

**P&T Committee Meeting Minutes  
Commercial/Marketplace/GHP Kids  
July 20, 2021**

<b>Present (via Teams):</b> Bret Yarczower, MD, MBA – Chair Megan Ammon, Pharm.D. Kristen Bender, Pharm.D. Kim Castelnovo Dean Christian, MD Kimberly Clark, Pharm.D. Tricia Heitzman, Pharm.D. Nichole Hossler, MD Jason Howay, Pharm.D. Derek Hunt, Pharm.D. Phillip Krebs, R.EEG T Perry Meadows, MD Jamie Miller, RPh Austin Paisley, Pharm.D. Kimberly Reichard, Pharm.D. Melissa Renn, Pharm.D. Angela Scarantino Kristen Scheib, Pharm.D. Leslie Shumlas, Pharm.D. Aubrielle Smith Pharm.D. Todd Sponenberg, Pharm.D. Jill Stone, Pharm.D. Kevin Szczecina, RPh Amanda Taylor, MD Brandon Whiteash, Pharm.D. Adam Root (non-voting participant)	<b>Absent:</b> Holly Bones, Pharm.D. Alyssa Cilia, RPh Michael Evans, RPh Rajneel Farley, Pharm.D. Kelly Faust Pharm.D. Keith Hunsicker, Pharm.D. Kelli Hunsicker, Pharm.D. Jonas Pearson, RPh William Seavey, Pharm.D. Michael Shepherd, MD Richard Silbert, MD Michael Spishock, RPh Robert Strony, MD MBA
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**Call to Order:**

Dr. Bret Yarczower called the meeting to order at 1:04 p.m., Tuesday, July 20, 2021.

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**Review and Approval of Minutes:**

Dr. Bret Yarczower asked for a motion or approval to accept the April 22, 2021, May 18, 2021, and June 25, 2021 minutes as written. Minutes approved unanimously. None were opposed.

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**DRUG REVIEWS**

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**JEMPERLI (dostarlimab-gxly)**

**Review:** Jemperli is a programmed death receptor-1 (PD-1) blocking antibody indicated for the treatment of adult patients with mismatch repair deficient (dMMR) recurrent or advanced endometrial cancer (EC), as determined by an FDA-approved test, that has progressed on or following prior treatment with a platinum-containing regimen. Jemperli is the third anti-PD-1 monoclonal antibody approved in the United States along with Keytruda and Opdivo. NCCN recommendations in uterine cancer recommend Jemperli, Keytruda, and Opdivo (off-label) as biomarker-directed systemic therapy for second-line treatment that is useful in certain circumstances (category 2A for all). Other studies and cohorts of the GARNET trial are evaluating Jemperli for earlier lines of treatment

in endometrial cancer and as monotherapy and combination therapy across multiple tumor types and other cancers, including ovarian cancer, non-small cell lung cancer, multiple myeloma, and melanoma.

The efficacy of Jemperli was evaluated in the GARNET study, a multi-cohort, open-label study in adult patients with advanced solid tumors. The efficacy population consisted of 71 patients with mismatch repair deficient (dMMR) recurrent or advanced EC who had progression on or after treatment with a platinum-containing regimen. Patients were treated with Jemperli 500 mg intravenously every 3 weeks for 4 doses followed by 1,000 mg intravenously every 6 weeks until disease progression or unacceptable toxicity. The major efficacy outcomes demonstrated an overall response rate (ORR) of 42.3% and a median duration of response (DOR) that was not reached at the time of analysis (range 2.6 months to 22.4+ months [ongoing]).

There are no black box warnings for Jemperli. There are warnings for immune-mediated adverse reactions, including immune-mediated pneumonitis, colitis, hepatitis, endocrinopathies, nephritis with renal dysfunction, and dermatologic adverse reactions. Other warnings include infusion-related reactions, embryo-fetal toxicity, and complications with allogeneic hematopoietic stem cell transplantation (HSCT) before or after being treated with a PD-1/PD-L1 blocking antibody (graft-versus-host disease, hepatic veno-occlusive disease, and steroid-requiring febrile syndrome). The most common adverse reactions were fatigue/asthenia, nausea, diarrhea, anemia, and constipation.

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

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

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

**Outcome:** Jemperli is a medical benefit. When Jemperli is processed at a specialty pharmacy, it will be processed on the Specialty tier or the Brand Non-preferred tier for members with a three tier benefit. Jemperli will require prior authorization with the following criteria:

- Medical record documentation that Jemperli 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 recurrent or advanced endometrial cancer **AND**
- Medical record documentation of mismatch repair deficient (dMMR) as determined by an FDA approved test **AND**
- Medical record documentation of disease progression on or following prior treatment with a platinum-containing regimen

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

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

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## **ZYNLONTA (loncastuximab tesirine-lpyl)**

**Review:** Zynlonta is a CD19-directed antibody and alkylating agent conjugate indicated for the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, DLBCL arising from low grade lymphoma, and

high-grade B-cell lymphoma. It will compete with other third-line or later treatment options which include CD19-directed CAR-T therapies Breyanzi, Kymriah, and Yescarta, and the nuclear export inhibitor Xpovio, and potentially with the second-line or later treatment options Polivy and Monjuvi (another CD19-directed antibody). Currently, there having been no trials directly comparing the different third-line treatment options and NCCN does not prefer one third-line option over another.

The efficacy of Zynlonta was evaluated in the LOTIS-2 trial, an open-label, single arm trial in 145 adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) after at least 2 prior systemic regimens. Patients received Zynlonta 0.15 mg/ kg every 3 weeks for 2 cycles, then 0.0075 mg/kg every 3 weeks for subsequent cycles until disease progression or unacceptable toxicity. The primary efficacy endpoint evaluating overall response rate (ORR) as assessed by an independent review committee (IRC) using Lugano 2014 criteria demonstrated a 48.3% ORR with a median duration of response of 10.3 months.

There are no black box warnings for Zynlonta. Warnings and precautions include effusion (pleural and pericardial) and edema, myelosuppression, fatal and serious infections, cutaneous reactions, and embryo-fetal toxicity. In the pooled safety data in 215 patients from LOTIS-2 and another trial, the most common (>20%) adverse reactions were thrombocytopenia, increased gamma-glutamyltransferase, neutropenia, anemia, hyperglycemia, transaminase elevation, fatigue, hypoalbuminemia, rash, edema, nausea, and musculoskeletal pain.

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

**Clinical Discussion:** Dr. Yarczower asking if B-cell lymphoma is included in VIA Oncology Pathways? Unable to answer as this time. The committee unanimously voted to accept the recommendations as presented. None were opposed.

**Financial Discussion:** Currently investigating medical rebating opportunities. Potential target given similar agents in this category. The committee unanimously voted to accept the recommendations as presented. None were opposed.

**Outcome:** Zynlonta is a medical benefit. When Zynlonta is processed at a specialty pharmacy, it will be processed on the Specialty tier or the Brand Non-preferred tier for members with a three tier benefit. Zynlonta will require prior authorization with the following criteria:

- Medical record documentation that Zynlonta 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 relapsed or refractory large B-cell lymphoma including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, DLBCL arising from low grade lymphoma, and high-grade B-cell lymphoma **AND**
- Medical record documentation of prior treatment with two or more lines of systemic therapy

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

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

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**ADUHELM (aducanumab-avwa)**

Review on hold at this time.

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**NULIBRY (fosdenopterin)**

**Review:** Nulibry is a substrate replacement therapy providing an exogenous source of cyclic pyranopterin monophosphate (cPMP) indicated to reduce the risk of mortality in patients with molybdenum cofactor deficiency (MoCD) Type A. It is the first treatment approved for MoCD Type A. Prior to the approval of Nulibry, the management of MoCD was mainly supportive to provide symptomatic relief and included antiepileptic medications and low sulfur diets with sulfate supplementation.

The efficacy of Nulibry for the treatment of MoCD Type A was established based on data from three clinical studies (Study 1, 2, and 3) that were compared to data from a natural history study. Efficacy was assessed in a combined analysis of 13 patients with genetically confirmed MoCD Type A from Study 1 (n=8), Study 2 (n=1), and Study 3 (n=4) who received Nulibry or rcPMP. The age of first dose was  $\leq 14$  days for 10 patients and  $\geq 32$  days and  $< 69$  days for the remaining 3 patients. Efficacy compared overall survival in pediatric patients treated with Nulibry or rcPMP (n=13) with an untreated natural history cohort of pediatric patients with genetically confirmed MoCD Type A who were genotype matched to the treated patients (n=18). Patients treated with Nulibry or rcPMP had an improvement in overall survival compared to the untreated, genotype-matched, historical control group. Earlier initiation of treatment is associated with better outcomes however even in patients with severe pre-existing brain lesions appeared to have favorable responses, with decreased seizure activity, improved levels of consciousness, and clearly reduced irritability. Treatment with Nulibry resulted in reduced urine concentrations of SSC in patients with MoCD Type A and the reduction was sustained over 48 months. The CNS SSC levels were not measured in humans, but this animal data suggests that Nulibry is able to cross the blood brain barrier and that changes in the peripheral SSC levels will reflect reductions in brain SSC. During the clinical trials of Nulibry, the lack of efficacy of cPMP was documented in five neonates with MoCD type B.

There are no black box warnings for Nulibry. Nulibry has warnings for the potential for photosensitivity based on findings in animal studies. The most common adverse reactions included respiratory infections and complications related to the central venous catheter. Additional safety data evaluating rcPMP showed adverse reactions consistent with those in Nulibry-treated patients, but all included additional adverse reactions of sepsis, oral candidiasis, varicella, fungal skin infection, and eczema.

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

**Clinical Discussion:** Dr. Yarczower questioned the rationale for starting treatment even with a presumptive diagnosis. Treatment should be started as early as possible, even if diagnosis is only presumptive in order to stop progression. Is there a newborn screening test for MoCD? Some patients in trials had family history and had neonatal testing. Uncertain if it's included in all neonatal screenings at this time. Will investigate who can perform this testing and how long it takes to receive results. Is there a point at which treatment is futile or should everyone receive treatment? Clinical trials treated all patient and those patients did see improvements in seizure activity, etc. Even though it's only indicated to improve mortality, patients did have some other positive outcomes. The committee unanimously voted to accept the recommendations as presented. None were opposed.

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

**Outcome:** Nulibry may be covered as a pharmacy or medical benefit. When Nulibry is processed at a specialty pharmacy, it will be processed on the Specialty tier or the Brand Non-preferred tier for members with a three tier benefit. Nulibry will require prior authorization with the following criteria:

- Medical record documentation that Nulibry is prescribed by a neonatologist, geneticist, or pediatric neurologist **AND**
- Medical record documentation of a diagnosis of molybdenum cofactor deficiency (MoCD) Type A as confirmed by genetic testing indicating a mutation in the molybdenum cofactor synthesis gene 1 (MOCS1) gene **OR**
- Medical record documentation of both of the following:
  - Documentation of biochemical and clinical features consistent with a diagnosis of molybdenum cofactor deficiency (MoCD) Type A, including but not limited to encephalopathy, intractable seizures, elevated urinary S-sulfocysteine levels, and decreased uric acid levels **AND**
  - Documentation that the member will be treated presumptively while awaiting genetic confirmation

#### **AUTHORIZATION DURATION:**

##### **For patients with a presumptive diagnosis of molybdenum cofactor deficiency (MoCD) Type A awaiting genetic confirmation:**

Approval will be given for an **initial duration of one (1) month** or less if the reviewing provider feels it is medically appropriate and will require:

- Medical record documentation of genetic testing confirming a diagnosis of molybdenum cofactor deficiency (MoCD) Type A

##### **For patients with genetically confirmed MoCD Type A diagnosis:**

Approval will be given for an initial **duration of twelve (12) months**. Subsequent approvals will be for a **duration of twelve (12) months** or less if the reviewing provider feels it is medically appropriate and will require:

- Medical record documentation of a clinically significant positive response or lack of disease progression with Nulibry treatment

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

#### **EVKEEZA (evinacumab-dgnb)**

**Review:** Evkeeza is a recombinant human monoclonal antibody that binds to and inhibits angiopoietin-like 3 (ANGPTL3) indicated as an adjunct to other low-density lipoprotein-cholesterol (LDL-C) lowering therapies for the treatment of adult and pediatric patients, aged 12 years and older, with homozygous familial hypercholesterolemia (HoFH). It offers a new mechanism of action for the treatment of patients with HoFH who often require multiple intensive LDL-lowering therapies to reach their LDL goals. The treatment guidelines for the management of dyslipidemias and HoFH have not been updated since the approval of Evkeeza but it is expected that placement in therapy will be similar to Juxtapid which is also reserved for patients who have failed other LDL-C lowering therapies and lipoprotein apheresis.

The efficacy of Evkeeza was evaluated in the ELIPSE-HoFH trial, a double-blind, randomized, placebo-controlled trial evaluating the efficacy and safety of Evkeeza compared to placebo in 65 patients 12 years of age and older with homozygous familial hypercholesterolemia (HoFH). During the 24-week, double-blind treatment period, patients were randomized to treatment with Evkeeza 15 mg/kg IV every 4 weeks (n=43) or placebo (n=22). After the double-blind treatment period, 64 of 65 patients entered a 24-week open-label extension period during which all patients received treatment with Evkeeza.

The primary efficacy endpoint was percent change in LDL-C from baseline to week 24. At week 24, the least mean squares difference between Evkeeza and placebo in mean percent change in LDL-C from baseline was -49%. After 24 weeks of open-label treatment (Week 24 to 48), the observed LDL-C reduction from baseline was similar in patients who crossed over from placebo to Evkeeza and was maintained in patients who remained on

Evkeeza for 48 weeks. At Week 24, the observed reduction in LDL-C was consistent across all predefined subgroups, including age, limited LDLR activity, concomitant treatment with lipoprotein apheresis, and concomitant background lipid-lowering medications.

There are no black box warnings for Evkeeza. There are warnings for serious hypersensitivity reactions (including 1 case of anaphylaxis during clinical trials) and embryo fetal toxicity based on animal reproduction studies. During clinical trials, the most common adverse reactions which occurred in over 3% of patients treated with Evkeeza and were greater than placebo included nasopharyngitis, influenza like illness, dizziness, rhinorrhea, nausea, pain in extremities and asthenia.

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

**Clinical Discussion:** Dr. Yarczower asked if there is a reason to include duplicate therapy criteria? Don't believe so as patients in clinical trials were receiving concomitant therapy with agents such as Juxtapid. Only indicated as adjunctive therapy. Would we want to see that other therapies aren't working before approving Evkeeza? We do have some additional criteria included in the financial section of the review. The committee unanimously voted to accept the recommendations as presented. None were opposed.

**Financial Discussion:** Do these criteria allow for jumping directly from statins/PCSK9 inhibitors to Juxtapid in combination with Evkeeza? Should we consider adding criteria to require failure of one before starting combination therapy? We will reach out for specialist feedback to determine what an appropriate trial would be before starting combination therapy. For the time being, we will recommend addition of a trial of each agent individually. Do we need to include language that the member has at least partially responded to the Juxtapid? The committee unanimously voted to accept the recommendations as presented. None were opposed.

**Outcome:** After the above discussion it was determined that the best course of action is to seek specialist input on the combination use of Evkeeza and Juxtapid prior to approving any recommendations. Evkeeza and Juxtapid will be further evaluated at a future P&T committee meeting.

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

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## **LUPKYNIS (voclosporin)**

**Review:** Lupkynis is a calcineurin-inhibitor immunosuppressant indicated in combination with a background immunosuppressive therapy regimen for the treatment of adult patients with active lupus nephritis (LN). Safety and efficacy of Lupkynis have not been established in combination with cyclophosphamide.

Both the American College of Rheumatology (ACR) and the Kidney Disease Improving Global Outcome (KDIGO) practice guidelines recommend the following for Class III and IV LN: mycophenolate mofetil (MMF) at a dose of 2 to 3 grams total daily (preferred) or cyclophosphamide for 6 months with glucocorticoids as induction therapy, followed by maintenance therapy with azathioprine, MMF, or a calcineurin inhibitor (CNI), and a low-dose steroid. The average length of immunosuppression in LN can be  $\geq 3$  years with up to 60% of patients never reaching full remission with current therapies. Lupkynis is the first oral treatment for lupus nephritis (LN). It is the second medication approved for LN, following Benlysta in December 2020. Lupkynis and Benlysta will likely be added to induction therapy and continued into maintenance therapy, pending results of longer-term extension studies.

Lupkynis is supplied as 7.9 mg capsules. Four individual 3 x 5 blister strips are assembled into a cardboard wallet. Lupkynis is available in a wallet containing 60 capsules or a carton containing 3 wallets (180 capsules). The recommended starting dose of Lupkynis is 23.7 mg twice daily. Lupkynis should be used in combination with mycophenolate mofetil (MMF) and corticosteroids. Prior to starting Lupkynis therapy, eGFR should be checked,

Lupkynis is not recommended in patients with a baseline eGFR  $\leq$  45 mL/min/1.73 m<sup>2</sup> unless the benefit exceeds the risk. If the patient does not experience therapeutic benefit by 24 weeks, consider discontinuation of Lupkynis. The safety and efficacy have not been established beyond one year.

The safety and efficacy of Lupkynis were investigated in Study 1, a 52-week, randomized, double-blind, placebo-controlled trial in patients (n=357) with a diagnosis of systemic lupus erythematosus and with International Society of Nephrology/Renal Pathology Society (ISN/RPS) biopsy-proven active Class III or IV LN (alone or in combination with Class V LN) or Class V LN. A total of 357 patients with LN were randomized in a 1:1 ratio to receive either Lupkynis 23.7 mg twice daily or placebo. Patients in both arms received background treatment with MMF and corticosteroids. Patients with baseline eGFR  $\leq$ 45 mL/min/1.73 m<sup>2</sup> were not enrolled in this study. The primary efficacy endpoint was the proportion of patients achieving complete renal response at Week 52, defined as the following: UPCR of  $\leq$  0.5 mg/mg and eGFR  $\geq$  60 mL/min/1.73 m<sup>2</sup> or no confirmed decrease from baseline in eGFR of  $>$  20% or no-treatment- or disease-related eGFR-associated event (defined as blood creatinine increased, creatinine renal clearance decreased, glomerular filtration rate decreased, serum creatinine increased, renal impairment, renal failure, or renal failure acute) at time of assessment. In order to be considered a responder, the patient must not have received more than 10 mg prednisone for  $\geq$  3 consecutive days or for  $\geq$  7 days in total during Weeks 44 through 52. A statistically significant higher proportion of patients in the Lupkynis arm (40.8%) achieved complete renal response at Week 52 compared to placebo (22.5%). A higher proportion of patients in the Lupkynis arm than the placebo arm achieved complete renal response at Week 24. Time to UPCR of  $\leq$  0.5 mg/mg was shorter in the Lupkynis arm than the placebo arm. Results were consistent regardless of baseline patient characteristics, suggesting a similar treatment response regardless of race and ethnicity. A phase 3 continuation study is ongoing to assess long-term safety and efficacy for an additional 24 months, following the 52-week period. Results are expected in August 2021.

Lupkynis has a boxed warning for increased risk for developing serious infections and malignancies with Lupkynis or other immunosuppressants that may lead to hospitalization or death. Lupkynis is contraindicated in patients concomitantly using strong CYP3A4 inhibitors (e.g. ketoconazole, itraconazole, clarithromycin). Lupkynis, like other calcineurin-inhibitors, may cause acute and/or chronic nephrotoxicity. Lupkynis may also cause hypertension, neurotoxicity, hyperkalemia, QTc prolongation. The most common adverse reactions ( $\geq$ 3%) were glomerular filtration rate decreased, hypertension, diarrhea, headache, anemia, cough, urinary tract infection, abdominal pain upper, dyspepsia, alopecia, renal impairment, abdominal pain, mouth ulceration, fatigue, tremor, acute kidney injury, and decreased appetite. The safety and efficacy of Lupkynis in pediatric patients has not been established.

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

**Clinical Discussion:** Dr. Yarczower asked if Lupkynis can be used if you have brain involvement? This is specifically approved for lupus nephritis. No specific comments in clinical trials regarding brain involvement. The presence of activity elsewhere does not preclude its use. The committee unanimously voted to accept the recommendations as presented. None were opposed.

**Financial Discussion:** If there is CNS involvement did the specialist make any comment about utilization of Benlysta? Was Benlysta well studied for lupus nephritis? Will be discussed later in the meeting during the Benlysta review. The committee unanimously voted to accept the recommendations as presented. None were opposed.

**Outcome:** Lupkynis is a pharmacy benefit and will be added to the formulary on the Specialty Tier or the Brand Non-Preferred Tier for members with a three-tier benefit. Lupkynis will require prior authorization with the following criteria:

- Medical record documentation of a diagnosis of active lupus nephritis, Class III, IV, V alone or in combination, confirmed by a kidney biopsy AND
- Medical record documentation of age greater than or equal to 18 AND

- Prescription written by or in consultation with a rheumatologist or nephrologist AND
- Medical record documentation that Lupkynis will be prescribed in combination with a background immunosuppressive therapy regimen (e.g. mycophenolate mofetil (MMF) and corticosteroids) AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Benlysta\*

**AUTHORIZATION DURATION:** Initial approval will be for 6 months. Subsequent approvals will be for 12 months. Re-authorization will require the following:

- Medical record documentation of a positive clinical response to Lupkynis (e.g. improvement/stabilization in UPCR, eGFR, renal-related events) AND
- Medical record documentation that Lupkynis will be prescribed in combination with a background immunosuppressive therapy regimen (e.g. mycophenolate mofetil (MMF) and corticosteroids)

**QUANTITY LIMIT:** 6 capsules per day

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

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### **RYBREVANT (amivantamab-vmjw)**

**Review:** Rybrevant is a human immunoglobulin G1-based bispecific antibody that binds the extracellular domains of EGF and MET receptors. It is the first bispecific antibody approved for the treatment of non-small cell lung cancer (NSCLC) which targets EGFR exon 20 insertion mutations. Prior to the approval of Rybrevant, patients with exon 20 insertion mutations had no targeted therapies or clear subsequent treatment options following progression on platinum-based chemotherapy.

The efficacy of Rybrevant was evaluated in one cohort of the CHRYSALIS trial, an open-label, multicohort trial in patients with locally advanced or metastatic NSCLC with EGFR exon 20 insert mutations whose disease had progressed on or after platinum-based chemotherapy. Patients received Rybrevant 1050 mg (for patient baseline body weight < 80 kg) or 1400 (for patient baseline body weight ≥ 80 kg) once weekly for 4 weeks, then every 2 weeks thereafter until disease progression or unacceptable toxicity. The major efficacy outcome evaluating overall response rate according to RECIST v1.1 evaluated by Blinded Independent Central Review (BICR) demonstrated a 40% response rate, with a majority of patients having a partial response. The median duration of response was 11.1 months, with 63% of patients having a response lasting at least 6 months.

There are no black box warnings for Rybrevant. Rybrevant carries warnings for infusion related reactions (IRR) which occurred in 66% of patients treated with Rybrevant, most commonly with the initial infusion on Week 1, Day 1. Other warnings and precautions include interstitial lung disease (ILD)/pneumonitis, dermatologic adverse reactions, ocular toxicity, and embryo fetal toxicity. During the CHRYSALIS trial, the most common adverse reactions were rash, IRR, paronychia, musculoskeletal pain, dyspnea, nausea, fatigue, edema, stomatitis, cough, constipation, and vomiting.

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

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

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



**Outcome:** Rybrevant is a medical benefit. When Rybrevant is processed at a specialty pharmacy, it will be processed on the Specialty tier or the Brand Non-preferred tier for members with a three tier benefit. Rybrevant will require prior authorization with the following criteria:

- Medical record documentation that Rybrevant 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 with locally advanced or metastatic non-small cell lung cancer (NSCLC) **AND**
- Medical record documentation of epidermal growth factor receptor (EGFR) exon 20 insertion mutations as determined by an FDA approved test\* **AND**
- Medical record documentation of disease progression on or following prior treatment with a platinum-based chemotherapy

**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.

**\*NOTE:** The FDA approved test for Rybrevant to detect the presences of EGFR exon 20 insertion mutations is the Guardant360® CDx.

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

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## **FENSOLVI (leuprolide acetate)**

**Review:** Fensolvi is a gonadotropin releasing hormone (GnRH) agonist indicated for the treatment of pediatric patients 2 years of age and older with central precocious puberty (CPP). Central precocious puberty is a specific type of precocious puberty defined with an underlying pathology of early maturation of the hypothalamic-pituitary-gonadal axis, which causes maturation of breasts and pubic hair in girls and testicular and penile enlargement and pubic hair in boys. Other types of precocious puberty include peripheral precocity and benign pubertal variants, both of which GnRH agonists are not expected to be effective for. The primary goal of treatment is to allow a child to grow to a normal adult height. The secondary goal of treatment is to relieve psychosocial distress. Other GnRH agonists indicated for CPP are Lupron Depot-Ped, Triptodur, Supprelin LA and Synarel. Fensolvi is dosed at 45 mg given subcutaneously every 6 months and is supplied in a kit with two syringes, one containing diluent for reconstitution and the other containing lyophilized leuprolide acetate powder.

The efficacy of Fensolvi was evaluated in an uncontrolled, open-label, single arm clinical trial that enrolled 64 pediatric patients, naïve to GnRH agonist therapy, with a diagnosis of CPP. Of the 64 patients, 62 were female, 2 were male, and the mean age was 7.5 years (range 4 to 9 years) at the start of treatment. Patients received two doses of Fensolvi 45 mg separated by 24 weeks, and were followed for a total of 48 weeks. The primary outcome was percentage of children with serum luteinizing hormone (LH) <4 IU/L 30 minutes following GnRH stimulation at week 24. 54 of 62 children (87%) achieved poststimulation LH <4 IU/L at week 24.

Fensolvi is contraindicated in patients with previous hypersensitivity to GnRH, GnRH agonists, or any component of Fensolvi, and in pregnancy. Fensolvi also carries warnings and precautions for initial rise of gonadotropin and sex steroid levels, psychiatric events and convulsions. Adverse reactions from clinical trial experience includes injection site pain (31%), nasopharyngitis (22%), pyrexia (17%) headache (16%) and cough (13%). No drug-drug interaction studies have been conducted with Fensolvi.

The National Organization for Rare Disorders (NORD) states the aim of treatment is to arrest physical maturation, prevent early menarche, bring final adult height closer to genetic expectation and allow normal psychosocial

development. Treatment with GnRH analogues have resulted in significant improvement in height in many children with precocious puberty. In general, treatment is required for those who progress rapidly through puberty. Those who progress slowly through puberty will do well without intervention.

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

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

**Financial Discussion:** Triptodur is more expensive once patients are greater than or equal to 25 kg. Not a significant price difference so not current value in preferring one agent over another. Are there any contracting opportunities in this space? No comments or questions. The committee unanimously voted to accept the recommendations as presented. None were opposed.

**Outcome:** Fensolvi is a medical benefit. When Fensolvi is processed at a specialty pharmacy, it will be processed on the Specialty tier or the Brand Non-preferred tier for members with a three tier benefit. Fensolvi will require prior authorization with the following criteria:

- Medical record documentation of a diagnosis of central precocious puberty (CPP) **AND**
- Prescription written by or in consultation with a pediatric endocrinologist **AND**
- Medical record documentation of age greater than or equal to 2 years of age **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Lupron Depot-Ped, Triptodur\* and Supprelin LA (\*prior authorization required)

**QUANTITY LIMIT:** Fensolvi (6 month) Subcutaneous Kit 45 mg: 45 mg per 6 months

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

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## FAST FACTS

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### NPLATE (romiplostim)

**Updated Indication:** Nplate is now indicated to increase survival in adults and in pediatric patients (including term neonates) acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome [HS-ARS]).

**Current formulary status:** Medical Benefit, requiring a prior authorization; When processed at a specialty pharmacy: Specialty tier or Brand NP tier

**Recommendation:** There are no changes to the current formulary placement of Nplate. It is recommended that the following criteria and auth duration be added to Medical Benefit Policy 68.0 to incorporate the new indication:

#### HS-ARS

- Medical record documentation of Hematopoietic Syndrome of Acute Radiation Syndrome (HS-ARS) AND
- Medical record documentation of suspected or confirmed acute exposure to myelosuppressive doses of radiation (estimated as radiation levels greater than 2 gray [Gy]).

**AUTHORIZATION DURATION FOR HS-ARS:** One-time authorization for one administration of Nplate

**Discussion:** No comments or questions.

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

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

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### GOCOVRI (amantadine)

**Updated Indication:** Gocovri are extended-release capsules of amantadine now indicated as adjunctive treatment to levodopa/carbidopa in patients with Parkinson's disease experiencing "off" episodes.

Previously Gocovri was indicated for the treatment of dyskinesia in patients with Parkinson's disease receiving levodopa-based therapy, with or without concomitant dopaminergic medications.

**Current formulary status:** Non-formulary

**Recommendation:** There are no changes recommended to the formulary placement or current quantity limits of Gocovri. The following changes are recommended to Commercial Policy 499.0 to incorporate the new indication:

- Medical record documentation of dyskinesia with a diagnosis of Parkinson's disease AND
- Medical record documentation that the member is currently receiving and will continue levodopa-based therapy with the addition of Gocovri AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to immediate-release amantadine

#### OR

- Medical record documentation of "off episodes" with a diagnosis of Parkinson's disease AND
- Medical record documentation that Gocovri will be used as adjunctive treatment to levodopa/carbidopa

**Discussion:** No comments or questions.

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

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

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**RAPIVAB (peramivir)**

**Updated Indication:** Rapivab is an influenza virus neuraminidase inhibitor now indicated for the treatment of acute uncomplicated influenza in patients 6 months and older who have been symptomatic for no more than two days.

*Previously Rapivab was only indicated for the treatment of acute uncomplicated influenza in patients 2 years of age and older who have been symptomatic for no more than two days*

**Current formulary status:** Rapivab is a medical benefit and does not require prior authorization.

**Recommendation:** No changes are recommended to the formulary placement of Rapivab at this time.

**Discussion:** No comments or questions.

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

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

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**BOTOX (onabotulinumtoxinA)**

**Updated Indication:** Botox is now indicated for the treatment of neurogenic detrusor overactivity (NDO) in pediatric patients 5 years of age and older who have an inadequate response to or are intolerant of anticholinergic medication.

Previously, Botox was indicated for the treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication.

**Current formulary status:** Medical Benefit, requiring a prior authorization, When processed at a specialty pharmacy: Specialty tier or Brand NP tier

**Recommendation:** No changes are recommended to the formulary placement, quantity limits, or authorization duration for Botox at this time. Currently Medical Benefit Policy 11 has criteria in place for urinary incontinence due to neurogenic bladder which do not specify age and are appropriate to the new indication. No changes are needed to the current policies.

**Discussion:** No comments or questions.

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

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

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## HUMIRA (adalimumab)

**Updated Indication:** Humira is now indicated for the treatment of moderately to severely active ulcerative colitis in adults and pediatric patients 5 years of age and older.

**Limitations of use:** Effectiveness has not been established in patients who have lost response to or were intolerant to TNF blockers.

*Previously, Humira was indicated for inducing and sustaining clinical remission in adult patients with moderately and severely active ulcerative colitis who have had an inadequate response to immunosuppressants such as corticosteroids, azathioprine or 6-mercaptopurine (6-MP). The effectiveness of Humira has not been established in patients who have lost response to or were intolerant to TNF blockers.*

**Current formulary status:** Medical benefit requiring prior authorization

**Recommendation:** There are no changes to formulary status at this time. However, it is recommended to update the current policy to the following:

- Medical record documentation of a diagnosis of moderate to severe ulcerative colitis **AND**
- Medical record documentation that Humira is prescribed by a gastroenterologist **AND**
- Medical record documentation of age greater than or equal to 5 years **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one conventional therapy: corticosteroids, aminosalicylates, or immunomodulators (e.g. 6-mercaptopurine or azathioprine) **AND**
- Medical record documentation that Humira is not being used concurrently with a tumor necrosis factor (TNF) blocker or other biologic agent

An exception for coverage of WEEKLY administration of Humira (which is self administered) may be made for members who meet all the following criteria:

- Medical record documentation of a diagnosis of moderate to severe ulcerative colitis **AND**
- Medical record documentation that Humira is prescribed by a gastroenterologist **AND**
- Medical record documentation of age greater than or equal to 5 years **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one conventional therapy: corticosteroids, aminosalicylates, or immunomodulators (e.g. 6-mercaptopurine or azathioprine) **AND**
- Medical record documentation that Humira is not being used concurrently with a tumor necrosis factor (TNF) blocker or other biologic agent **AND**
- Medical record documentation of one of the following:
  - **For an adult:**
    - Medical record documentation of a contraindication to, intolerance to, or therapeutic failure on BIWEEKLY (every other week) administration of Humira **AND**
    - Medical record documentation that the member has been compliant with BIWEEKLY administration of Humira **AND**
    - Medical record documentation of inadequate drug trough level (less than 7.5mcg/mL) to support weekly dosing, per American Gastroenterological Association (AGA) guidelines **OR**
    - Medical record documentation that weekly dosing was initiated prior to the member turning 18 years and the member is well-controlled on this dose.
  - OR**
  - Medical record documentation that the member is less than 18 years of age and receiving an appropriate dose based on body weight.

**AUTHORIZATION DURATION:**

For biweekly or weekly administration:

Approval for new starts and dose increases (biweekly to weekly), adalimumab will be given for an initial duration of six (6) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in signs and symptoms of ulcerative colitis on six (6) months of adalimumab therapy is required.

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

**MEDISPAN AUTHORIZATION LEVEL: GPI-10****QUANTITY LIMIT FOR INITIAL APPROVALS:**

- Initial approvals (one week, one time approvals):
  - Humira Pen Crohn's, UC-HS 40 mg/0.8 mL (6 pack pen kit) starter: 6 per 28 days
  - Humira CF Crohn's-UC-HS 80 mg/0.8 mL (3 pack pen kit) or Humira CF pediatric Crohn's 80/0.8 mL (3 pack syringe kit) starter: 3 per 28 days
  - Humira Pen 80 mg/0.8 mL pen (2 pack pen kit): 4 per 28 days
  - Humira Pen-Pediatric UC Starter 80 mg/0.8mL (4 pack pen kit): 4 per 28 days
  - Humira Pen 80 mg/0.8 mL and 40 mg/0.4 mL- Psoriasis, Uveitis, or adolescent Hidradenitis Suppurativa starter pack (3 pack pen kit): 3 per 28 days
- Maintenance dose:
  - Adults:
    - Biweekly: 2 per 28 days
    - Weekly: 4 per 28 days
  - Pediatric patients:
    - 20 mg pen/syringe: 4 per 28 days
    - 40 mg pen/syringe: 4 per 28 days
    - 80 mg pen kit: 2 per 28 days
- Renewals:
  - Adults:
    - Biweekly: 2 per 28 days
    - Weekly: 4 per 28 days
  - Pediatric patients:
    - 20 mg pen/syringe: 4 per 28 days
    - 40 mg pen/syringe: 4 per 28 days
    - 80 mg pen kit: 2 per 28 days

**Discussion:** Dr. Yarczower asked if we are ready to address changes in therapy due to antibody development or was this not addressed by the specialists? We didn't have this particular discussion with the specialists. Our main focus as part of this review was the failure of thiopurines. This may come up in the future as we evaluate preferred agents as part of class reviews.

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

**Other Recommendations:** It is recommended to update the criteria (highlighted in yellow) in the following policies for UC:

**MBP 5.0 (Remicade, Inflectra, Renflexis, Avsola)**

- Must be at least 6 years of age; **AND**
- Must be prescribed by a gastroenterologist; **AND**
- Physician provided documentation of a diagnosis of moderate to severe ulcerative colitis **AND**

- Physician provided documentation of failure on, intolerance to, or contraindication to at least one conventional therapy: corticosteroids, aminosalicylates or immunomodulators (eg, 6-mercaptopurine or azathioprine **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of one of the following:
  - Therapeutic failure on, intolerance to, or contraindication to at least a 12 week trial of Humira\* **OR**
  - Medical record documentation that infliximab is being prescribed to induce disease remission **AND**
- One of the following:
  - For infliximab biosimilar requests other than Avsola (e.g. Renflexis, Inflectra), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **OR**
  - For infliximab reference product requests (i.e. Remicade), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **AND** infliximab-abda (Renflexis), **AND** infliximab-dyyb (Inflectra).

#### MBP 5.0 (Remicade, Inflectra, Renflexis, Avsola)

- Must be at least 6 years of age; **AND**
- Must be prescribed by a gastroenterologist; **AND**
- Physician provided documentation of a diagnosis of moderate to severe ulcerative colitis **AND**
- Physician provided documentation of failure on, intolerance to, or contraindication to at least one conventional therapy: corticosteroids, aminosalicylates or immunomodulators (eg, 6-mercaptopurine or azathioprine **AND**
- Medical record documentation that the infliximab product is not being used concurrently with a TNF blocker or other biologic agent **AND**
- Medical record documentation of one of the following:
  - Therapeutic failure on, intolerance to, or contraindication to at least a 12 week trial of Humira\* **OR**
  - Medical record documentation that infliximab is being prescribed to induce disease remission **AND**
- One of the following:
  - For infliximab biosimilar requests other than Avsola (e.g. Renflexis, Inflectra), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **OR**
  - For infliximab reference product requests (i.e. Remicade), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) **AND** infliximab-abda (Renflexis), **AND** infliximab-dyyb (Inflectra).

**Discussion:** No comments or questions.

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

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

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#### **ACTEMRA (tocilizumab)**

**Updated Indication:** Actemra subcutaneous injection is indicated for slowing the rate of decline in pulmonary function for adult patients with systemic sclerosis-associated interstitial lung disease (SSc-ILD).

**Current formulary status:** Pharmacy benefit, Brand Non-preferred tier, with a prior authorization required. Quantity limits apply.

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

**Systemic Sclerosis-associated Interstitial Lung Disease (SSc-ILD)**

- Prescription written by or in consultation with a pulmonologist and/or rheumatologist **AND**
- Medical record documentation that member is 18 years of age or greater **AND**
- Medical record documentation of a diagnosis of systemic sclerosis-associated interstitial lung disease **AND**
- Medical record documentation of all of the following:
  - Onset of disease (first non-Raynaud symptom) less than or equal to 5 years
  - Baseline forced vital capacity (FVC)
- Medical record documentation that medication is not being used concurrently with a TNF blocker or other biologic agent

**AUTHORIZATION DURATION:**

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

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

**MEDISPAN AUTHORIZATION LEVEL:** GPI-14

**QUANTITY LIMIT:** 3.6 mL per 28 days (for the Letter ONLY)

**Discussion:** Aubrielle asked how significant it is having the onset of disease information? Inclusion criteria for the trial required members to meet diagnostic criteria as recommended by EULAR. There was also discussion regarding confirmation of diagnosis. It was recommended to mimic something similar to the existing Ofev policy and/or seek specialist input.

**Outcome:** After the above discussion it was determined that the best course of action is to seek specialist input the appropriate diagnosis of SSc-ILD as well as the significant of the time of disease onset. Actemra for SSc-ILD will be further evaluated at a future P&T committee meeting.

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

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**KEYTRUDA (pembrolizumab)**

**Updated Indication:** Keytruda is now indicated:

- in combination with trastuzumab and fluoropyrimidine- and platinum-containing chemotherapy, for the first-line treatment of patients with locally advanced unresectable or metastatic HER2 positive gastric or gastroesophageal junction adenocarcinoma. Previously Keytruda was indicated for third-line treatment of PD-L1 positive recurrent or metastatic gastric or GEJ adenocarcinoma.
- for the treatment of patients with locally advanced cutaneous squamous cell carcinoma (cSCC) that is not curable by surgery or radiation. Previously Keytruda was indicated for recurrent and metastatic disease.



**Current formulary status:** Medical Benefit, requiring a prior authorization; When processed at a specialty pharmacy: Specialty tier or Brand NP tier

**Recommendation:** There are no changes to the formulary placement or authorization duration of Keytruda. The following changes are recommended to the criteria in the Medical Benefit Policy 119.0 for Keytruda to incorporate the new indications.

## 7. Gastric Cancer

- Prescription written by a hematologist/oncologist **AND**
- **Medical record documentation of one of the following:**
  - Medical record documentation of a diagnosis of recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma **AND**
  - Medical record documentation that tumors express PD-L1 (combined positive score [CPS] greater than or equal to 1) as determined by an FDA-approved test **AND**
  - Medical record documentation of disease progression on or after two or more prior lines of therapy (including fluoropyrimidine- and platinum-containing chemotherapy)\* **AND**
  - If patient has HER2-positive disease, medical record documentation of disease progression on or after HER2/neu-targeted therapy (including but not limited to trastuzumab (Herceptin))\*

**OR**

- Medical record documentation of a diagnosis of locally advanced unresectable or metastatic HER-2 positive gastric or gastroesophageal junction adenocarcinoma **AND**
- Medical record documentation that Keytruda will be used as first-line treatment **AND**
- Medical record documentation that Keytruda will be used in combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy

\*Note to reviewer: Current recommendations intend Keytruda to be used as third-line treatment (i.e. patient is to have 2 prior lines of therapy, one of which must include HER2/neu-targeted therapy if the patient has HER-2 positive disease)

## 17. Cutaneous Squamous Cell Carcinoma (cSCC)

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation of recurrent or metastatic cutaneous squamous cell carcinoma **OR** locally advanced cutaneous squamous cell carcinoma **AND**
- Medical record documentation that the patient's disease is not curable by surgery **AND**
- Medical record documentation that the patient's disease is not curable by radiation

Upon review of the Medical Benefit Policy 119.0 Keytruda (pembrolizumab) it was identified by DHS that the policy was more restrictive than FDA label for the Esophageal Cancer indication. The policy was updated as below to be consistent with FDA approved indication for DHS approval.

## 12. Esophageal Cancer

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is  $\geq 18$  years of age **AND**
- One of the following:
  - Medical record documentation of a diagnosis of locally advanced or metastatic squamous cell carcinoma of the esophagus or gastroesophageal junction (GEJ) **AND**
  - Medical record documentation that tumors express PD-L1 (CPS  $\geq 10$ ) as determined by an FDA-approved test **AND**
  - Medical record documentation of disease progression after one or more prior lines of systemic therapy for advanced disease.

**OR**

- Medical record documentation of a diagnosis of locally advanced or metastatic esophageal or gastroesophageal junction (GEJ) carcinoma not amenable to surgical resection or definitive chemoradiation **AND**
- Medical record documentation of use in combination with platinum (oxaliplatin or cisplatin) and fluoropyrimidine-based (fluorouracil or capecitabine) chemotherapy
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**Discussion:** No comments or questions.

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

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

## **BENLYSTA (belimumab)**

**Updated Indication:** Benlysta is now indicated in adult patients with active lupus nephritis (LN) who are receiving standard therapy.

*Note: Benlysta is also indicated in patients 5 years of age and older with active, antibody-positive systemic lupus erythematosus (SLE) who are receiving standard therapy.*

**Limitations of use:** The efficacy of Benlysta has not been evaluated in patients with severe active central nervous system lupus. Benlysta has not been studied in combination with other biologics. The use of Benlysta is not recommended in these situations.

**Current formulary status:** Benlysta autoinjector/prefilled syringes are a pharmacy benefit available at the Specialty tier or the Brand Non-Preferred tier for members with a three tier benefit. Benlysta vials are a medical benefit, if processed through a specialty pharmacy, it will process at Specialty tier or the Brand Non-Preferred tier for members with a three tier benefit. Benlysta requires a prior authorization with the following criteria.

**Recommendation:** There are no changes to the current formulary status at this time. However, it is recommended to add a section to the Benlysta SC and Benlysta vial policies for Lupus Nephritis. It is also recommended to update the authorization duration and quantity limits for Lupus Nephritis. It is recommended to update the limitation from the vial policy to the following: “Limitation: Benlysta has not been studied in combination with other biologics. Use of Benlysta is not recommended in these situations.”

Update the criteria in the SLE section of the SC policy- “Medical record documentation of no ~~active severe nephritis or~~ central nervous system (CNS) involvement”

### Lupus Nephritis

- Medical record documentation of a diagnosis of active lupus nephritis, Class III, IV, V alone or in combination, confirmed by a kidney biopsy **AND**
- Medical record documentation of age greater than or equal to 18 **AND**
- Prescription written by or in consultation with a rheumatologist or nephrologist **AND**
- Medical record documentation that Benlysta will be prescribed in combination with standard therapy (e.g. mycophenolate mofetil (MMF), corticosteroids, cyclophosphamide, azathioprine)

**Authorization Duration:** Initial approval will be for 12 months. Subsequent approvals will be for 12 months. Re-authorization will require the following:

- Medical record documentation of a positive clinical response to Benlysta (e.g. improvement/stabilization in UPCR, eGFR, renal-related events) **AND**

- Medical record documentation that Benlysta will be prescribed in combination with standard therapy (e.g. mycophenolate mofetil (MMF), corticosteroids, cyclophosphamide, azathioprine)

QL for Benlysta SC: For SLE: 4 mL per 28 days; For LN: initial: one-time, two week auth duration: 8 mL per 28 days, remainder of the authorization: 4 mL per 28 days; subsequent authorization: 4 mL per 28 days

**Discussion:** No comments or questions.

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

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

## **YERVOY (ipilimumab)**

**Updated Indication:** Yervoy is now indicated in combination with nivolumab (Opdivo) for the treatment of adult patients with unresectable or metastatic melanoma.

Yervoy is also indicated for treatment of unresectable or metastatic melanoma in adults and pediatric patients 12 years and older as monotherapy and for adjuvant treatment of patients with cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 mm who have undergone complete resection, including total lymphadenectomy.

**Current formulary status:** Medical Benefit, requiring a prior authorization; When processed at a specialty pharmacy: Specialty tier or Brand NP tier

**Recommendation:** No changes are recommended for the formulary placement of Yervoy. Currently, the melanoma criteria in Medical Benefit Policy 91.0 for Yervoy was based on previous NCCN guidelines. The following changes are recommended to the Medical Benefit Policy to match the new indication and current NCCN guidelines:

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation of unresectable ~~stage III or IV~~ **or metastatic** melanoma **AND**
- One of the following:
  - Medical record documentation of use in combination with nivolumab for first line therapy **OR**
  - Medical record documentation of use as a single agent or in combination with nivolumab as second-line or subsequent therapy for disease progression if not previously used **OR**
  - Medical record documentation of use as a single-agent reinduction therapy in select patients who experienced no significant systemic toxicity during prior ipilimumab therapy and who relapse after initial clinical response or progress after stable disease >3 months

**OR**

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation of use as a single agent for adjuvant therapy:
  - For Stage IIIA with metastases > 1 mm, or Stage IIIB or Stage IIIC cutaneous melanoma with nodal metastases following a complete lymph node dissection or resection **OR**
  - Following complete lymph node dissection and/or complete resection of nodal recurrence

**Discussion:** No comments or questions.

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

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

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## TRODELVY (sacituzumab govitecan-hziy)

**Updated Indication:** Trodelvy is now indicated for the treatment of adult patients with unresectable locally advanced or metastatic triple-negative breast cancer (mTNBC) who have received two or more prior systemic therapies, at least one of them for metastatic disease.

Previously, Trodelvy had an accelerated approval for the treatment of adult patients with only metastatic triple-negative breast cancer (mTNBC) who have received at least two prior therapies for metastatic disease.

**Current formulary status:** Medical Benefit, requiring a prior authorization; When processed at a specialty pharmacy: Specialty tier or Brand NP tier

**Recommendation:** There are no changes to the formulary placement of Trodelvy. The following changes are recommended to Medical Benefit Policy 216.0 to incorporate the changes to the indication:

### Breast Cancer

- Medical record documentation that Trodelvy is written by a hematologist/oncologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of diagnosis of **unresectable locally advanced or** metastatic triple-negative breast cancer\* **AND**
- Medical record documentation of trial of **at least** two previous lines of **systemic** therapy, **of which at least one was** for metastatic disease

**\*Note:** Triple negative breast cancer lacks expression of estrogen receptor (ER-negative), progesterone receptor (PR-negative) and human epidermal growth factor receptor 2 (HER2-negative).

**Discussion:** No comments or questions.

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

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

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## UPDATES

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### METFORMIN ER OSMOTIC AND METFORMIN ER GASTRIC TABLETS UPDATE

**Background:** Based on discussion at the June Quarterly Case Audit, it was recommended that a policy be created for reviewing metformin ER osmotic (generic Fortamet ER) and metformin ER gastric (generic Glumetza ER) to ensure consistency among reviewers as pharmacists have noticed that there is inconsistency with alternatives given between reviewers.

**Recommendations:** It is recommended that the following prior authorization criteria and quantity limits apply:

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to metformin IR tablets AND metformin ER tablets (generic Glucophage XR) at maximum dosage (2 grams per day = 4 tablets of 500mg per day).

**QUANTITY LIMIT:** 2 tablets per day

**Discussion:** No comments or questions.

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

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

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### SANTYL OINTMENT (collagenase)

**Background:** We discussed the current re-authorization criteria and we determined it is not measurable. We decided it would be more appropriate to review the renewal requests with the initial criteria to determine medical necessity of continued use.

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

**AUTHORIZATION DURATION:** Initial approval will be for 3 months. Subsequent approval will be for 3 months. Re-authorization will require the following:

- Medical record documentation that the member has been evaluated by a burn, a wound care specialist, or other specialist with experience in the management of severe wounds AND
- Medical record documentation of the wound length and width AND
- Medical record documentation of anticipated duration of therapy AND
- Medical record documentation that the prescribed dose is medically necessary based on the size and intended duration of therapy\*

\*NOTE: Please calculate the dose on the manufacturer's website to confirm it is within a medically appropriate range- <https://santyl.com/hcp/dosing>

**Discussion:** No comments or questions.

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

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

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## QVAR AND ASMANEX

**Background:** At the previous P&T, it was recommended that Asmanex and Qvar should move to a Tier 3 for Commercial/Exchange/CHIP. However, this tier does not translate appropriately to exchange plans.

**Recommendation:**

Commercial/Exchange/CHIP (1/1/2022):

**Asmanex:**

For Commercial/Exchange/CHIP, it is recommended to move Asmanex to a Brand Non-Preferred tier and it will require a Step Therapy with the following criteria:

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Arnuity Ellipta or Flovent Diskus/Flovent HFA AND Pulmicort Flexhaler.

**Qvar:**

For Commercial/Exchange/CHIP, it is recommended to move Qvar to a Brand Non-Preferred tier and it will require a Step Therapy with the following criteria:

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Arnuity Ellipta or Flovent Diskus/Flovent HFA AND Pulmicort Flexhaler.

**Discussion:** No comments or questions.

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

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

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## CRESEMBA (isavuconazonium sulfate)

**Background:** Cresemba is an azole antifungal with activity against invasive aspergillosis and mucormycosis. It is indicated for the treatment of invasive aspergillosis and mucormycosis in adults. Aspergillosis and mucormycosis are two different types of invasive species that primarily affect patients with a weakened immune system, such as patients undergoing chemoradiation, patients being treated for HIV, or patients taking immunosuppressive therapy. An off-label, but medically accepted use of Cresemba is for the treatment of esophageal Candidiasis in patients with HIV. Other agents in the same class have a similar spectrum of activity but different places in therapy. While Cresemba is indicated for the treatment of these invasive infections, agents like posaconazole are indicated for both the prophylaxis and treatment of these infections. Voriconazole is another azole antifungal that does not have an FDA indication for prophylaxis of invasive infections, but studies have demonstrated its effectiveness as an alternate therapy to posaconazole in prophylaxis.

As a class, azole antifungals have significant drug-drug interactions as they are inhibitors of CYP3A4. Cresemba and fluconazole are only moderate inhibitors of CYP3A4, while voriconazole, itraconazole, and posaconazole are all considered strong inhibitors of CYP3A4. The metabolism of CYP3A4 substrates is significantly affected by this class of medication. As posaconazole and voriconazole are the two agents used for anti-mold prophylaxis, patients required to take medications that are substrates of CYP3A4 for other conditions risk severe safety concerns. This interaction may increase the concentration of the CYP3A4 substrate which may lead to toxicities or increased risk of other concerns such as QT prolongation. The potential severity of safety concerns related to this interaction may lead providers to recommend Cresemba as an alternative to posaconazole or voriconazole due to its moderate inhibition of CYP3A4. It is also important to note that while Posaconazole and voriconazole may increase the QTc interval, Cresemba may shorten this interval.

**Current formulary status:** Capsules: Non-formulary requiring a prior authorization; Vial: Brand preferred, requiring a prior authorization

**Recommendation:** No changes are recommended to the auth duration or formulary placement. It is recommended that the following changes are made to the prior authorization criteria:

- Medical record documentation of age greater than or equal to 18 years **AND**
    - Medical record documentation that Cresemba is being used for the treatment of Invasive aspergillosis **OR** for the treatment of invasive mucormycosis
- OR**
- Medical record documentation that Cresemba is prescribed by an oncologist, hematologist, infectious disease specialist, or transplant service provider **AND**
  - Medical record documentation of use for prophylaxis of invasive Aspergillus or Candida infections in patients at high risk of developing these infections due to being severely immunocompromised **AND**
  - Medical record documentation that member requires treatment with an anti-cancer medication that interacts with posaconazole

**Discussion:** No comments or questions.

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

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

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## QUARTERLY CASE AUDIT

**Background:** The Quarterly Case Audit for 1st quarter 2021 was held on June 3, 2021. A policy for metformin ER osmotic and metformin ER gastric tablets was created as an update and brought to this P&T meeting. This policy will help to ensure consistency among reviewers. We will continue to look for opportunities to create more drug specific policies at future quarterly case audit meetings.

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

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## TERIPARATIDE QUANTITY LIMIT UPDATE

**Background:** Generic teriparatide is billed as a different quantity when compared to brand name Forteo.

- Teriparatide billing unit: 2.48 mL per syringe
- Forteo billing unit: 2.4 mL per syringe

Each pen contains a total of 28, 20 mcg doses.

**Recommendation:** It is recommended that the quantity limit on teriparatide is updated to 2.48 mL/28 days in order to account for the difference.

**Discussion:** No comments or questions.

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

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

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## **PRIOR AUTHORIZATION FOR NEW STARTS ONLY**

**Background:** The following medications were identified as requiring a prior authorization for new starts only:

- Afinitor Tablet
- Chorionic Gonadotropin
- Crinone Vaginal Gel
- Eletriptan Tablet
- Follistim AQ
- HCG Injection
- Menopur
- Novarel
- ProAir Digihaler
- ProAir HFA
- ProAir RespiClick
- Proventil HFA
- Santyl
- Tarceva Tablet
- Zioptan

**Recommendation:** It is recommended that the prior authorization for new starts only is immediately converted to a standard prior authorization.

The following medications either have no current utilization or all active members have a PA on file and can be converted with no disruption:

- Afinitor Tablet
- Crinone Vaginal Gel
- Follistim AQ
- HCG Injection
- Menopur
- Novarel
- Tarceva Tablet

The following medications were recommended for grandfathering at the time of initial PA addition. A grandfather authorization will be placed for members with utilization in the prior 180 days (4 members):

- Eletriptan Tablet
- Zioptan

Members with utilization in the previous 180 days of the following medications will be sent a letter alerting them of the need for prior authorization in order to continue therapy (37 members):

- Chorionic Gonadotropin
- ProAir Digihaler
- ProAir HFA
- ProAir RespiClick
- Proventil HFA
- Santyl

**Discussion:** No comments or questions.

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

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



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Meeting adjourned at 4:42 pm

**Future Scheduled Meetings:** The next bi-monthly scheduled meeting will be held on September 21<sup>st</sup>, 2021 at 1:00 p.m.

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 or will be held virtually.