P&T Committee Meeting Minutes
Commercial/Marketplace/GHP Kids
December 17, 2021 e-vote

DRUG REVIEWS

INVEGA HAFYERA (paliperidone palmitate)

Review: Invega Hafyera is a new extended release formulation of the antipsychotic medication paliperidone indicated for the treatment of adult patients with schizophrenia. It offers an advantage over other extended release antipsychotic formulations with its every 6 month dosing but should only be initiation in patients who are established on and able to tolerate another extended release formulation of paliperidone (Invega Sustenna or Trinza).

The efficacy of Invega Hafyera was evaluated in a randomized, double-blind, active-controlled, parallel group, non-inferiority study in adult patients with a DSM-5 diagnosis of schizophrenia who were stable on either Invega Sustenna or Invega Trinza. Patients were randomized 2:1 to receive Invega Hafyera (n=478) or PP3M (n=224). The primary efficacy endpoint evaluating time to first relapse in the double-blind phase demonstrated non-inferiority of Invega Hafyera to PP3M, with a relapse event occurring in 7.5% and 4.9%, respectively.

Invega Hafyera has a black box warning for increased mortality in elderly patients with dementia-related psychosis. Other warnings and precautions are consistent with paliperidone and other antipsychotics. During the double-blind, active controlled clinical trial of Invega Hafyera, the most common adverse reactions were upper respiratory tract infection, injection site reaction, increased weight, headache, and parkinsonism. Overall adverse events reported were comparable between treatment groups (Invega Hafyera vs. PP3M) and were consistent with the known safety profile of paliperidone.

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 voted to accept the recommendations as presented. None were opposed.

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

Outcome: Invega Hafyera is a medical benefit. Invega Hafyera will be added to the medical benefit cost share list when processed on the medical benefit. If processed at a specialty pharmacy, Invega Hafyera will process at the Specialty tier or the Brand Non-preferred tier for members with a three tier benefit. Invega Hafyera will be added to the Medical Benefit Policy 106.0 for Injectable Antipsychotic Medications as follows:

- Medical record documentation that the patient is 18 years of age or older **AND**
- Medical record documentation of a history of poor adherence to oral medications and documentation that education to improve adherence has been attempted AND
- Medical record documentation of use for an FDA approved indication.
    - Abilify Maintena – Schizophrenia or maintenance monotherapy treatment of Bipolar I Disorder
    - Aristada – Schizophrenia
    - Aristada Initio – Initiation of Aristada (in combination with oral aripiprazole) to treat schizophrenia
    - Invega Hafyera – Schizophrenia
    - Invega Sustenna – Schizophrenia or Schizoaffective disorders as monotherapy and as an adjunct to mood stabilizers or antidepressants

    - Invega Trinza – Schizophrenia
    - Perseris- Schizophrenia
    - Risperdal Consta – Schizophrenia or Bipolar I Disorder as monotherapy or as adjunctive therapy to lithium or valproate
    - Zyprexa Relprevv – Schizophrenia
- In addition: The following criteria should apply to Invega Trinza:
    - Medical record documentation that the patient has been adequately treated with Invega Sustenna for at least 4 months.
- In addition: The following criteria should apply to Invega Hafyera:
    - Medical record documentation that the patient has been adequately treated with Invega Sustenna for at least 4 months OR Invega Trinza for at least 3 months.

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

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

- Abilify Maintena – One syringe or vial per 28 days
- Aristada – One syringe per 28 days (441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml strength), one syringe per 56 days (1064mg/3.9ml strength)
- Aristada Initio – Enter claims payment note as follows: o Aristada Initio – Rx Count of 1, quantity limit of 2.4mL (one syringe) per 28 days
- Aristada – Open-ended authorization with quantity limit: One syringe per 28 days (441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml strength), one syringe per 56 days (1064mg/3.9ml strength)
- Invega Hafyera – One syringe per 168 days (6 months)
- Invega Sustenna –two syringes per 1 week, then one syringe per 28 days thereafter
  Enter claims payment note as follows to account for loading dose in the first week:
    - Rx Count of 1 approved by GPID for 234 mg, quantity limit 1
    - Rx Count of 1 approved by GPID for 156 mg, quantity limit 1
    - Open-ended authorization for quantity limit 1 syringe per month, request to be approved by GPID for the prescribed strength.
- Invega Trinza – One syringe per 84 days (3 months)
- Perseris- One syringe kit per 28 days
- Risperdal Consta – Two vials per 28 days
- Zyprexa Relprevv – Two vials per 28 days

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

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

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

AZSTAYRS (serdexmethylphenidate/dexmethylphenidate)

Review: Azstarys is a new stimulant indicated in the treatment of ADHD in patients 6 years and older which consists of 30% immediate-release dexmethylphenidate and 70% serdexmethylphenidate, a prodrug that is slowly converted to dexmethylphenidate. Azstarys offers an alternative treatment option which offers rapid acting symptom control along with an extended treatment duration. Clinical trials compared Azstarys to placebo, so it is unclear if Azstarys offers an advantage in efficacy or safety compared to other long-acting stimulants.

The efficacy of Azstarys was evaluated in a randomized, double-blind, placebo-controlled, parallel group, analog classroom study in 150 pediatric patients aged 6 to 12 years who met DSM-5 criteria for a primary diagnosis of ADHD. The primary efficacy endpoint which evaluated the mean change from baseline (pre-dose at randomization visit) of the SKAMP-Combined scores averaged across the test day (not including baseline score) demonstrated statistically significantly lower for Azstarys compared to placebo, indicating improvement in ADHD manifestations.

Azstarys has a black box warning for high potential for abuse and dependence. Other warnings and precautions are consistent with other CNS stimulants and methylphenidate.

In the short term study of Azstarys in pediatric patients 6 to 12 years of age with ADHD (3 week dose optimization + 1 week double-blind controlled phase), adverse reaction rates cannot be used to predict the rates expected in clinical practice due to study design. Adverse events that occurred more frequently in the Azstarys group compared to placebo were headache, upper abdominal pain, insomnia, and pharyngitis. This population was also evaluated in a long-term open-label safety study in 238 patients receiving open label Azstarys, with 154 patients receiving Azstarys for 12 months. Because of the open-label, uncontrolled design of this study, the reported adverse reaction rates cannot be assessed in terms of a causal relationship to Azstarys treatment. Azstarys labeling reports the safety study findings relative to height and weight were not clinically significant (z-score changes less than 0.5 SD) but further studies are needed to determine if Azstarys is a safer drug compared to other stimulants in regard to growth effects.

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 voted to accept the recommendations as presented. None were opposed.

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

Outcome: Azstarys is a pharmacy benefit and will not be added to the formulary. Azstarys will be added to Commercial Policy 94.0 which includes other non-preferred ADHD medications.

- 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 CD$^{\Omega}$ **AND** amphetamine/dextroamphetamine SR combination

QUANTITY LIMIT: 1 capsule per day

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

KLOXXADO (naloxone intranasal)

Review: Kloxxado is an opioid antagonist indicated for the emergency treatment of known or suspected opioid overdose as manifested by respiratory and/or central nervous system depression for adult and pediatric patients. Kloxxado is intended for immediate administration as emergency therapy in settings where opioids may be present. Kloxxado is not a substitute for emergency medical care.

Kloxxado is an opioid antagonist that competes and displaces opioids at opioid receptor sites. Kloxxado is for intranasal use only. Kloxxado is one of three naloxone products on the market that can be administered by a layperson. These products are Narcan 4 mg nasal spray, Kloxxado 8 mg nasal spray and Zimhi 5 mg injection. Zimhi has been approved by the FDA and should be available the first quarter of 2022. Evzio and the authorized generic for Evzio have been discontinued and are no longer on the market.

To note intranasal and injectable naloxone are not comparable on a per-milligram basis. The bioavailability of intranasal naloxone is lower than intramuscular naloxone, meaning a higher dose of the intranasal naloxone is required to see a similar therapeutic effect. With the ongoing opioid crisis here in the United States it is evident the need for open access to easily administered naloxone products for our caregivers, family members, and first responders. There has been a large focus on providing education on the prevention of opioid overdoses as well as education on how to react if witnessing an opioid overdose with use of naloxone products.

Kloxxado is available with a strength of 8 mg/0.1 mL which is double the dose of Narcan nasal spray (4 mg/0.1 mL). This higher dose may reduce the need for repeat dosing for some patients. There is no clinical data available to help guide when a higher dose of naloxone should be administered however with synthetically manufactured opioids the use of a higher dose may be warranted. To note release of generic Narcan is on the horizon (projected as early 2022).

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 voted to accept the recommendations as presented. None were opposed.

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

Outcome: Kloxxado is a pharmacy benefit and will be added to the Commercial, Exchange, and CHIP pharmacy formularies on the Brand Preferred tier without prior authorization.

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

BYLVAY (odevixibat)

Review: Bylvay is an ileal bile acid transporter (IBAT) inhibitor indicated for the treatment of pruritus in patients 3 months of age and older with progressive familial intrahepatic cholestasis (PFIC). Bylvay may not be effective in PFIC type 2 patients with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3). BSEP-3 protein works as a pump that moves bile salts out of the liver. Bylvay is the only FDA-approved treatment for PFIC.

Bylvay is available as the following: 200 mcg oral pellets, 600 mcg oral pellets, 400 mcg capsules, and 1200 mcg capsules. The recommended dosage of Bylvay is 40 mcg/kg once daily in the morning with a meal. If there is no improvement in pruritus after 3 months, the dosage may be increased in 40 mcg/kg increments up to 120 mcg/kg once daily not to exceed a total daily dose of 6 mg (6000 mcg). Bylvay oral pellets are intended for use by patients weighing less than 19.5 kilograms. Bylvay capsules are intended for use by patients weighing 19.5 kilograms or above.

Bylvay was studied in 24-week, randomized, double-blind, placebo-controlled trial that included 62 pediatric patients, aged 6 months to 17 years, with a confirmed molecular diagnosis of PFIC type 1 or type 2, and presence of pruritus at baseline. Patients were randomized to placebo (n=20), odevixibat 40 mcg/kg (n=23), or odevixibat 120 mcg/kg (n=19). The primary outcome was the change in pruritus from baseline to Week 24. The trial also looked at bile acid reduction (defined as bile acid reduction ≥ 70% or reaching bile acid level ≤ 70 micromol/L). Patients treated with Bylvay demonstrated greater improvement in pruritus compared with placebo. The serum bile acid response was also met. Patients also experienced improvements in growth and weight gain as well as in sleep.

There are warnings for liver test abnormalities, diarrhea, and fat-soluble vitamin deficiency (vitamins A, D, E, and K). The most common adverse reactions (>2%) are liver test abnormalities, diarrhea, abdominal pain, vomiting, and fat-soluble vitamin deficiency. The safety and effectiveness of Bylvay have been established in pediatric patients 3 months to 17 years of age for the treatment of pruritus in PFIC. The safety and effectiveness of Bylvay for the treatment of pruritus in PFIC in adult patients, including those 65 years of age and older have not been established.

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 voted to accept the recommendations as presented. None were opposed.

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

Outcome: Bylvay is a pharmacy benefit. Bylvay will be added to the formulary at the Specialty tier. Bylvay will require a prior authorization with the following criteria.

- Prescription written by or consultation with a hepatologist or gastroenterologist **AND**
- Medical record documentation of diagnosis of progressive familial intrahepatic cholestasis (PFIC) confirmed by genetic testing **AND**
- Medical record documentation of the presence of moderate to severe pruritus **AND**
- Medical record documentation of age greater than or equal to 3 months **AND**
- Medical record documentation that the member is receiving an appropriate dose* based on the patient's weight **AND**
- Medical record documentation of concurrent use or therapeutic failure on, intolerance to, or contraindication to ursodiol

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 the following:

- Medical record documentation of improvement in pruritus and/or reduction in serum bile acid **AND**
- Medical record documentation that the member is receiving an appropriate dose* based on the patient's weight

QUANTITY LIMIT:

- 200 mcg pellets: 30 capsules per day
- 600 mcg pellets: 10 capsules per day
- 400 mcg capsules: 15 capsules per day
- 1200 mcg capsules: 5 capsules per day

***NOTE:** The recommended dosage of Bylvay is 40 mcg/kg once daily. If there is no improvement in pruritus after 3 months, the dosage may be increased in 40 mcg/kg increments up to 120 mcg/kg once daily not to exceed a total daily dose of 6 mg (6000 mcg).

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

BREXAFEMME (ibrexafungerp)

Review: Brexafemme is a triterpenoid antifungal with concentration-dependent fungicidal activity against *Candida* species indicated for the treatment of adult and post-menarchal pediatric females with vulvovaginal candidiasis. Brexafemme is the first approved drug in a new antifungal class and the first oral non-azole treatment indicated for acute vulvovaginal candidiasis. Other current treatment options include oral fluconazole and OTC and prescription topical azole antifungals (e.g., clotrimazole, miconazole, terconazole). For uncomplicated VVC, the Centers for Disease Control and Prevention (CDC) and the Infectious Diseases Society of America (IDSA) currently recommend 1 to 3 days of topical treatment or a single oral dose of fluconazole. Treatment guidelines have not been updated since the approval of Brexafemme. Brexafemme is being evaluated in the Phase 3 CANDLE study for the prevention of recurrent VVC.

The efficacy of Brexafemme was evaluated in two randomized, placebo-controlled clinical trials in non-pregnant, post-menarchal females with a diagnosis of vulvovaginal candidiasis (VVC). Trial 1 modified intention to treat (MITT) population (baseline positive *Candida* culture and at least 1 dose of study medication) included 190 patients treated with Brexafemme and 100 patients treated with placebo. Trial 2 MITT population included 189 patients treated with Brexafemme and 89 patients treated with placebo. Efficacy was assessed by clinical outcome at the TOC visit. Complete clinical response was defined as a complete resolution of signs and symptoms (VSS score of 0). Additional endpoints included a negative *Candida* culture at the TOC visit and clinical outcome at the follow-up visit. A statistically significant greater proportion of patients treated with Brexafemme experienced a complete clinical response at TOC, negative culture at TOC, and complete clinical response at follow-up compared to placebo.

There are no black box warnings for Brexafemme. Brexafemme has warnings for risk of fetal toxicity based on findings from animal studies showing a risk of fetal malformations. During clinical trials, the most common adverse reactions were diarrhea, nausea, abdominal pain, dizziness, and vomiting. No serious adverse reactions occurred and 2 out of 545 (0.4%) patients discontinued treated due to vomiting (1 patient) and dizziness (1 patient).

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 voted to accept the recommendations as presented. None were opposed.

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

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

- Medical record documentation of a diagnosis of vulvovaginal candidiasis (VVC) **AND**
- Medical record documentation that member is greater than or equal to 12 years of age and post-menarchal **AND**
- Medical record documentation of therapeutic failure, contraindication, or intolerance to oral fluconazole tablets **AND** one formulary topical antifungal indicated for the treatment of vulvovaginal candidiasis

QUANTITY LIMIT: 4 tablets per day, 1 day supply per fill

AUTHORIZATION DURATION: 1 month, RX count 1

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

EXKIVITY (mobocertinib)

Review: Exkivity is a kinase inhibitor of the epidermal growth factor receptor (EGFR) which irreversibly binds and inhibits EGFR exon 20 insertion mutations. Exkivity is a first-in-class oral tyrosine kinase inhibitor (TKI) approved for NSCLC with EGFR exon 20 insertion mutations. Rybrevant, an EGFR-directed and MET receptor-directed antibody, was approved in May 2021 for this same indication and will compete with Exkivity. Rybrevant is administered intravenously while Exkivity is given orally. Exkivity is also being evaluated for first-line treatment of NSCLC with EGFR exon 20 insertion mutations.

The efficacy of Exkivity was evaluated in an open-label, multi-cohort clinical trial (Study AP32788-15-101) in a subset of patients with EGFR exon 20 insertion mutation-positive metastatic or locally advanced NSCLC with disease progression on or after platinum-based chemotherapy. The efficacy population included 114 patients who were treated with Exkivity 160 mg once daily until disease progression or unacceptable toxicity.

The major efficacy outcome measure demonstrated overall response rate (ORR) according to RECIST v1.1 as evaluated by blinded independent central review (BICR) of 28%. The median duration of response (DOR) evaluated by BICR was 17.5 months. Investigator-assessed ORR was 35% with a median duration of response (DOR) of 11.2 months with 63% of patients having responses lasting longer than 6 months.

Exkivity has a black box warning for life threatening heart rate-corrected QT (QTc) prolongation, including Torsades de Pointes. Other warnings and precautions include interstitial lung disease and pneumonitis, cardiac toxicity, diarrhea, and embryo-fetal toxicity. The most common adverse reactions in the pooled safety population were diarrhea, rash, nausea, stomatitis, vomiting, decreased appetite, paronychia, fatigue, dry skin, and musculoskeletal pain. In Study AP32788-15-101 in patients with EGRF exon 20 insertion mutation-positive locally advanced or metastatic NSCLC, serious adverse events occurred in 46% of patients who received Exkivity. Fatal adverse reactions occurred in 1.8% of patients, including cardiac failure and pneumonitis. Permanent discontinuation occurred in 17% of patients. Dose interruptions and reductions occurred in 51% and 25% of patients, respectively. Clinically relevant adverse reactions which occurred in more than 10% of patients treated with Exkivity included edema, acute kidney injury, peripheral neuropathy, palmar-plantar erythrodysaesthesia, pneumonitis, and cardiac failure.

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

Other intravenous and subcutaneous immune globulin products are in the pipeline, including Newnorm, a subcutaneous formulation in Phase III development with an estimated study completion date of December 2023.

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 voted to accept the recommendations as presented. None were opposed.

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

Outcome: Exkivity is a pharmacy benefit and will be added to the Oral Oncology Brand Non-preferred tier ($0 copay) of the Commercial, Marketplace, and GHP Kids pharmacy formulary. The following prior authorization criteria will apply for new starts only:

- Medical record documentation that Exkivity 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 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 detected by an FDA-approved test* **AND**
- Medical record documentation of disease progression on or after platinum-based chemotherapy

***NOTE:** The FDA approved test for detection of epidermal growth factor receptor (EGFR) exon 20 insertion mutations for Exkivity is the Oncomine Dx Target Test.
QUANTITY LIMIT: 4 capsules per day, 30 day supply per fill

RE-AUTHORIZATION CRITERIA: Exkivity will be configured as a prior authorization for new starts only. Exkivity will no longer be covered if it is identified that the member is not receiving appropriate follow-up care from the prescribing specialist or if the member has greater than or equal to a 90 day break in therapy.

- Medical record documentation that the member is receiving appropriate follow-up care from the prescribing specialist

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

Asceniv (immune globulin intravenous, human-slra) & Xembify (immune globulin subcutaneous, human-klhw)

Review:
Asceniv
Asceniv does not carry any new contraindications compared to the former, most recently approved subcutaneous immune globulin product, Cutaquig. Asceniv carries new warnings and precautions, compared to Cutaquig for hyperproteinemia, increased serum viscosity, hyponatremia, and monitoring laboratory tests. There is insufficient data to determine safety of Asceniv in pediatric patients younger than 12 years, and safety of Asceniv has not been studied in patients under 3 years. Asceniv does not carry any new drug interactions compared to Cutaquig. Headache, sinusitis, diarrhea, gastroenteritis viral, nasopharyngitis, upper respiratory tract infection, bronchitis, and nausea were the most common adverse reactions to Asceniv, reported in ≥ 5% of clinical study subjects.

Xembify

Xembify does not carry any new contraindications or warnings and precautions compared to the former, most recently approved subcutaneous immunoglobulin product, Cutaquig. The safety of Xembify has not been established in patients under 2 years. Xembify does not carry any new drug interactions compared to Cutaquig. Infusion site erythema, pain, swelling, bruising, nodule, pruritus, induration, scab, and edema were the most common local adverse reactions to Xembify, reported in ≥ 5% of clinical study subjects. Cough and diarrhea were the most common systemic adverse reactions to Xembify, reported in ≥ 5% of clinical study subjects.

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

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

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

Outcome: Asceniv and Xembify are medical benefits. Asceniv and Xembify will be added to the medical benefit cost share list when processed on the medical benefit. If processed at a specialty pharmacy, Asceniv and Xembify will process at the Specialty tier or the Brand Non-preferred tier for members with a three tier benefit. Asceniv and Xembify will be added to Medical Benefit Policy 4.0. Additional changes as recommended are captured below:

MBP 4.0

DESCRIPTION: Immune Serum Globulins are used to provide passive immunity or to alter the immune response by increasing the recipients' antibody titer and antigen-antibody reaction potential. IgG antibodies help to prevent or modify certain infectious diseases in susceptible individuals. Five major classes of immunoglobulin proteins exist in human serum and other body fluids (IgA, IgD, IgE, IgG, and IgM). Immune globulin is an antibody-containing solution obtained from the pooled plasma of pre-screened, presumably healthy blood donors. Throughout the policy, the term "intravenous immune globulin" and "IVIG" is intended to refer to *all* immune globulin injections, including intravenous, intramuscular and subcutaneous administrations.

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

This policy refers to the following intravenous immune globulin drug products:

Asceniv
Bivigam
Carimune NF
Cutaquig
Cuvitru
Flebogamma
Flebogamma DIF
Gammagard Liquid
Gammagard S/D
Gammaked
Gammaplex
Gamunex
Gamunex-C
Hizentra
Hyqvia (Primary Humoral Immunodeficiencies indications only)
Octagam
Panzyga
Privigen
Xembify

- **For Asceniv (immune globulin intravenous, human – slra) requests:**
  The following criteria must be met
  1. Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to at least three (3) immune globulin products.

IVIG is considered to be medically necessary for the following, however not limited to, indications when specified criteria are met:

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

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

- **Idiopathic Thrombocytopenia Purpura (ITP)**
  1. Acute ITP when either of the following are present:
  - Active bleeding and a platelet count of less than 30,000/mm^3; **or** documented history of significant bleeding and a platelet count of less than 30,000/mm^3; **AND**
  - Medical record documentation of use in conjunction with a corticosteroid or a contraindication to or failure on corticosteroid therapy~~; **OR**~~

  OR
  - As a preoperative treatment prior to major invasive surgical procedures **AND**
  - IVIG be used with corticosteroids when a more rapid increase in platelet count is required

  OR
  - A platelet count of less than 20,000/mm3 **AND**
  - Medical record documentation of use in conjunction with a corticosteroid or a contraindication to or failure on corticosteroid therapy

  2. Chronic ITP when the following criteria are met:
  - ~~Platelet count less than 30,000/mm^3 in children or less than 20,000/mm^3 in adults; **AND**~~
  - Duration of Immune Thrombocytopenia (ITP) greater than 12 months **AND**
  - No concurrent illness or disease explaining thrombocytopenia; **AND**
  - Medical documentation of prior treatment with ~~a long course or high dose of~~ corticosteroids (ex, ~~prednisone 1 mg/kg orally for 21 days then tapered off~~ prednisone 2 mg/kg/day for ≤ 6 weeks (for adults) or 4 mg/kg/day for ≤ 7 days (for children)); and a splenectomy, if over 12 months have elapsed from date of initial diagnosis; **OR**

- Active bleeding and a platelet count of less than 30,000/mm^3; **or** documented history of significant bleeding and a platelet count of less than 30,000/mm^3 **OR**
- A platelet count of less than 20,000/mm3 **OR**

- As a preoperative treatment prior to major invasive surgical procedures

3. ITP in pregnancy with medical documentation ~~of any~~ of the following:
   - ~~Platelet counts less than 10,000/mm^3 during the third trimester~~
   - ~~Platelet count of 10,000/mm^3 to 30,000/mm^3 and active bleeding~~
   - ~~Platelet counts less than 10,000/mm^3 after steroid failure~~
   - ~~Platelet count of 10,000/mm^3 to 30,000/mm^3 and active bleeding after steroid failure~~
   - ~~Platelet count of 10,000/mm^3 to 30,000/mm^3 during third trimester and asymptomatic after steroid failure~~
   - Active bleeding and a platelet count of less than 30,000/mm3; or documented history of significant bleeding and a platelet count of less than 30,000/mm3; **OR**
   - A platelet count of less than 20,000/mm3; **OR**
   - Intent to increase platelet counts to a level considered safe for procedures

   AND
   - A contraindication to, intolerance to or therapeutic failure on corticosteroid therapy **OR** a more rapid increase in platelets is necessary, as determined by the prescriber*

   *Note: initial response to corticosteroids usually occurs within 4-14 days and reaches a peak response within 1-4 weeks. Initial response to IVIG usually occurs within 1-3 days and reaches a peak response within 2-7 days.

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

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

- **Post-transfusion purpura**
  The following criteria must be met:
  1. Medical record documentation of an onset of severe thrombocytopenia (platelet count less than or equal to 30,000/mm3) occurring 2-14 days post blood product transfusion.

- **Kawasaki Disease**
  The following criteria must be met:
  1. Documentation of a diagnosis of Kawasaki disease.
  2. Treatment with IVIG is begun within 10 days of the onset of fever. OR
  3. Patient has a delayed diagnosis (i.e., later than day 10 of fever) with ongoing systemic inflammation as manifested by elevation of ESR or CRP (CRP>3.0mg/dL) together with either persistent fever without other explanation or coronary artery aneurysms.

- **Pediatric HIV infection – Bacterial infection prevention**
  The following criteria must be met:
  1. Indicated in HIV positive children with humoral immunodeficiency AND
  2. Entry CD4+ lymphocyte count of 200/mm^3 or greater AND
  3. Hypogammaglobulinemia AND one or more of the following:
  4. Recurrent serious bacterial infections OR
  5. Failure to form antibodies to common antigens OR

6. There is a high risk for measles OR
7. There is a documented bronchiectasis that has not adequately responded to antimicrobial and pulmonary therapy.

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

- **Myasthenia Gravis (Acute use)**
  The following criteria must be met:
  1. Must be prescribed by a neurologist; AND

  Medical documentation of one of the following indications:
  2. Diagnosis of acute myasthenic crisis with decompensation; OR
  3. Use during postoperative period following a thymectomy for acute exacerbations; OR
  4. Use prior to planned thymectomy OR
  5. For short term bridge therapy (one-course of treatment) in patients with acute worsening symptoms with plans to start other immunosuppressive treatments or corticosteroids.

*IVIG for any of the above acute indications will be approved for one course of treatment. One course of treatment will be limited to 5 days of IVIG therapy.

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

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

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

- **Chronic Inflammatory Demyelinating Polyneuropathy**

All of the following criteria must be met:

1. Must be prescribed by a neurologist; AND
2. Documented evidence of focal or symmetric neurologic deficits that are slowly progressive or relapsing over 2 months or longer AND
3. Physician provided documentation of EMG abnormalities consistent with the diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy with the presence of at least ONE of the following:
    a. Motor distal latency prolongation ≥ 50% above ULN in two nerves (excluding median neuropathy at the wrist from carpal tunnel syndrome), OR
    b. Reduction of motor conduction velocity ≥ 30% below LLN in two nerves, OR
    c. Prolongation of F-wave latency ≥ 30% above ULN in two nerves (≥ 50% if amplitude of distal negative peak CMAP <80% of LLN values), OR
    d. Absence of F-waves in two nerves if these nerves have distal negative peak CMAP amplitudes ≥ 20% of LLN + ≥ 1 other demyelinating parameter in ≥ 1 other nerve, OR
    e. Partial motor conduction block: ≥ 50% amplitude reduction of the proximal negative peak CMAP relative to distal, if distal negative peak CMAP ≥ 20% of LLN, in two nerves, or in one nerve + ≥1 other demyelinating parameter in ≥ 1 other nerve, OR
    f. Abnormal temporal dispersion (>30% duration increase between the proximal and distal negative peak CMAP) in ≥ 2 nerves, OR
    g. Distal CMAP duration (interval between onset of the first negative peak and return to baseline of the last negative peak) increase in ≥ 1 nerve (median ≥ 6.6 ms, ulnar ≥ 6.7 ms, peroneal ≥ 7.6 ms, tibial ≥ 8.8 ms) + ≥ 1 other demyelinating parameter in ≥ 1 other nerve

Improvement should be apparent after 3 months of treatment; otherwise, requests for further treatment will require Medical Director review.

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

The following criteria must be met:

1. History of previous fetus or newborn with serologically confirmed Fetal or Neonatal Alloimmune Thrombocytopenia (FNAIT) with thrombocytopenia **OR**
2. History of previous fetus or newborn with serologically confirmed Fetal or Neonatal Alloimmune Thrombocytopenia (FNAIT) with intracranial hemorrhage **OR**
3. History of previous fetus or newborn with thrombocytopenia or intracranial hemorrhage of unknown etiology **AND** documentation a complete diagnostic workup was performed*

*Note, a complete diagnostic workup, per ACOG guidelines may include:

- Maternal anti-HPA antibody screening and cross matching with paternal platelets at 12, 24 and 32 weeks OR
- Paternal incompatibility for human platelet antigen OR
- A single antibody screening study including the crossmatching of paternal and maternal platelets at 30 weeks gestation

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

- **Multifocal Motor Neuropathy**

The following criteria must be met:

1. Must be prescribed by a neurologist; AND
2. Medical documentation of progressive symptoms for a minimum of 1 month; AND
3. Asymmetric limb weakness in at least two nerves AND
4. No objective sensory abnormalities except for minor vibration sense abnormalities in the lower limb AND

5. Documentation of a diagnosis of multifocal motor neuropathy with conduction block as shown on electrophysiologic study as evidenced by:
    - Definite Conduction block on a single nerve
      OR
    - Probable Conduction block in at least two nerves
      OR
    - Probable Conduction block in at least one nerve AND at least two (2) of the following:
        i. Elevated IgM anti-ganglioside GM1 antibodies
        ii. Increased CSF protein
        iii. increased T2-signal intensity on MRI of brachial plexus with diffuse nerve swelling
        iv. Objective clinical improvement following IVIG treatment

- **CMV Interstitial Pneumonia in Allogenic Bone Marrow Transplant or HSCT patients** **(Ib/A)**
  The following criteria must be met:
  1. Medical record documentation of CMV pneumonia
  2. Medical record documentation that IVIG is being used in combination with or patient has a contraindication to ganciclovir

- **Toxic shock syndrome** **(III/C)**
  The following criteria must be met:
  ~~1. Used in conjunction with conventional therapy~~
  1. Medical record documentation of severe disease and failure on, intolerance to, or contraindication to conventional therapy, which may include, but is not limited to surgical debridement, fluid replacement, vasopressors or antibiotic therapy **AND**
  2. Caused by staphylococcal ~~or streptococcal~~ organisms

OR

  3. Medical record documentation of Streptococcal Toxic Shock Syndrome (TSS)

~~• **Neonatal sepsis** **(Ia/A)**~~
~~The following criteria must be met:~~
~~Used in conjunction with conventional therapy~~

- **Graves' Ophthalmopathy** **(Ib/A)**
  The following criteria must be met:
  1. Medical record documentation of failure on, contraindication to, or intolerance to conventional treatment (corticosteroids)
  2. Prescription must be written by an ophthalmologist

- **Autoimmune Mucocutaneous Blistering Diseases (pemphigus, pemphigoid, pemphigus vulgaris, pemphigus foliaceus, Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis** **(III/C)**
  The following criteria must be met:
  1. Diagnosis must be substantiated by biopsy; AND
  2. Failure or contraindication to two or more conventional therapies (corticosteroids, azathioprine, cyclophosphamide, etc.);
  OR
  3. Have rapidly progressive disease in which a clinical response could not be quickly achieved utilizing conventional therapy. IVIG would be given in conjunction with conventional therapy and only until such time as conventional therapy could take effect

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

- **Solid Organ Transplant**
  The following criteria must be met:
  Prevention of acute humoral rejection

- Medical record documentation that patient is at high risk for antibody-mediated rejection, including highly sensitized patients or receiving ABO incompatible organ

OR

Treatment of acute humoral rejection

- Medical record documentation of antibody-medicated rejection

- **Rasmussen's Encephalitis** **(IIb/B)**

  The following criteria must be met:

  1. Medical record documentation that short-term amelioration of encephalitis is needed prior to definitive surgical therapy
  2. Medical record documentation of intractable focal motor seizures and progressive neurologic deterioration

- **Stiff-Person Syndrome** **(Ib/A)**

  The following criteria must be met:

  1. Prescription written by a neurologist
  2. Medical record documentation of failure on, intolerance to, or contraindication to all standard therapies (muscle relaxants, benzodiazepines, and gabapentin-related medications)

- **Eaton-Lambert myasthenic syndrome** **(Ib/A)**

  All of the following criteria must be met:

  1. Prescription written by a neurologist
  2. Medical record documentation of failure on, contraindication to, or intolerance to other treatments including corticosteroids or other immunosuppressants, cholinesterase inhibitors, and 3,4-diaminopyridine.

- **Multiple Sclerosis (relapsing/remitting type)**

  All of the following criteria must be met:

  1. Must be prescribed by a neurologist; **AND**
  2. Medical record documentation of RRMS **AND**
  3. Medical record documentation of current MS exacerbation **AND**
  4. Medical record documentation of therapeutic failure on, contraindication to, or intolerance to an appropriate trial of high dose corticosteroids

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

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

- **Warm Antibody Autoimmune hemolytic anemia** **(III/D)**

  The following criteria must be met:

  1. Refractory to or contraindicated to corticosteroids and immunosuppressive agents
  2. Refractory to splenectomy

- **Parvovirus B19 Infection**

  All of the following criteria must be met

  1. Prescribed by or in consultation with an infectious disease specialist, immunologist, hematologist, or transplant specialist
  2. Medical record documentation of chronic immunodeficient condition (HIV, solid organ transplant ect)
  3. Medical record documentation of chronic parvovirus B19 infection
  4. Medical record documentation of severe anemia as defined by hemoglobin < 8 g/dL

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

  All of the following criteria must be met:

1. Documentation of patient with antiphospholipid syndrome (APS) with multiorgan failure (evidence of involvement of three or more organs, systems, and/or tissues AND
2. Development of manifestations simultaneously or in less than one week AND
3. Confirmation by histopathology of small vessel occlusion in at least one organ or tissue AND
4. Medical record documentation Intravenous Immunoglobulin (IVIG) will be used in combination with conventional therapies (eg. anticoagulation and corticosteroids) AND
5. Laboratory confirmation of the presence of antiphospholipid antibodies (lupus anticoagulant, anticardiolipin antibodies, and/or anti-beta2-glycoprotein I antibodies)
   OR
   - All four criteria are met, except for only two organs, systems and/or sites of tissues involvement OR
   - All four criteria are met, except for laboratory confirmation OR
   - Criteria 1, 2, and 4 are met OR
   - Criteria 1,3, and 4 and the development of a third event in more than a week but less than a month, despite anticoagulation

AUTHORIZATION DURATION: Each treatment period will be defined as 6 months or less, unless otherwise stated (e.g. Chronic Inflammatory Demyelinating Polyneuropathy, Multiple Sclerosis, and Multifocal Motor Neuropathy). Re-review will occur every 6 months or less, dependent on the indication. Documentation of clinical response to therapy is required after initiation of therapy. If initial benefit is seen and continued therapy is deemed necessary, documentation of objective monitoring must be seen. Clinical improvement is superior to laboratory monitoring. IVIG will no longer be covered if there is a medical record documentation of disease progression.
LIMITATIONS: When approved, IVIG will be administered in a setting determined by the Plan, in consultation with the requesting physician to be the most clinically appropriate and/or medically necessary.
Initial Dosing: Dosing should be calculated using adjusted body weight (ABW) if one or more of the following criteria are met:

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

Dosing formulas:

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

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

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

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

FAST FACTS

SOLOSEC (secnidazole)

Updated Indication: Solosec is now indicated for the treatment of trichomoniasis caused by *Trichomonas vaginalis* in adults. Because trichomoniasis is a sexually transmitted disease with potentially serious sequelae, treat partners of infected patients simultaneously in order to prevent reinfection.

Current formulary status: Non-Formulary

Recommendation: No changes are recommended for the formulary placement, quantity limits, or auth duration of Solosec. The following prior authorization criteria will be added to the Commercial Policy 501.0 incorporate the new indication:

Trichomoniasis

- Medical record documentation of trichomoniasis caused by *Trichomonas vaginalis* **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to oral metronidazole **AND** tinidazole

Discussion: No comments or questions.

Outcome: The committee 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.

VERZENIO (abemaciclib)

Updated Indication: Verzenio is now indicated in combination with endocrine therapy (tamoxifen or an aromatase inhibitor) for the adjuvant treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node positive, early breast cancer at high risk of recurrence and a Ki-67 score ≥ 20% as determined by an FDA approved test.

Verzenio also expanded two other indications to include male patients and the indications are updated as follows:

- in combination with an aromatase inhibitor as initial endocrine-based therapy for the treatment of postmenopausal women, and men, with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.
- in combination with fulvestrant for the treatment of adult patients (previously for women only) with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer with disease progression following endocrine therapy.

Current formulary status: Oral oncology Brand NP tier, requires a PA for new starts only

Recommendation: changes are recommended to the quantity limits of Verzenio. In order to incorporate the recommended duration of treatment for Verzenio for Commercial, a standard prior authorization will be required. The following changes are recommended to the criteria and authorization duration in Commercial Policy 473.0 to incorporate the new indication and the new population of male patients to the other indications:

Advanced or Metastatic Breast Cancer

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Verzenio is prescribed by an oncologist **AND**
- Medical record documentation of a diagnosis of advanced or metastatic breast cancer that is hormone receptor positive, human epidermal growth factor receptor 2 negative (HR+/HER2-) **AND**
- One of the following:
    - Medical record documentation that Verzenio is being prescribed as initial endocrine-based therapy **AND**
    - Medical record documentation of postmenopausal status **OR** if the patient is male, that they have received a gonadotropin-releasing hormone agonist (e.g., LHRH agonist; goserelin) for at least 4 weeks prior to and will continue for the duration of Verzenio therapy **AND**
    - Medical record documentation that Verzenio will be prescribed in combination with an aromatase inhibitor (i.e., letrozole, anastrozole, etc.)

    OR
    - Medical record documentation that the patient experienced disease progression following prior endocrine therapy* **AND** prior chemotherapy^ in the metastatic setting **AND**
    - Medical record documentation that Verzenio is being used as monotherapy

    OR
    - Medical record documentation that the patient experienced disease progression following prior endocrine therapy* **AND**
    - Medical record documentation that fulvestrant (Faslodex) will be administered along with Verzenio **AND**
    - Medical record documentation of postmenopausal status **OR** if the patient is pre/perimenopausal, that they have received a gonadotropin-releasing hormone agonist (e.g., LHRH agonist; goserelin) for at least 4 weeks prior to and will continue for the duration of Verzenio therapy

Early Breast Cancer

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Verzenio is prescribed by an oncologist **AND**
- Medical record documentation of a diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node-positive, early breast cancer **AND**
- Medical record documentation that member has a high risk of recurrence[&] **AND**
- Medical record documentation of a Ki-67 score greater than or equal to 20% determined by an FDA approved test[#] **AND**
- Medical record documentation that Verzenio will be used as adjuvant treatment in combination with endocrine therapy (i.e., tamoxifen or an aromatase inhibitor) **AND**
- If patient is treated with an aromatase inhibitor (i.e., letrozole, anastrozole, etc.):
    - Medical record documentation of postmenopausal status **OR** if the patient is pre/perimenopausal or male, that they have received a gonadotropin-releasing hormone agonist (e.g., LHRH agonist; goserelin) for at least 4 weeks prior to and will continue for the duration of Verzenio therapy

QUANTITY LIMIT: 2 tablets per day, 28 day supply per fill

NOTE:

*Examples of endocrine therapy include: exemestane, letrozole, anastrozole, tamoxifen, and toremifene

^Examples of preferred chemotherapy include: Anthracyclines (doxorubicin/pegylated liposomal doxorubicin), taxanes (paclitaxel), anti-metabolites (capecitabine/gemcitabine), other microtubule inhibitors

(vinorelbine/eribulin). Other chemotherapy agents that can be used include: cyclophosphamide, carboplatin, docetaxel, albumin-bound paclitaxel, cisplatin, epirubicin, and ixabepilone.

[&]In clinical trials, high risk of recurrence was defined as either tumor involvement in one to three axillary lymph nodes with either tumor grade 3 disease or tumor size ≥ 50 mm **OR** tumor involvement of ≥ 4 axillary lymph nodes

[#]The FDA approved test for the measurement of Ki-67 score is the Ki-67 IHC MIB-1 pharmDx.

****For adjuvant treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node positive, early breast cancer:**
One approval will be given for 24 months or less if the reviewing provider feels it is medically appropriate. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Authorization of Verzenio for adjuvant treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node positive, early breast cancer should not exceed the FDA-approved treatment duration of 2 year (24 months) in patients. For requests exceeding the above limit, medical record documentation of the following is required:

- Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

For all other indications:
Initial approval will be for 24 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 24 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: The committee 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.

PROGRAF (tacrolimus)

Updated Indication: Prograf is now indicated for the prophylaxis of organ rejection in adult and pediatric patients receiving allogeneic lung transplants, in combination with other immunosuppressants.

Previously Prograf was indicated for the organ rejection prophylaxis following liver, kidney, or heart transplants.

Current formulary status: Prograf 0.5 mg, 1 mg, 5 mg capsules: Brand Non-Preferred tier
Tacrolimus 0.5 mg, 1 mg, 5 mg capsules : generic tier

Recommendation: No changes are needed to the formulary placement of Prograf or tacrolimus capsules for Commercial, Exchange, or CHIP. It is recommended that the Prograf oral packets be added to the Brand Non-Preferred tier to match the placement of Prograf capsules. No prior authorization will be required.

Discussion: No comments or questions.

Outcome: The committee 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.

VIMPAT (lacosamide)

Updated Indication: Vimpat is now indicated for the treatment of partial-onset seizures in patients 1 month of age and older

Previously this was indicated for the treatment of partial-onset seizures in patients aged 4 years and older.

Current formulary status: Brand Non-Preferred tier requiring a prior authorization

Recommendation: There will be no changes to the formulary status or authorization duration at this time. It is recommended to update the policy to include the new indication:

For Partial-Onset Seizures

- Medical record documentation of a diagnosis of partial-onset seizures **AND**
- Medical record documentation of age greater than or equal to 1 month **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to three (3) formulary alternatives

For Primary Generalized Tonic-Clonic Seizures

- Medical record documentation of a diagnosis of primary generalized tonic-clonic seizures **AND**
- Medical record documentation of age greater than or equal to 4 years**AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to three (3) formulary alternatives

FORMULARY ALTERNATIVES:
For patients aged ≥ 1 month of age: carbamazepine, levetiracetam IR, phenobarbital, phenytoin, pregabalin

Additional formulary alternatives for patients over certain ages: lamotrigine IR (2+), topiramate IR (2+), topiramate ER (2+)*, gabapentin (3+), oxcarbazepine (4+), divalproex (10+), levetiracetam ER (12+), Gabitril (12+), lamotrigine ER (13+), felbamate (14+), and zonisamide (16+)
*prior authorization required

Discussion: No comments or questions.

Outcome: The committee 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.

NUCALA (mepolizumab)

Updated Indication: Nucala is now indicated as add-on maintenance treatment of adult patients aged 18 years and older with chronic rhinosinusitis with nasal polyps (CRSwNP)

Previously this was indicated as add-on maintenance treatment of adult and pediatric patients aged 6 and older with severe asthma with an eosinophilic phenotype, the treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA), and the treatment of adult and pediatric patients aged 12 years and older with hypereosinophilic syndrome (HES) for ≥6 months without an identifiable non-hematologic secondary cause.

Current formulary status: Nucala Vial: Medical Benefit requring a prior authorization
Nucala prefilled syringe or autoinjector: Specialty tier or Brand Non-Preferred tier for members with a three-tier benefit, requiring a prior authorization

Recommendation: There will be no changes to the formulary status or authorization duration at this time. It is recommended to update the Medical Benefit Policy 141.0 and the Commercial Policy 592.0 to include the new indication.

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

- Medical record documentation that Nucala is prescribed by or in consultation with an otolaryngologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) **AND**
- Medical record documentation that Nucala will be used as add-on maintenance treatment **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to three (3) intranasal corticosteroids

The following quantity limit will apply to this specific indication in the **Commercial Policy** as follows:

QUANTITY LIMIT: *QL must be entered within the authorization.*

- QL FOR LETTER & AUTHORIZATION: 1 prefilled syringe or 1 autoinjector (100 mg) per 28 days

The following change is recommended to add to the **Medical Benefit Policy** quantity limit:

Quantity Limit: 1 vial (100mg) per 28 days (for eosinophilic asthma or CRSwNP), 3 vials (300mg) per 28 days (for EGPA or HES)

Discussion: No comments or questions.

Outcome: The committee 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.

TECENTRIQ (atezolizumab)

Updated Indication: Tecentriq, as a single-agent, is now indicated as adjuvant treatment following resection and platinum-based chemotherapy for adult patients with stage II to IIIA non-small cell lung cancer (NSCLC) whose tumors have PD-L1 expression on ≥ 1% of tumor cells, as determined by an FDA-approved test

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

Recommendation: No changes are needed to the formulary placement of Tecentriq. The following changes are recommended to Medical Benefit Policy 144.0 to incorporate the new indication:

2. Non-Small Cell Lung Cancer:

- Prescription written by an oncologist **AND**
- Medical record documentation of a diagnosis of non-small cell lung cancer meeting one of the following situations:
    - Medical record documentation of disease progression during or following platinum-containing chemotherapy

OR

    - Medical record documentation of disease progression on at least one FDA-approved therapy targeting EGFR or ALK if the patient has EGFR or ALK genomic tumor aberrations (e.g. mutation, deletion, insertion, etc.)

OR

    - Medical record documentation of a non-squamous histologic subtype **AND**
    - Medical record documentation that Tecentriq will be given as first-line treatment **AND**
    - Medical record documentation that Tecentriq will be given in combination with bevacizumab, paclitaxel, AND carboplatin **OR** paclitaxel protein-bound AND carboplatin **AND**
    - Medical record documentation that the patient does not have an EGFR or ALK genomic tumor aberration.

OR

    - Medical record documentation that Tecentriq will be given as first-line treatment for metastatic disease **AND**
    - Medical record documentation that tumors have high PD-L1 expression (PD-L1 stained ≥ 50% of tumor cells [TC ≥ 50%] or PD-L1 stained tumor-infiltrating immune cells [IC] covering ≥ 10% of the tumor area [IC ≥ 10%]) as determined by an FDA-approved test **AND**
    - Medical record documentation that the patient does not have an EGFR or ALK genomic tumor aberration.

OR

    - Medical record documentation of stage II to IIIA disease AND
    - Medical record documentation of use as adjuvant treatment following resection and platinum-based therapy **AND**
    - Medical record documentation that tumors have PD-L1 expression on ≥1% of tumor cells as determined by an FDA-approved test **AND**
    - Medical record documentation that Tecentriq is being given as a single agent.

****For adjuvant treatment of stage II to IIIA non-small cell lung cancer (NSCLC) following resection and platinum-based chemotherapy:**
One approval will be given for 12 months or less if the reviewing provider feels it is medically appropriate. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Authorization of Tecentriq for adjuvant treatment of stage II to IIIA non-small cell lung cancer (NSCLC) following resection and platinum-based chemotherapy should not exceed the FDA-approved treatment duration of 1 year (12 months) in patients. For requests exceeding the above limit, medical record documentation of the following is required:

- Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

For all other indications:
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.

Discussion: No comments or questions.

Outcome: The committee 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.

CABOMETYX (cabozantinib)

Updated Indication: Cabometyx is a kinase inhibitor now indicated for the treatment of adult and pediatric patients 12 years of age and older with locally advanced or metastatic differentiated thyroid cancer (DTC) that has progressed following prior VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible

Current formulary status: ral oncology Brand NP tier, requires a PA for new starts only

Recommendation: No changes are recommended for the formulary placement, quantity limits or authorization duration of Cabometyx. It is recommended that the following criteria be added to Commercial Policy 420.0 to incorporate the new indication.

Differentiated Thyroid Cancer (DTC)

- Medical record documentation that Cabometyx is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of age greater than or equal to 12 years **AND**
- Medical record documentation of locally advanced or metastatic differentiated thyroid cancer (DTC) **AND**
- Medical record documentation of progression following prior VEGFR-targeted therapy **AND**
- Medical record documentation that radioactive iodine-refractory or ineligible

Discussion: No comments or questions.

Outcome: The committee 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.

Voting responses were received from 25 of 39 members. The vote was unanimously approved.

Future Scheduled Meetings

The next bi-monthly scheduled meeting will be held on January 18th, 2022 at 1:00 p.m.

Meeting will be via phone/Microsoft Teams