Max quantity supply: 4, Min day supply: 28, Max day supply: 28

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

Discussion: No comments or questions.

Outcome: 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.

DOPTELET (avatrombopag)

Updated Indication: Doptelet is now indicated for the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia who have had an insufficient response to a previous treatment.

Previously, Doptelet was only indicated for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure.

Current Formulary Status: Pharmacy benefit at the Specialty tier or Brand Non-Preferred tier for members with a three tier benefit requiring prior authorization

Recommendation: There will be no changes to formulary status at this time. Doptelet is now significantly cheaper than Mulpleta, as a result we will not require failure of Mulpleta for Doptelet for chronic liver disease. The Doptelet policy will updated as follows.

Chronic Liver Disease

- Medical record documentation that Doptelet is prescribed by or in consultation with a hematologist, gastroenterologist, hepatologist, immunologist, transplant specialist, interventional radiologist, or endocrinologist AND
- Medical record documentation of age greater than or equal to 18 years AND

- Medical record documentation of thrombocytopenia in adult patients with chronic liver disease AND
- Medical record documentation of a platelet count of less than 50 x 109/L measured within the past 30 days AND
- Medical record documentation of a planned invasive procedure to be performed 10-13 days after initiation date for Doptelet treatment AND
- Medical record documentation that the member is not receiving other thrombopoietin receptor agonists (TPO-Ras) (Nplate/romiplostim, Promacta/eltrombopag) AND
- Medical record documentation of the correct dose being used (Platelet count 40,000 to less than 50,000 x 109/L - 40 mg once daily for 5 consecutive days OR for platelet count less than 40,000 x 109/L - 60 mg once daily for 5 consecutive days)

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

- Platelet count 40,000 to less than 50,000 x 109/L: 10 tablets per fill
- Platelet count less than 40,000 x 109/L: 15 tablets per fill

AUTHORIZATION DURATION: 30 days, RX count 1

<u>Chronic Immune Thrombocytopenia</u>

- Medical record documentation that the prescription for Doptelet is written 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 that the member is not receiving other TPO-RAs (Nplate/romiplostim, Promacta/eltrombopag) AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to three (3) previous treatment, including, but not limited to:
    - Corticosteroids
    - IVIG*
    - Rhogam (if RhD-positive and spleen intact)
    - Rituximab*
    - 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 $\geq 50 \times 10^9$/L and continued or sustained reduction in bleeding events AND
- One of the following:
    - Medical record documentation that the platelet count does <u>not</u> exceed 400×10^9/L OR
    - If the platelet count does exceed 400×10^9/L, medical record documentation that the dose will be adjusted AND documentation that the member has not been on 20 mg once weekly for 2 weeks

QUANTITY LIMIT: Pharmacist note to CSR: Authorization should be entered by HICL and only checking the Formulary PA required box (no QLs need to be entered within the authorization). Quantity Limit- 2 tablets per day

Other Recommendations - *Mulpleta*

For all lines of business, the following criterion will be added to all the Mulpleta policies (541.0, 1477.0F, 712.0D).

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Doptelet

Discussion: No comments or questions

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

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

NUCALA (mepolizumab)

Updated Indication: Nucala is now indicated for

- Add-on maintenance treatment of patients with severe asthma aged 6 years and older, and with an eosinophilic phenotype.
- The treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA).

Limitations of use: Not for relief of acute bronchospasm or status asthmaticus

Previously, Nucala was indicated as add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype and the treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA).

In addition to the updated indication, Nucala is now approved as a 100 mg/mL prefilled syringe and a 100 mg/mL autoinjector for administration by a patient/caregiver. Previously Nucala was only available as a 100 mg vial for reconstitution indicated for administration by a healthcare provider.

Current Formulary Status: (single-dose vial for reconstitution) Medical Benefit requiring a prior authorization

Recommendation: For the new indication, the age restriction for eosinophilic asthma will be updated in the Medical Benefit Policy 141.0 for Nucala single-dose vials for reconstitution to the following:

- Documentation of patient age ≥ 6 years

For children less than 6 years of age, the full 100 mg single dose vial is used (discarding the remaining after the 40 mg dosage is used) no changes will be made to the current quantity limit of 1 vial (100 mg) per 28 days (for eosinophilic asthma). There are no changes to the formulary placement or authorization duration for the single-dose vial.

Nucala prefilled syringe and autoinjector will be added to the pharmacy formularies to the Specialty tier or the Brand Non-Preferred tier for members with a three-tier benefit. The following prior authorization criteria will apply.

Severe Eosinophilic Asthma

- Documentation of patient age ≥ 12 years **AND**
- Medical record documentation of a diagnosis of severe eosinophilic asthma AND that Nucala is being used as add-on maintenance treatment **AND**
- Prescription written by an allergist or pulmonologist AND
- Medical record documentation of a blood eosinophil count of either > 300 cells/mcL during the 12-month period before screening and/or > 150 cells/mcL within 3 months of the start of therapy **AND**
- Medical record documentation of:
    - Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3- month trial of: high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR**
    - Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist **AND**
- Insured individual must be adherent with current therapeutic regimen and must demonstrate appropriate inhaler technique **AND**
- Known environmental triggers within the member's control have been eliminated **AND**
- Medical record documentation that Nucala is not being used in combination with Fasenra (benralizumab), Cinqair (reslizumab), or Xolair (omalizumab).

*****Measures of disease severity

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

Eosinophilic Granulomatosis (EGPA)

- Prescription written by an allergist/immunologist, pulmonologist, and/or rheumatologist **AND**
- Medical record documentation that patient is ≥18 years of age **AND**
- Medical record documentation of eosinophilic granulomatosis (EGPA) confirmed by biopsy evidence of vasculitis AND at least four (4) of the following criteria:
    - Asthma (a history of wheezing or the finding of diffuse high-pitched wheezes on expiration)
    - Eosinophilia (blood eosinophil level of ≥10% or ≥1500 cells/microL on differential white blood cell count)
    - Mononeuropathy (including multiplex) or polyneuropathy
    - Migratory or transient pulmonary opacities detected radiographically
    - Paranasal sinus abnormality
    - Biopsy containing a blood vessel showing the accumulation of eosinophils in extravascular areas

AND

- Medical record documentation of a therapeutic failure on, contraindication to, or intolerance to systemic glucocorticoid therapy AND at least one immunosuppressant therapy (cyclophosphamide, azathioprine, methotrexate)

Quantity Limit: 1 prefilled syringe or 1 autoinjector (100mg) per 28 days (for eosinophilic asthma), 3 prefilled syringes or 3 autoinjectors (300mg) per 28 days (for EGPA)

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

LIMITATIONS:
- Nucala is not indicated for the relief of acute bronchospasm or status asthmaticus.

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.

FASENRA (benralizumab)

Updated Indication: Fasenra Pen™ is an autoinjector formulation of benralizumab indicated for administration by patients/caregivers. Previously, Fasenra was only available as a prefilled syringe indicated for administration by a healthcare provider. There was no change to the indication with the new formulation of the Fasenra Pen™. Fasenra is indicated for the add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.

Current Formulary Status/Prior Authorization Criteria: Medical benefit requiring a prior authorization (Prefilled Syringe)

Recommendation: There will be no changes to the current formulary placement, quantity limits and authorization duration for the prefilled syringe indicated for administration by a healthcare professional. Fasenra Pen™ will be added as a pharmacy benefit to the Commercial/GHP Kids/Marketplace formularies at the Specialty tier or the Brand Non-Preferred tier for members with a three-tier benefit. The following prior authorization criteria will apply.

- Prescribed by an allergist/immunologist or pulmonologist **AND**
- Patient is 12 years of age or older **AND**
- Medical record documentation of a diagnosis of severe eosinophilic asthma AND that Fasenra is being used as add-on maintenance treatment **AND**
- Medical record documentation of blood eosinophil count >150 cells/microL (0.15 x 10E3/uL) within the past 3 months **AND**
- Medical record documentation of:
    - Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3-month trial of high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR**
    - Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist

AND

- Medical record documentation that individual is adherent to current therapeutic regimen and 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)

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 the following:

- Documentation that patient is not experiencing toxicity or worsening of disease AND
- Medical record documentation of at least one of the following:
    - Medical record documentation of continued disease improvement or lack of disease progression as evidenced by a reduction in asthma exacerbations (e.g. reduced use of rescue medications, reduced urgent care visits, reduced hospitalizations) **OR**
    - Medical record documentation of decreased oral corticosteroid use (if on maintenance treatment prior to Fasenra initiation)

QUANTITY LIMITS: An initial 3-month auth for QL of 1 pen (1 mL) per 28 days. Remainder of the 12-month authorization duration and subsequent renewals, QL of 1 pen (1 mL) per 56 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.

KEYTRUDA (pembrolizumab) AND LENVIMA (lenvatinib)

Updated Indication: Keytruda and Lenvima, used in combination, are indicated, under accelerated approval, for the treatment of patients with advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), who have disease progression following prior systemic therapy and are not candidates for curative surgery or radiation.

Previously, neither product was indicated for the treatment of endometrial carcinoma. Both products maintain their previously approved indications.

Current Formulary Status: Keytruda: NF (Medical benfit requiring PA)
Lenvima: Pharmacy benefit on the OralOncBrandNP Tier ($0 Brand NP tier) requiring PA

Recommendation: There are no changes to the formulary placement of Lenvima or Keytruda at this time. The current Lenvima policies (Policy 373.0, Policy 1302.0F, Policy 470.0D) and Keytruda policies (MBP 119.0, Policy 425.0D) will updated to account for the updated indication.

For Keytruda:
Endometrial Carcinoma

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

- Medical record documentation of a diagnosis of advanced endometrial carcinoma **AND**
- Medical record documentation of disease progression following at least one prior systemic therapy **AND**
- Medical record documentation that patient is not a candidate for curative surgery or radiation **AND**
- Medical record documentation that tumors are **not** microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) **AND**
- Medical record documentation that Keytruda will be given in combination with lenvatinib (Lenvima)

For Lenvima:
Endometrial Carcinoma

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation of a diagnosis of advanced endometrial carcinoma **AND**
- Medical record documentation of disease progression following at least one prior systemic therapy **AND**
- Medical record documentation that patient is not a candidate for curative surgery or radiation **AND**
- Medical record documentation that tumors are **not** microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) **AND**
- Medical record documentation that Lenvima will be given in combination with pembrolizumab (Keytruda)

Discussion: No comments or questions.

Outcome: Todd Sponenberg 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.

ERLEADA (apalutamide)

Updated Indication: Erleada is an androgen receptor inhibitor that is now indicated for the treatment of patients with metastatic castration-sensitive prostate cancer.

Previously Erleada was indicated for the treatment of non-metastatic castration-resistant prostate cancer.

Current Formulary Status/Prior Authorization Criteria: ORALONCBRANDNP tier requiring a prior authorization

Recommendation: There are no changes to the current formulary placement, quantity limits, or authorization duration. The following changes will be made to the current prior authorization criteria:

Medicare Part D Policy 649.0D

- Medical record documentation that Erleada is prescribed by an oncologist or urologist **AND**
- Medical record documentation of one of the following:
    - Medical record documentation of a diagnosis of prostate cancer with evidence of metastatic castration-sensitive disease **OR**
    - Medical record documentation of a diagnosis of prostate cancer with evidence of **non**-metastatic disease **AND** 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

Discussion: No comments or questions.

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

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

DARZALEX (daratumumab)

Updated Indication: Darzalex is now indicated for the treatment of adult patients with multiple myeloma in combination with bortezomib, thalidomide, and dexamethasone (DVTd) in newly diagnosed patients who are eligible for autologous stem cell transplant (ASCT).

Previously, the use of Darzalex in newly diagnosed multiple myeloma patients was limited to patients not eligible for stem cell transplant

Current Formulary Status: Medical benefit requiring PA

Recommendation: There are no changes to the formulary placement of Darzalex at this time. The prior authorization criteria for MBP 139.0 (pending DHS approval) will be changed as outlined below to account for the updated indication.

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation a diagnosis of multiple myeloma **AND**

If newly diagnosed multiple myeloma (transplant **ineligible**):

- Medical record documentation that the member is not eligible for stem-cell transplantation (e.g. coexisting conditions, age greater than 65, etc.) **AND**
- Medical record documentation that Darzalex will be given in combination with one of the following options:
    - Bortezomib (Velcade), melphalan, AND prednisone [VMP] **OR**
    - Lenalidomide (Revlimid) AND dexamethasone

OR

If newly diagnosed multiple myeloma (transplant **eligible**):

- Medical record documentation that the member is eligible for stem-cell transplantation AND
- Medical record documentation that Darzalex will be given in combination with bortezomib (Velcade), thalidomide, and dexamethasone (DVTd)

OR

If relapsed/refractory multiple myeloma:

- One of the following:
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least three prior lines of therapy including a proteasome inhibitor (including but not limited to Velcade*, Kyprolis*, or Ninlaro*) and an immunomodulatory agent (including but not limited to Pomalyst*, Revlimid*, Thalomid*) **OR**
    - Medical record documentation that the patient is double-refractory to a proteasome inhibitor (including but not limited to Velcade*, Kyprolis*, or Ninlaro*) and an immunomodulatory agent (including but not limited to Pomalyst*, Revlimid*, Thalomid*) **OR**
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least 1 prior therapy including a proteasome inhibitor (including but not limited to Velcade*, Kyprolis*, or Ninlaro*) or

an immunomodulatory agent (including but not limited to Pomalyst*, Revlimid*, Thalomid*) AND one of the following:

- Medical record documentation that Darzalex will be prescribed in combination with lenalidomide and dexamethasone **OR**
- Medical record documentation that Darzalex will be prescribed in combination with bortezomib and dexamethasone

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.

DESCOVY (emtricitabine and tenofovir alafenamide)

Updated Indication: Descovy is now indicated in at-risk adults and adolescents weighing at least 35 kg for pre-exposure prophylaxis (PrEP) to reduce the risk of HIV-1 infection from sexual acquisition, excluding individuals at risk from receptive vaginal sex. Individuals must have a negative HIV-1 test immediately prior to initiating Descovy for HIV-1 PrEP.

Previously, Descovy was indicated for HIV-1 treatment only in combination with other antiretroviral agents for the treatment of HIV-1 infection in adults and pediatric patients weighing at least 35 kg or in combination with other antiretroviral agents other than protease inhibitors that require a CYP3A inhibitor for the treatment of HIV-1 infection in pediatric patients weighing at least 25 kg and less than 35 kg.

Current Formulary Status: Brand Preferred tier; Quantity Limit: 1 tablet per day

Recommendation: Because there is currently unrestricted access to Descovy and there were no changes to the dosing for the new indication, there will be no changes to the current formulary placement and quantity limits for Descovy.

Discussion: No comments or questions.

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

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

RITUXAN (rituximab)

Updated Indication: Rituxan is now indicated in adult and pediatric patients 2 years of age and older in combination with glucocorticoids for the treatment of Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA).

Previously, this indication was restricted to the adult population.

Current Formulary Status: Medical benefit requiring PA

Recommendation: There are no changes to the formulary placement of Rituxan at this time. The diagnosis of Wegner's Granulomatosis is already addressed by the applicable Rituxan policies. Age is not restricted by those policies. The policy MBP 48.0 will be updated as follows to further clarify covered diagnoses.

MBP 48.0

5. **For Granulomatosis with Polyangiitis (GPA) (Wegner's Granulomatosis) and Microscopic Polyangiitis (MPA)**
   - Medical record documentation of a diagnosis of Granulomatosis with Polyangiitis (GPA) (Wegner's granulomatosis) or Microscopic Polyangiitis (MPA) used in combination with glucocorticoids

Discussion: No comments or questions.

Outcome: Aubrielle Prater 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.

PIFELTRO (doravirine)

Updated Indication: Pifeltro is a non-nucleoside reverse transcriptase inhibitor (NNRTI) which is now indicated in combination with other antiretroviral agents for the treatment of HIV-1 infection in adult patients:

- With no prior antiretroviral treatment history OR
- To replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no history of treatment failure and no known substitutions associated with resistance to doravirine.

Current Formulary Status: Brand Preferred tier, QL: 2 tablets per day

Recommendation: Since we allow unrestricted access to antiretrovirals for treatment of HIV infection at this time, there will be no changes to the current formulary status of Pifeltro. Since there was no change to the dosing regimen with the new indication, there will be no changes to the current quantity limits for Pifeltro.

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.

DELSTRIGO (doravirine/lamivudine/tenofovir disoproxil fumarate)

Updated Indication: Delstrigo is three-drug combination of doravirine (a non-nucleoside reverse transcriptase inhibitor [NNRTI]), lamivudine, and tenofovir disoproxil fumarate (both nucleoside analogue reverse transcriptase inhibitors) and is indicated as a complete regimen for the treatment of HIV-1 infection in adult patients:

- With no prior antiretroviral treatment history OR
- To replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no history of treatment failure and no known substitutions associated with resistance to the individual components of Delstrigo.

Current Formulary Status: Brand Preferred tier, QL: 1 tablet per day

Recommendation: Since we allow unrestricted access to antiretrovirals for treatment of HIV infection at this time, there are no changes to the current formulary status of Delstrigo. There will be no change to the current quantity limits of Delstrigo, since there was no change to dosing regimen with the new indication.

Discussion: No comments or questions.

Outcome: Aubrielle Prater 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

Ampyra – formulary status

Current Formulary Status/PA criteria:
Commercial/GHP Kids-

- Ampyra: Multi-source Brand tier requiring a prior authorization.
- Dalfampridine: Generic tier requiring a prior authorization.

Exchange-

- Ampyra: BrandNP tier requiring a prior authorization.
- Dalfampridine: Pending requiring a prior authorization.

Prior Authorization Criteria:

- Medical record documentation that Ampyra is prescribed written by a neurologist **AND**
- Medical record documentation of a diagnosis of multiple sclerosis **AND**
- For members with a diagnosis of relapsing-remitting multiple sclerosis, medical record documentation the member is currently receiving therapy with a formulary disease modifying agent or has failed all formulary disease modifying agents **AND**
- Medical record documentation that the member has difficulty walking or ambulating **AND**
- Medical record documentation of a baseline 25 foot walking speed

Authorization Duration: Initial authorization will be for a period of 3 months. Continued authorization, after the initial 3 months, will be indefinite and will require medical record documentation of at least a 10% improvement in the timed 25 foot walk speed, as compared to baseline submission.

Quantity Limit: 2 tablets per day, 30 day supply per fill.

Recommendations:
For all lines of business, the current, clinical prior authorization criteria for Ampyra and Dalfampridine will be removed. Dalfampridine will be preferred and requests for Ampyra will be reviewed using the Brand vs. Generic policies.

Commercial/GHP Kids-

- Ampyra: Will remain at the Multi-source Brand tier requiring a brand vs. generic review.
    - Quantity Limit: 2 tablets per day, 30 day supply per fill
- Dalfampridine: Will remain at the Generic tier and will not require a prior authorization.
    - Quantity Limit: 2 tablets per day, 30 day supply per fill

Exchange-

- Ampyra: It is recommended to make Ampyra non-formulary requiring a brand vs. generic review.
    - Quantity Limit: 2 tablets per day, 30 day supply per fill
- Dalfampridine: It is recommended to add Ampyra to the Generic Non-Preferred tier. Dalfampridine will not require a prior authorization.
    - Quantity Limit: 2 tablets per day, 30 day supply per fill

Discussion: No comments or questions.

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

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

GATTEX – policy update

Current Policy Criteria:
Commercial Policy 286.0

- Medical record documentation that Gattex is prescribed by a gastroenterologist **AND**
- Medical record documentation of age greater than or equal to 1 year **AND**
- Medical record documentation of a diagnosis of short bowel syndrome **AND**
- Medical record documentation that the member has been dependent on parenteral nutrition/intravenous support for a minimum of 12 consecutive months continuously **AND**
- Medical record documentation that the member requires parenteral nutrition at least 3 times per week

Recommendation: The study inclusion criteria for adults was to be an adult with SBS who was dependent on parenteral nutrition/intravenous (PN/I.V.) support for at least 12 months and required parenteral nutrition at least 3 times per week. However, the study inclusion criteria for pediatrics included those aged 1 year through 17 years with SBS who were dependent on parenteral support. The following updates will be made to the prior authorization criteria for all LOB:

- Prescription is written by a gastroenterologist **AND**
- Member is ≥1 year of age **AND**
- Medical record documentation of a diagnosis of short bowel syndrome **AND**

If age 1 to 17 years of age:

- Medical record documentation that the member is dependent on parenteral nutrition/intravenous support

If age ≥ 18 years of age:

- Medical record documentation that the member has been dependent on parenteral nutrition/intravenous support for a minimum of 12 consecutive months continuously **AND**
- Medical record documentation that the member requires concurrent parenteral nutrition at least three days per week

Discussion: No comments or questions.

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

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

Freestyle Libre

FreeStyle Libre is a continuous glucose monitoring (CGM) device indicated for replacing blood glucose testing and detecting trends and tracking patterns aiding in the detection of episodes of hyperglycemia and hypoglycemia, facilitating both acute and long-term therapy adjustments in persons (age 18 and older) with diabetes. The systems are intended for single patient use and require a prescription.

In order to improve access to members and to provide an alternative to the traditional fingerstick glucose monitoring system, FreeStyle Libre will be added to the Brand Preferred tier of the Commercial, GHP Kids, and Marketplace formularies requiring a prior authorization. The following prior authorization and quantity limit criteria will be added.

Prior Authorization Criteria:

- Medical record documentation of type 1 or 2 diabetes mellitus **AND**
- Medical record documentation of member age greater than or equal to 18 years **AND**
- One of the following:
    - Medical record documentation of current insulin therapy use **OR**
    - Medical record documentation of functional barriers to finger stick blood glucose monitoring **OR**
    - Medical record documentation of history of recurrent hypoglycemia episodes **OR**
    - Medical record documentation of HgA1c greater than 9

Quantity Limit:

- Freestyle Libre 10 or 14 day reader: 1 reader every 2 years
- Freestyle Libre 10 day sensors: 3 sensors per 30 days (quantity limit by ratio)
- Freestyle Libre 14 day sensors: 2 sensors per 28 days (quantity limit by ratio)

Discussion: No comments or questions.

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

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

2020 Marketplace Formulary

The PDF version of the 2020 Marketplace formulary was distributed with the electronic binder prior to the in person meeting.

NOTE: Formulary is effective as of 10/1/2019. Ongoing maintenance and updates will continue to be made as approved at the November P&T committee meeting.

Meeting adjourned at 4:25 pm.

Future Scheduled Meetings

An electronic P&T meeting will be held sometime in December.

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

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