P&T Committee Meeting Minutes
Commercial/Exchange/CHIP
February 2026 e-Vote

DRUG REVIEWS

HYRNUO (sevabertinib)

Review: Hyrnuo is a kinase inhibitor indicated for the treatment of adult patients with locally advanced or metastatic non-squamous non-small cell lung cancer (NSCLC) whose tumors have human epidermal growth factor receptor 2 (HER2) (ERBB2) tyrosine kinase domain (TKD) activating mutations, as detected by an FDA-approved test, and who have received a prior systemic therapy. Hyrnuo exhibits reversible kinase inhibition of HER2 and also has activity against epidermal growth factor receptor (EGFR).

The recommended dosage of Hyrnuo is 20 mg orally twice daily with food until disease progression or unacceptable toxicity. In the event of adverse reactions, the dosage of Hyrnuo can be reduced to 10 mg twice daily, then 10 mg once daily if needed, then discontinued in patients unable to tolerate 10 mg once daily. Hyrnuo is supplied as 10 mg tablets.

The efficacy of Hyrnuo was evaluated in SOHO-01, an open-label, single-arm, multi-cohort clinical study in patients who had previously treated locally advanced or metastatic NSCLCL with HER2 activating mutations. Patients with treated, stable, and asymptomatic brain metastases were eligible for inclusion in the study. Patients with symptomatic CNS metastases, clinically significant cardiac disease, and history of steroid dependent interstitial lung disease (ILD)/pneumonitis were excluded.

Patients were treated with Hyrnuo 20 mg orally twice daily until disease progression or unacceptable toxicity. The major efficacy outcomes were confirmed objective response rate (ORR) and duration of response (DOR), as assessed by Blinded Independent Central review (BICR) using RECIST v1.1. The efficacy population included 70 patients from Group D, and 52 patients from Group E, with advanced non-squamous NSCLC with HER2 (ERBB2) tyrosine kinase domain (TKD) activating mutations.

Group D included 70 patients with HER2 TKD activating mutations who received prior systemic therapy but were naïve to therapy targeting HER2 mutations. All patients had adenocarcinoma histology. Ninety-one percent (91%) of patients had stage IV disease and 20% had stable brain metastases. The median number of prior therapies was 1 (range 1 to 8); 94% of patients received prior platinum-based chemotherapy, 71% received prior immunotherapy, and 69% received both in combination. Results are shown in Table 4.

Table 4. Group D Efficacy Results in SOHO-01[1]

Efficacy Parameter	HYRNUO N=70
Objective Response Rate (ORR)[a], (95% CI)	71% (59, 82)
Complete Response	2.9%
Partial Response	69%
Duration of Response (DOR)[c]	**N=50**
Median, months (95% CI)[b]	9.2 (6.3, 15.0)
DOR ≥ 6 months[c]	54%
DOR ≥ 12 months[c]	18%

CI – Confidence Interval
[a] ORR 95% CI calculated using Clopper-Pearson method.
[b] Kaplan-Meier estimate.
[c] Observed proportion of responding patients with duration of response beyond landmark time.

Group E included 52 patients with HER2 (ERBB2) TKD activating mutations who had received prior systemic therapy including HER2-targeted ADCs. All patients had adenocarcinoma histology. Eighty-five percent (85%) of patients had stage IV disease and 29% had stable brain metastases. The median number of prior therapies was 2 (range 1 to 8), 77% of patients received prior platinum-based chemotherapy, 56% received prior immunotherapy, and 56% received both in combination.

The overall response rate was 38% with 6% of patients having a complete response and 33% of patients having a partial response. The median duration of response was 7 months, ranging from 1 to 17.2 months. Observed proportion of patients with a DOR lasting ≥ 6 months and ≥ 12 months was 60% and 10%, respectively.

There are no black box warnings for Hyrnuo. Warnings include risk of diarrhea, hepatotoxicity, interstitial lung disease, ocular toxicity, pancreatic enzyme elevation, and embryo-fetal toxicity. The most common adverse reactions included diarrhea, rash, paronychia, stomatitis, and nausea. The most common laboratory abnormalities were decreased potassium, increased lipase, decreased lymphocytes, decreased sodium, increased amylase, and increased AST and ALT. Serious adverse reactions occurred in 31% of patients who received Hyrnuo, including diarrhea, pneumonia, dyspnea, and pleural effusion. Permanent discontinuation occurred in 3.7% of patients. Dosage interruptions and dosage reductions occurred in 46% and 28% of patients, respectively.

The safety and efficacy of Hyrnuo has not been established in pediatric patients. Of the 268 patients with locally advanced or metastatic NSCLC harboring HER2 activating mutations, 43% were 65 years and over and 13% were 75 years and over. No overall differences were observed between older and younger patients. Grade 3 diarrhea was observed in 23% of patients age ≥ 75 years and 14% of patients < 75 years.

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

Outcome: Hyrnuo is a pharmacy benefit and will be added to the Commercial, Marketplace, and GHP Kids formularies as follows:

2 Tier/CHIP	**3 Tier**	**4 Tier**	**ACA**
Tier 2 – Brand (Oral Oncology $0 Copay)	Tier 3 – Brand NP (Oral Oncology $0 Copay)	Tier 3 – Brand NP (Oral Oncology $0 Copay)	Tier 1 – Brand NP (Oral Oncology $0 Copay)

It will require a prior authorization for new starts only and will be reviewed with the Preferred Oral Oncology Policy (outlined in the Oral Oncology Update included in the updates of the February 2026 electronic vote).

Prior Authorization:

- Medical record documentation that the medication is prescribed by or in consultation with a hematologist, oncologist, or other appropriate specialist **AND**
- Medical record documentation of a diagnosis that is supported by one of the following:
    - U.S. Food and Drug Administration (FDA)- approved package labeling or
    - The National Comprehensive Cancer Network (NCCN) guidelines or
    - American Society of Clinical Oncology (ASCO) **AND**
- Medical record documentation of an age consistent with FDA approval or medically accepted indication **AND**
- Medical record documentation that the medication is being prescribed at a dose and duration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature **AND**
- For a non-preferred product with a therapeutically equivalent generic or biosimilar, medical record documentation of a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent generic or biosimilar

Authorization Duration for Oral Oncology Policy: All products (unless listed below) are configured as a prior authorization for new starts only. The medication 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

GPI LEVEL: GPI-12

QUANTITY LIMIT: 4 tablets per day, 30-day supply per fill

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

KOMZIFTI (ziftomenib)

Review: Komzifti is indicated for the treatment of adult patients with relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 (NPM1) mutation who have no satisfactory alternative treatment options.

Komzifti blocks the interaction of menin and lysine [K]-specific methyltransferase 2A (KMT2A). Acute leukemias can be driven by mutations in NPM1 that recruit the wild-type menin-KMT2A complex to promoters of leukemogenic genes. Pharmacologic disruption of the menin-KMT2A protein-protein interaction by ziftomenib blocks oncogenic activity of mutant NPM1, which induces differentiation of leukemic cells as evidenced by increased expression of differentiation markers. Komzifti is the second menin-inhibitor approved for this indication following Revuforj and the first with once daily dosing.

The recommended dosage of Komzifti is 600 mg once daily until disease progression or unacceptable toxicity. Komzifti should not be started in patients until there is a reduction in white blood cells to less than 25×10^9/L. Treatment should be continued for a minimum of 6 months to allow time for a clinical response. In the event of adverse reactions, the dose may be reduced to 400 mg once daily, then 200 mg once daily if needed, then discontinued in patients unable to tolerate 200 mg once daily. Komzifti is supplied as 200 mg capsules.

Patients should avoid concomitant use of proton pump inhibitors, histamine-2 receptor antagonists, or locally acting antacids. If concomitant use of H2 receptor antagonists can't be avoided, take Komzifti 2 hours before or 20 hours after administration of an H2 receptor antagonist. If concomitant use with a locally acting antacid can't be avoided, take Komzifti 2 hours before or 2 hours after administration of a locally acting antacid.

The efficacy of Komzifti was evaluated in KO-MEN-001, an open-label, single-arm trial in 112 adult patients with relapsed or refractory AML with an NPM1 mutation identified using next-generation sequencing or polymerase chain reactions. Komzifti was given at a dose of 600 mg once daily until disease progression or unacceptable toxicity. Patients were permitted to resume treatment with Komzifti following hematopoietic stem cell transplant (HSCT). Four of 112 patients underwent stem cell transplant following Komzifti treatment.

Efficacy was based on complete remission (CR) plus CR with partial hematological recovery (CRh), duration of CR+CRh, and the rate of conversion from transfusion dependence to transfusion independence. Results are shown in Table 4.

Table 4. Efficacy of Komzifti in patients with relapsed or refractory AML[1]

Endpoint	KOMZIFTI (600 mg once daily) N=112
CR[a]+CRh[b], n (%)	24 (21.4)
95% CI	(14.2, 30.2)
Median DOCR+CRh[c] (months)	5.0
95% CI	(1.9, 8.1)
CR[a], n (%)	19 (17.0)
95% CI	(10.5, 25.2)
Median DOCR[d] (months)	5.0
95% CI	(2.8, 8.1)
CRh[b], n (%)	5 (4.5)
95% CI	(1.5, 10.1)
Observed DOCRh[e] (months)	0.0^{+}, 1.5^{+}, 1.5, 1.6, 11.4

CI: confidence interval; the 95% CI rate was calculated using the exact method based on binomial distribution; NE: not estimable; +: censor.

[a] CR is defined as bone marrow blasts <5%, absolute neutrophil count (ANC) > 1.0 x 10^9/L, and platelet count > 100 x 10^9/L.

[b] CRh is defined as bone marrow blasts <5%, (ANC) > 0.5 x 10^9/L; platelet count > 50 x 10^9/L.

[c] Duration of CR+CRh (DOCR + CRh) is defined as the time from first CR/CRh to the first documented relapse or death, whichever occurs first.

[d] Duration of CR (DOCR) is defined as the time from first CR to the first documented relapse or death, whichever occurs first.

[e] Duration of CRh (DOCRh) is defined as the time from first CRh to the first documented relapse or death, whichever occurs first.

For members with a CR or CRh, the median time to first response was 2.7 months (range, 0.9 to 15 months). Of the 24 patients who achieved a response of CR or CRh, 21 (88%) patients did so withing 6 months of initiating Komzifti. Among the 66 patients who were dependent on red blood cell (RBC) and/or platelet transfusions at baseline, 14 (21.2%) became independent of RBC and platelet transfusions during any 56-day post-baseline period. Of the 46 patients who were independent of both RBC and platelet transfusions at baseline, 12 (26.1%) patients remained transfusion independent during any 56-day post-baseline period.

Komzifti has a black box warning for differentiation syndrome, which is associated with rapid proliferation and differentiation of myeloid cells. In the clinical trial, differentiation syndrome occurred in 29 (26%) of 112 patients with relapsed or refractory AML with an NPM1 mutation who were treated with Komzifti at the recommended dosage. Differentiation syndrome was Grade 3 in 13% and fatal in two patients.

Komzifti has additional warnings for QTc interval prolongation and embryo fetal toxicity. During clinical trials of Komzifti, fatal adverse reactions occurred in 4 patients who received Komzifti, including 2 with differentiation syndrome. Serious adverse reactions were reported in 79% of patients, most commonly infection, febrile neutropenia, bacterial infection, differentiation syndrome, and dyspnea. Dosage interruptions and reductions occurred in 54% and 4%, respectively.

The most common adverse reactions were infection without an identified pathogen, hemorrhage, diarrhea, nausea, fatigue, edema, bacterial infection, musculoskeletal pain, differentiation syndrome, pruritic, febrile neutropenia, and increased transaminases.

The most common laboratory abnormalities included increased AST and ALT, decreased potassium, decreased albumin, decreased sodium, decreased creatinine, increased alkaline phosphatase, increased bilirubin, and increased potassium.

The safety and efficacy of Komzifti in pediatric patients has not been established. Of the 112 patients with relapsed or refractory AML with an NPM1 mutation treated with KOMZIFTI, 70 (63%) patients were 65 years of age or older and 31 (28%) were 75 years or older. No overall differences in effectiveness, safety, or pharmacokinetics of KOMZIFTI were observed between patients aged 65 years or older and younger patients

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

Outcome: Komzifti is a pharmacy benefit and should be added to the Commercial, Marketplace, and GHP Kids formularies to the following tiers:

2 Tier/CHIP	3 Tier	4 Tier	ACA
Tier 2 – Brand (Oral Oncology $0 Copay)	Tier 3 – Brand NP (Oral Oncology $0 Copay)	Tier 3 – Brand NP (Oral Oncology $0 Copay)	Tier 1 – Brand NP (Oral Oncology $0 Copay)

It will require a prior authorization for new starts only and will be reviewed with the Preferred Oral Oncology Policy (outlined in the Oral Oncology Update included in the updates of the February 2026 electronic vote).

Prior Authorization:

- Medical record documentation that the medication is prescribed by or in consultation with a hematologist, oncologist, or other appropriate specialist **AND**
- Medical record documentation of a diagnosis that is supported by one of the following:
    - U.S. Food and Drug Administration (FDA)- approved package labeling or
    - The National Comprehensive Cancer Network (NCCN) guidelines or
    - American Society of Clinical Oncology (ASCO) **AND**
- Medical record documentation of an age consistent with FDA approval or medically accepted indication **AND**
- Medical record documentation that the medication is being prescribed at a dose and duration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature **AND**
- For a non-preferred product with a therapeutically equivalent generic or biosimilar, medical record documentation of a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent generic or biosimilar

Authorization Duration for Oral Oncology Policy: All products (unless listed below) are configured as a prior authorization for new starts only. The medication 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

GPI LEVEL: GPI-12

QUANTITY LIMIT: 3 capsules per day, 30-day supply per fill

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

FAST FACTS

AKEEGA (niraparib and abiraterone acetate)

Clinical Summary: Akeega (niraparib and abiraterone acetate) tablets are approved for the use with prednisone for the treatment of adult patients with metastatic prostate cancer further defined as BRCA-mutated metastatic castration-resistant prostate cancer (mCRPC) and the newly approved indication BRCA2-mutated metastatic castration-sensitive prostate cancer (mCSPC).

There is no updated dosing for the new indication other than prednisone dosing. The recommended dosage of Akeega is 200 mg niraparib/ 1,0000 mg abiraterone (1 tablet) orally once daily. BRCA2 prednisone dosing is 5 mg once daily versus BRCA prednisone dosing of 10 mg once daily. Patients receiving Akeega should also receive concurrent GnRH analog therapy or have had a bilateral orchiectomy. Tablets should be taken at least 1 hour before or 2 hours after food.

The AMPLITUDE trial (NCT04497844) enrolled patients with BRCA2-mutated metastatic castration-sensitive prostate cancer (n=323, Akeega=162, placebo=161). They were randomized 1:1 to receive Akeega plus prednisone or placebo plus abiraterone acetate and prednisone. Both groups were receiving androgen deprivation therapy as well. The primary efficacy point was radiographic progression-free survival (rPFS). The Akeega group demonstrated a statistically significant improvement in rPFS compared to placebo as shown in Table 6.

Table 6: Efficacy Results from the *BRCA2*m Subgroup of the AMPLITUDE Study

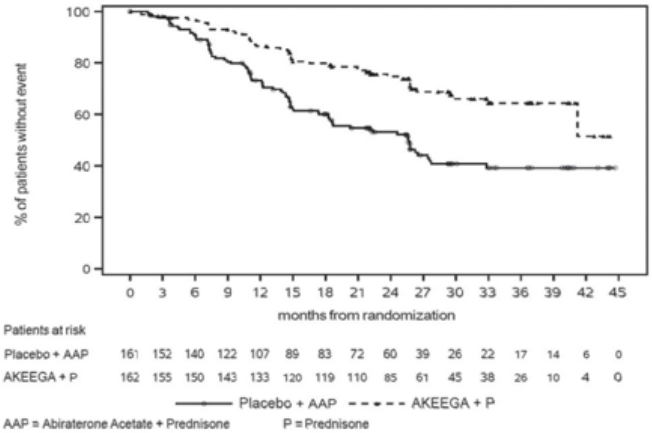
Endpoints	AKEEGA (N=162)	Placebo + Abiraterone Acetate (N=161)
Radiographic Progression-free Survival[a]		
Events	48 (30%)	82(51%)
Median (95% CI) time to event (months)	NE (41, NE)	26 (18, 28)
Hazard Ratio (95% CI)[b]	0.46 (0.32, 0.66)	

[a] Investigator-assessed
[b] Calculated using an unstratified Cox proportional hazards model
NE=not estimable

At the first interim analysis for OS, 91 deaths occurred in the *BRCA2*m population, 36 [22%] in the AKEEGA arm) and 55 [34%] in the placebo and abiraterone acetate arm.

The change from baseline to the time of symptomatic progression is shown in Figure 1. This included the use of external beam radiation for skeletal or pelvic symptoms, cancer-related morbid events, initiation of new systemic anti-cancer therapy, and other cancer-related procedures.

Figure 1: Kaplan-Meier Plot of Radiographic Progression-Free Survival in the *BRCA2*m Population (AMPLITUDE)



There were no additional safety considerations for the new indication.

Current Formulary Status: Akeega is on the Oral Oncology Brand NP tier (0$ copay) and requires a prior authorization for new starts only.

Recommendation: No formulary changes recommended. It is recommended to update the prior authorization criteria to the following:

- Medical record documentation that Akeega is prescribed by an oncologist or urologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- ~~Medical record documentation of a diagnosis of metastatic castration-resistant prostate cancer (mCRPC) **AND**~~
- ~~Medical record documentation of deleterious or suspected deleterious BRCA-mutation (BRCAm) as detected by an FDA-approved test **AND**~~
- Medical record documentation of ONE of the following based on an FDA approved test:
    - Medical record documentation of a diagnosis of deleterious or suspected deleterious BRCA-mutation (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) **OR**
    - Medical record documentation of a diagnosis of deleterious or suspected deleterious BRCA2-mutation (BRCA2m) metastatic castration-sensitive prostate cancer (mCSPC) **AND**
- Medical record documentation that Akeega will be given in combination with prednisone **AND**
- Medical record documentation of one of the following:
    - Medical record documentation that Akeega will be given concurrently with a gonadotropin-releasing hormone (GnRH) **OR**
    - Medical record documentation that member has had bilateral orchiectomy

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

DARZALEX FASPRO (daratumumab and hyaluronidase-fihj)

Clinical Summary: Darzalex Faspro is a combination of daratumumab, a CD38-directed cytolytic antibody, and hyaluronidase, an endoglycosidase, now indicated for multiple myeloma in combination with bortezomib, lenalidomide, and dexamethasone in newly diagnosed patients who are ineligible for autologous stem cell transplant. Darzalex Faspro is also indicated in high-risk smoldering multiple myeloma as monotherapy. The accelerated approval disclaimer contained within the light chain amyloidosis indication has been removed. Previously, Darzalex Faspro was indicated for the treatment of adult patients with:

- multiple myeloma in combination with bortezomib, lenalidomide, and dexamethasone for induction and consolidation in newly diagnosed patients who are eligible for autologous stem cell transplant.
- multiple myeloma in combination with bortezomib, melphalan and prednisone in newly diagnosed patients who are ineligible for autologous stem cell transplant.
- multiple myeloma in combination with lenalidomide and dexamethasone in newly diagnosed patients who are ineligible for autologous stem cell transplant and in patients with relapsed or refractory multiple myeloma who have received at least one prior therapy.
- multiple myeloma in combination with bortezomib, thalidomide, and dexamethasone in newly diagnosed patients who are eligible for autologous stem cell transplant.
- multiple myeloma in combination with bortezomib and dexamethasone in patients who have received at least one prior therapy.
- multiple myeloma in combination with pomalidomide and dexamethasone in patients who have received at least one prior line of therapy including lenalidomide and a proteasome inhibitor.
- multiple myeloma in combination with carfilzomib and dexamethasone in patients with relapsed or refractory multiple myeloma who have received one to three prior lines of therapy.

- multiple myeloma as monotherapy, in patients who have received at least three prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double-refractory to a PI and an immunomodulatory agent.
- newly diagnosed light chain (AL) amyloidosis in combination with bortezomib, cyclophosphamide and dexamethasone

The dosing for Darzalex Faspro has been updated to include recommendations for the new indications. The recommended dose in combination with bortezomib, lenalidomide, and dexamethasone (Darzalex Faspro-VRd) for patients who are ineligible for autologous stem cell transplant (ASCT) is summarized in Table 1. The recommended dose of Darzalex Faspro for high-risk smoldering multiple myeloma (MM) is 1,800mg/30,000units given subcutaneously over 3 to 5 minutes. The dosing schedule for high-risk smoldering MM is summarized in Table 2.

Table 1. Darzalex Faspro dosing schedule in combination with bortezomib, lenalidomide and dexamethasone (4-week cycle) for MM and ineligible for ASCT

Weeks	Schedule
Weeks 1 to 6	weekly (total of 6 doses)
Weeks 7 to 24[a]	every three weeks (total of 6 doses)
Week 25 onwards until disease progression[b]	every four weeks

[a] First dose of the every-3-week dosing schedule is given at Week 7

[b] First dose of the every-4-week dosing schedule is given at Week 25

Table 2. Darzalex Faspro dosing schedule as monotherapy for High-Risk Smoldering MM (4-week cycle)

Weeks	Schedule
Weeks 1 to 8	weekly (total of 8 doses)
Weeks 9 to 24[a]	every two weeks (total of 8 doses)
Week 25 onwards until diagnosis of multiple myeloma or a maximum of 3 years[b]	every four weeks

[a] First dose of the every-2-week dosing schedule is given at Week 9

[b] First dose of the every-4-week dosing schedule is given at Week 25

The efficacy of Darzalex Faspro in combination with bortezomib, lenalidomide and dexamethasone (Darzlex Faspro-VRd) as initial therapy for newly diagnosed MM patients who were ineligible for or refusing ASCT was evaluated in 395 patients in an open-label, active-controlled trial (CEPHEUS, NCT03652064). Median age was 70 years (range 31 to 80), 50% were male, 81% were White, 5% were Black or African American, and 6% were Asian. 34% of patients had ISS Stage I disease, 38% ISS Stage II, and 28% ISS Stage III. High-risk cytogenetics (presence of del(17p), t(4;14), t(14,16)) were present in 13% of patients.

Patients were randomized 1:1 to receive either Darzalex Faspro-VRd or VRd. Darzalex Faspro was given once weekly on weeks 1-6, once every three weeks on weeks 7-24, and once every 4 weeks on weeks 25 and on. The major efficacy outcomes were overall minimal residual disease (MRD) negativity rate and progression-free survival (PFS). The trial demonstrated a statistically significant improvement in overall MRD negativity rate, PFS, CR or better rate, and sustained MRD negativity rate. Results are summarized in Table 3 and Figure 1.

Table 3. Efficacy Outcomes from CEPHEUS

	DARZALEX FASPRO -VRd (N=197)	VRd (N=198)
PFS based on IRC[c]		
Number of events, n (%)	46 (23.4%)	68 (34.3%)
Median, months with 95% CI	NR (NE, NE)	NR (NE, NE)
Hazard ratio with 95% CI[d]	0.60 (0.41, 0.88)	
p-value[e]	0.0078	
MRD negativity rate n (%)[f,g]	103 (52.3%)	69 (34.8%)
p-value[h]	0.0005	
Overall CR or better (sCR+CR) n (%)[f]	150 (76.1%)	116 (58.6%)
p-value[h]	0.0002	
MRD negativity rate in patients with CR or better[f,i]		
Number of patients with CR or better	n=150	n=116
MRD negativity rate n (%)	103 (68.7%)	69 (59.5%)
95% CI (%)[j]	(60.6%, 76.0%)	(50.0%, 68.5%)
Sustained MRD negativity rate n (%)[c,k]	84 (42.6%)	50 (25.3%)
p-value[l]	0.0003	
Overall response (sCR+CR+VGPR+PR) n(%)[m]	191 (97.0%)	185 (93.4%)
Stringent Complete Response (sCR)	128 (65.0%)	89 (44.9%)
Complete response (CR)	32 (16.2%)	33 (16.7%)
Very good partial response (VGPR)	23 (11.7%)	49 (24.7%)
Partial response (PR)	8 (4.1%)	14 (7.1%)

VRd=bortezomib-lenalidomide-dexamethasone; PFS=progression-free survival; MRD=minimal residual disease; CI=confidence interval; NR = not reached; NE = not evaluable.

[a] Based on intent-to-treat population unless otherwise noted.

[b] The hierarchical testing order in the CEPHEUS study was overall MRD negativity rate followed by CR or better rate, PFS, and sustained MRD negativity rate.

[c] Interim analysis: Median follow-up of 39 months (cut-off date 08 September 2022).

[d] Hazard ratio and 95% CI from a Cox proportional hazards model with treatment as the sole explanatory variable and stratified with ISS staging (I, II, III), and age/transplant eligibility (<70 years ineligible, or <70 years and refusal to transplant, or ≥70 years) as randomized. A hazard ratio <1 indicates an advantage for D-VRd.

[e] p-value is based on the log-rank test stratified with ISS staging (I, II, III), and age/transplant eligibility (<70 years ineligible, or <70 years and refusal to transplant, or ≥70 years) as randomized.

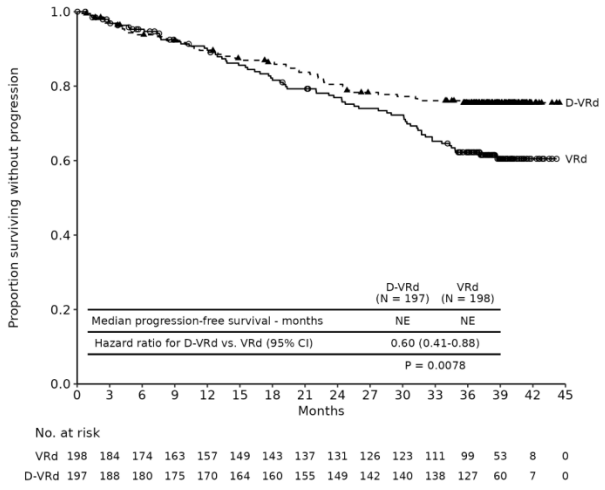
[f] Primary analysis: Median follow-up of 22 months (cut-off date 08 April 2021).

[g] Patients achieved both MRD negativity (threshold of 10^{-5}) and CR or better. All MRD testing was performed with a next-generation sequencing assay (clonoSEQ).

[h] p-value from Cochran Mantel-Haenszel Chi-Squared test.

[i] Patients achieving MRD negativity (threshold of 10^{-5}) among only patients achieving a response of CR or better.

Figure 1. Kaplan-Meier Curve of PFS in CEPHEUS[a]



[a] PFS median follow-up of 39 months

The efficacy of Darzalex Faspro as monotherapy for high-risk smoldering multiple myeloma was evaluated in AQUILA (NCT03301220), an open-label, randomized trial. 390 total patients were included in the study with a median age of 64 years (range 31 to 86), and 12% being 75 years or older. 48% of patients were male, 83% White, 8% Asian, and 3% were Black or African American. Of all patients, 41% had 2 or more high-risk criteria, which included: serum monoclonal protein level >2 g/dL, involved-to-uninvolved serum-free light chain ratio >20, and bone marrow plasma cells >20%.

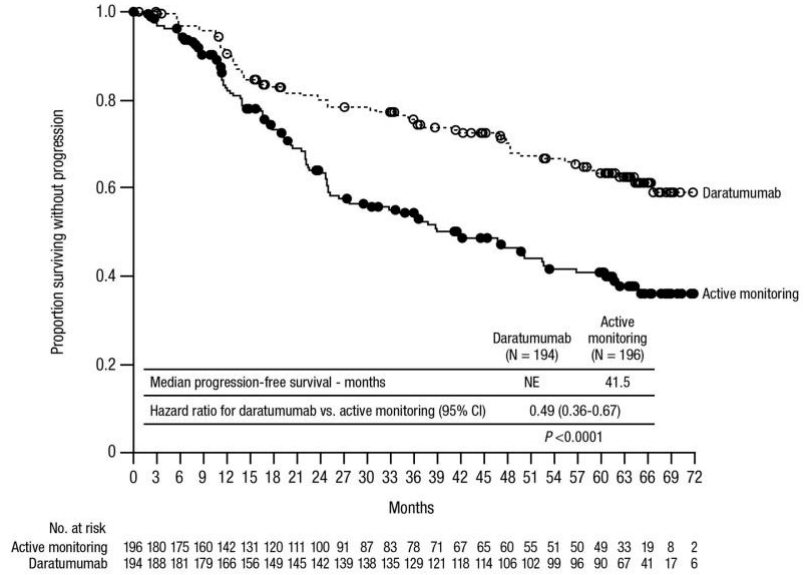
Patients were randomized 1:1 to receive either Darzalex Faspro or active monitoring. Darzalex Faspro was given as 1,800 mg/30,000 units once weekly from weeks 1-8, then once every 2 weeks from weeks 9-24, then once every 4 weeks from week 25-month 36, or until diagnosis to multiple myeloma or unacceptable toxicity. The major efficacy outcome was progression-free survival (PFS) within a 77 month time frame, defined as the duration from the date of randomization to the date of diagnosis of multiple myeloma or death. Overall response rates were measured as secondary outcomes. Results are summarized in Table 4 and Figure 2.

Table 4. Efficacy Results from AQUILA[a]

	DARZALEX FASPRO (n=194)	Active Monitoring (n=196)
Overall response (sCR+CR+VGPR+PR), n (%)[a]	123 (63.4%)	2 (1.0%)
Stringent complete response (sCR)	7 (3.6%)	0
Complete response (CR)	10 (5.2%)	0
Very good partial response (VGPR)	41 (21.1%)	1 (0.5%)
Partial response (PR)	65 (33.5%)	1 (0.5%)

[a] Based on intent-to-treat population per investigator assessment

Figure 2. Kaplan-Meier Curve of PFS in AQUILA



No new contraindications were added to the prescribing information with the new indications. Darzalex Faspro is contraindicated in patients with a severe hypersensitivity to daratumumab, hyaluronidase or any of the components of the formulation. One new warning and precaution was added, which is serious, life-threatening, or fatal infections. In smoldering MM and AL amyloidosis, serious infections occurred in 24% of patients, including fatal infections occurring in 2.5%. Other warnings and precautions include hypersensitivity reactions, cardiac toxicity in AL amyloidosis, neutropenia, thrombocytopenia, embryo-fetal toxicity, interference with serological testing, and interference with determination of complete response.

Serious adverse events occurred in 72% of patients who received Darzalex Faspro-VRd in CEPHEUS, including pneumonia (19%), COVID-19 (12%), thromboembolism (7%) and diarrhea (6%). Fatal adverse reactions included pneumonia (4%), COVID-19 (4%), and myocardial infarction (2%). Permanent discontinuation due to an adverse reaction occurred in 8% of patients. Median duration of treatment with Darzalex Faspro-VRd was about 56 months and for VRd was about 34 months.

Serious adverse reactions occurred in 29% of patients who received Darzalex Faspro in AQUILA, including pneumonia (7%), fracture (3%), sepsis (2%), and upper respiratory tract infection (2%). Fatal

adverse reactions included COVID-19 (0.5%) and pneumonia (0.5%). Permanent discontinuation due to adverse events occurred in 6% of patients. Median duration of treatment with Darzalex Faspro was 35 months.

Current Formulary Status: Medical benefit requiring prior authorization. If processed at a specialty pharmacy, Specialty tier or the Brand Non-preferred tier for members with a three tier benefit.

Recommendation: There are no changes recommended to the formulary placement or quantity limit of Darzalex Faspro. It is recommended to change the prior authorization criteria and authorization duration for MBP 230.0.

MBP 230.0 Darzalex Faspro (daratumumab/hyaluronidase)

Multiple Myeloma

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

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

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

AND

- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

OR

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

- Medical record documentation that the member is eligible for stem-cell transplantation **AND**
- Medical record documentation that Darzalex Faspro will be given in combination with one of the following options:
    - Bortezomib (Velcade)*, lenalidomide (Revlimid)*, and dexamethasone **OR**
    - Bortezomib (Velcade)*, thalidomide (Thalomid)*, and dexamethasone (DVTd) **OR**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

If relapsed/refractory multiple myeloma:

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

(Ninlaro)*] AND Darzalex Faspro will be prescribed in combination with pomalidomide (Pomalyst)* and dexamethasone **OR**

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one prior therapy including a proteasome inhibitor [including but not limited to bortezomib (Velcade)*, carfilzomib (Kyprolis)*, or ixazomib (Ninlaro)*] or an immunomodulatory agent [including but not limited to pomalidomide (Pomalyst)*, lenalidomide (Revlimid)*, thalidomide (Thalomid)*] AND one of the following:
  - Medical record documentation that Darzalex Faspro will be prescribed in combination with lenalidomide (Revlimid)* and dexamethasone **OR**
  - Medical record documentation that Darzalex Faspro will be prescribed in combination with bortezomib (Velcade)* and dexamethasone **OR**
  - Medical record documentation that Darzalex Faspro will be prescribed in combination with carfilzomib (Kyprolis)* and dexamethasone

AND

- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

High-risk smoldering multiple myeloma

- Prescription written by or in consultation with and hematologist/oncologist **AND**
- Medical record documentation of a diagnosis of high-risk smoldering multiple myeloma **AND**
- Medical record documentation that Darzalex Faspro will be used as monotherapy **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Light-chain (AL) amyloidosis

- Prescription written by or in consultation with and hematologist/oncologist **AND**
- Medical record documentation of a diagnosis of light-chain (AL) amyloidosis **AND**
- Medical Record documentation that the patient does NOT have New York Heart Association (NYHA) Class IIIB (defined by marked limitation of physical activity, comfortable at rest, less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain, symptomatic with recent history of dyspnea at rest) or Class IV heart failure, or mayo cardiac stage IIIB **AND**
- Medical record documentation that Darzalex Faspro will be used in combination with bortezomib (Velcade)*, cyclophosphamide and dexamethasone **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Note: Mayo Cardiac Stage IIIB defined as NT-proBNP > 8500 ng/L
*Prior authorization may be required

AUTHORIZATION DURATION ~~(all diagnoses except light-chain (AL) amyloidosis)~~:
Multiple Myeloma
Initial approval will be for 3 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 the following:

- Continued disease improvement or lack of disease progression **AND**
- An FDA approved dose and dosing interval

The medication will no longer be covered if patient experiences toxicity or worsening of disease or a non-FDA approved dose or dosing interval.

For requests exceeding United States Food and Drug Administration (FDA) labeling, National Comprehensive Cancer Network® (NCCN), or indication specific peer-reviewed literature, 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

High-Risk Smoldering Multiple Myeloma
Initial approval will be for 3 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 the following:
- Continued disease improvement or lack of disease progression **AND**
- An FDA approved dose and dosing interval

The medication will no longer be covered if patient experiences toxicity or worsening of disease or a non-FDA approved dose or dosing interval.

Authorization of Darzalex Faspro for light-chain (AL) amyloidosis should not exceed the FDA-approved treatment duration of 3 years (36 months). 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

Light Chain (AL) Amyloidosis
Initial approval will be for 3 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 the following:
- Continued disease improvement or lack of disease progression **AND**
- An FDA approved dose and dosing interval.

The medication will no longer be covered if patient experiences toxicity, worsening of disease, or a non-FDA approved dose or dosing interval.

Authorization of Darzalex Faspro for light-chain (AL) amyloidosis should not exceed the FDA-approved treatment duration of 2 years (24 months). 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

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

DUPIXENT (dupilumab)

Clinical Summary: Dupixent is now indicated for the treatment of adult and pediatric patients aged 12 years and older with chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment.

The recommended dosage of Dupixent in adult patients for CSU is 600 mg (two 300 mg injections), followed by 300 mg given every 2 weeks (Q2W). For pediatric patients, the recommended dosage is based on weight (Table 1).

Table 1. Pediatric Weight Based Dose

Body Weight	Initial Loading Dose	Subsequent Dosage
30 to less than 60 kg	400 mg (two 200 mg injections)	200 mg every 2 weeks (Q2W)
60 kg or more	600 mg (two 300 mg injections)	300 mg every 2 weeks (Q2W)

The efficacy of Dupixent was evaluated in the CUPID trial which include three 24-week, randomized, double-blind, parallel-group, placebo-controlled trials followed by a 12-week blinded safety follow-up periods. Efficacy was based on results from CUPID Study A and Study C which included 284 adults and pediatric patients 12 years and older with chronic spontaneous urticaria who remain symptomatic despite

H1 antihistamine treatment and were anti-IgE treatment naïve. CUPID Study B included patients who remained symptomatic despite H1 antihistamine and anti-IgE treatment and failed to meet the primary endpoint. Patients included in the trial had an Itch Severity Score over 7 days (ISS7) ≥ 8 (scale 0 to 21) and Urticaria Activity Score over 7 days (UAS7) ≥ 16 (scale 0 to 42). Patients were randomized to receive Dupixent or placebo, with patients weighing ≥ 60 kg receiving Dupixent 600 mg on Day 1, followed by 300 mg every 2 weeks and patients 30 kg to less than 60 kg receiving Dupixent 400 mg on Day 1, followed by 200 mg every 2 weeks.

The primary endpoint was change from baseline in ISS7 at Week 24. The ISS7 score is the sum of daily itch severity scores, from 0 to 3, recorded at the same time for a 7 day period. The key secondar endpoint was change from baseline in UAS7 at Week 24. The UAS7 was a composite of the weekly itch severity score (ISS7) and the weekly hive count score (HSS7, range 0 to 21). Results are shown in Table 2.

Table 2. Efficacy results in CUPID Study A and Study C

	CUPID Study A			CUPID Study C		
	DUPIXENT (N=68)	Placebo (N=68)	DUPIXENT vs. Placebo (95% CI)	DUPIXENT (N=73)	Placebo (N=75)	DUPIXENT vs. Placebo (95% CI)
Primary Endpoint						
Change from baseline in ISS7 at Week 24[a]	-10.44 (0.92)	-6.02 (0.94)	-4.42 (-6.84, -2.01)[b]	-8.50 (1.39)	-6.13 (1.38)	-2.37 (-4.48, -0.27)[b]
Secondary Endpoints						
Change from baseline in UAS7 at Week 24[a]	-20.99 (1.77)	-11.95 (1.81)	-9.04 (-13.68, -4.40)[b]	-15.61 (2.62)	-11.27 (2.61)	-4.34 (-8.31, -0.36)[b]
Change from baseline in HSS7 at Week 24[a]	-10.54 (0.91)	-5.85 (0.93)	-4.69 (-7.08, -2.30)[b]	-7.16 (1.30)	-5.15 (1.29)	-2.01 (-3.98, -0.04)[b]
Proportion of patients with UAS7 ≤6 at Week 24[a]	32 (47.1)	16 (23.5)	3.23 (1.43, 7.27)[c]	29 (39.7)	17 (22.7)	3.05 (1.32, 7.02)[c]
Proportion of patients with UAS7 = 0 at Week 24[a]	22 (32.4)	9 (13.2)	3.09 (1.24, 7.69)[c]	22 (30.1)	13 (17.3)	2.73 (1.15, 6.50)[c]

[a] Values presented are LS mean change from baseline (SE) for continuous variables and number and percent of responders for binary variables.
[b] Values presented are LS mean differences.
[c] Values presented are odds ratios.

Safety findings from CUPID Study A and Study C were consistent with the known safety profile of Dupixent and no new safety signals were identified.

Current Formulary Status:

2 Tier/CHIP	3 Tier	4 Tier	ACA
Tier 2 – Brand	Tier 3 – Brand NP	Tier 4 – Specialty tier	Tier 6 – Specialty tier

Requires a prior authorization, QL: 200 mg/1.14 mL: 2.28 mL per 28 days, 300 mg/2 mL: 4 mL per 28 days, Authorization duration: Initial 6 months, subsequent 12 months

Recommendation: There are no changes recommended for the formulary placement of Dupixent. The following criteria should be added to Commercial Policy 457.0 to incorporate the new indications.

Chronic Spontaneous Urticaria:

- Medical record documentation that Dupixent is prescribed by an allergist, immunologist, or dermatologist **AND**
- Medical record documentation of age greater than or equal to 12 years of age **AND**
- Medical record documentation of a diagnosis of moderate-to-severe chronic spontaneous urticaria **AND**

- Medical record documentation of at least 6 week history of symptoms (e.g., hives associated with itching, angioedema) **AND**
- Medical record documentation that the member is receiving an appropriate dose# based on patient's age and weight
- Medical record documentation of contraindication to, therapeutic failure on, or intolerance to a four week trial of ALL of the following treatment alternatives:
    - At least two different high dose antihistamines
    - Maximum dose antihistamine(s) used in combination with a leukotriene receptor antagonist (e.g., montelukast)
    - High dose antihistamine used in combination with H2 receptor antagonist (e.g., ranitidine
    - Dose advancement of potent antihistamine (e.g., hydroxyzine or doxepin)

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. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

- Medical record documentation of continued disease improvement or lack of disease progression AND
- Medical record documentation that the member is receiving an appropriate dose# based on patient's age and weight

#Note: The recommended dosage for adults and pediatric patients 12 years of age and older weighing at least 60 kg is 600 mg loading dose followed by 300 mg every 2 weeks. The recommended dosage for pediatric patients 12 years of age and older weighing 30 to less than 60 kg is 400 mg loading dose followed by 200 mg every 2 weeks.

QUANTITY LIMIT

- **Initial Approval**
    - 600 mg once, followed by 300 mg every <u>other</u> week
        1. In NCRx: Add Treat as "Include" Process Modifier, Ignore Misc Handler, DS, enter 1 in max number of claims authorized, max quantity dispensed 8, minimum day supply 42, and maximum day supply 42 with a duration of two-weeks.
        2. In PA Hub: Add Treat as "Include" Process Modifier, Ignore Misc Handler, and max quantity dispensed 4 with a start date 1 day after the loading dose ends for the remainder of the authorization.
            - QL FOR LETTER: Loading dose: 8 mL per 42 days, Maintenance dose: 4 mL per 28 days
    - 400 mg once, followed by 200 mg every other week
        2. In NCRx: Add Treat as "Include" Process Modifier, Ignore Misc Handler, DS, enter 1 in max number of claims authorized, max quantity dispensed 4.56, minimum day supply 42, and maximum day supply 42 with a duration of two-weeks.
        3. In PA Hub: Add Treat as "Include" Process Modifier, Ignore Misc Handler, and max quantity dispensed 2.28 with a start date 1 day after the loading dose ends for the remainder of the authorization.
            - QL FOR LETTER: Loading dose: 4.56 mL per 42 days, Maintenance dose: 2.28 mL per 28 days
- **Renewal –**
    - 300 mg every other week
        1. In PA Hub: Add Treat as "Include" Process Modifier, Ignore Misc Handler, and max quantity dispensed 4
            - QL FOR LETTER: 4 mL per 28 days
    - 200 mg every other week
        2. In PA Hub: Add Treat as "Include" Process Modifier, Ignore Misc Handler, and max quantity dispensed 2.28
            - QL FOR LETTER: 2.28 mL per 28 days

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

EPKINLY (epcoritamab-bysp)

Clinical Summary: The FDA approved epcoritamab-bysp (Epkinly) with lenalidomide and rituximab for relapsed or refractory follicular lymphoma (FL). The approval of epcoritamab-bysp with lenalidomide and rituximab (R2) was based on EPCORE FL-1 (NCT05409066) which was a randomized, multicenter, open label trial that included 488 patients who had failed at least one line of systemic therapy. Patients enrolled in the study were randomized 1:1 to receive epcoritamab-bysp plus R2 or R2 alone. The recommended EPKINLY dosage schedule was:

- Cycle 1: EPKINLY 0.16 mg SUBQ on Day 1, 0.8 mg on Day 8, 3 mg on Day 15 and 48 mg on Day 22
- Cycles 2-3: EPKINLY 48 mg SUBQ on Days 1, 8, 15, and 22
- Cycles 4-12: EPKINLY 48 mg SUBQ on Day 1

In both treatment arms, lenalidomide was given orally at a dose of 20 mg once daily from Days 1 to 21 for 12 cycles and Rituximab was administered intravenously at a dose of 375 mg/m2 on Days 1, 8, 15, and 22 of Cycle 1, followed by administration on Day 1 of Cycles 2 to 5.

Efficacy was determined based on progression free survival (PFS) and overall response rate (ORR). The PFS hazard ratio was 0.21 (95% CI: 0.13, 0.33; p-value <0.0001). The median PFS was not reached (NR) (95% CI: 21.9 months, NR) in the epcoritamab-bysp arm and was 11.2 months (95% CI: 10.5, NR) in the control arm. The ORR was 89% (95% CI: 84, 93) in the epcoritamab-bysp arm and 74% (95% CI: 68, 79) in the control arm. Based on this data, it is evident that this study demonstrated superiority of PFS and ORR in the epcoritamab-bysp arm compared to the R2 alone arm.

Outcome per IRC	**EPKINLY + Lenalidomide and Rituximab (N=243)**	**Lenalidomide and Rituximab (N=245)**
PFS		
Number of events, n (%)	23 (9)	75 (31)
Progressive disease	19 (83)	63 (84)
Death	4 (17)	12 (16)
Median (95% CI), months	NR (21.9, NR)	11.2 (10.5, NR)
Hazard ratio[a] (95% CI)	0.21 (0.13, 0.33)	
P-value[b]	< 0.0001	
ORR, n (%)	216 (89)	181 (74)
(95% CI)	(84, 93)	(68, 79)
P-value[c,d]	< 0.0001	
CR, n (%)	181 (74)	106 (43)
(95% CI)	(69, 80)	(37, 50)

The prescribing information includes boxed warnings for cytokine release syndrome (CRS) and immune effector cell-associated neurotoxicity syndrome (ICANS), as well as warnings and precautions for infections and cytopenias. Serious adverse reactions occurred in 51% of the patients in the epcoritamab-

bysp arm, including serious infections in 28%. CRS occurred in 24% of patients, including serious CRS in 12%. ICANS occurred in 0.8%. Other common reactions were rash, URI, fatigue, injection site reactions, constipation, diarrhea, pneumonia, COVID-19, and fever.

Due to the risk of CRS and ICANS, Epkinly must be administered by a health care provider.

Current Formulary Status: Medical benefit only with prior authorization required

Recommendation: There are no changes recommended for the formulary placement of Epkinly. The following will be added to medical benefit policy 290.0

Follicular Lymphoma

- Medical record documentation of age greater than or equal to 18 years AND
- Medical record documentation that epcoritamab-bysp is written by a hematologist or oncologist AND
- Medical record documentation of a diagnosis of relapsed or refractory follicular lymphoma (FL) AND
- Medical record documentation of prior therapy with at least two lines of systemic therapy OR
- Medical record documentation that epcoritamab-bysp is being used in combination with lenalidomide and rituximab

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.

For the treatment of FL in combination with lenalidomide and rituximab: Initial approval will be for 6 months. One subsequent approval will be for an additional 6 months 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.

- Authorization of Epkinly for the treatment of FL in combination with lenalidomide and rituximab should not exceed the FDA-approved treatment duration of 1 year (12 months).

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

EVKEEZA (evinacumab-dgnb)

Clinical Summary: Updated Indication[1]: Evkeeza is an angiopoietin-like 3 (ANGPTL3) inhibitor previously indicated as an adjunct to other low-density lipoprotein-cholesterol (LDL-C) lowering therapies for the treatment of adult and pediatric patients, aged 5 years and older, with homozygous familial hypercholesterolemia (HoFH). It is now approved in adults and pediatrics patients, aged 1 year and older.

Updated Dosing for New indication[1]: There is no new dosing for the updated indication. The recommended dosage of Eveeza is 15mg/kg administered by intravenous (IV) induction over 60 minutes once a month (every 4 weeks).

Summary of Updated Clinical Studies[1]: The safety and effectiveness of Evkeeza as an adjunct to other LDL-C lowering therapies for the treatment of HoFH have been established in pediatric patients aged 1 year and older. Use of Evkeeza for this indication is supported by evidence from adequate and well controlled trials in adults with additional pharmacokinetic, efficacy and safety data. For Pediatric patients, aged 1 to less than 5 years with HoFH, clinical data was collected through an expanded access program.

This program required each patient's treating physician to provide adequate documentation to demonstrate that the patient met the eligibility criteria for the program and to provide effectiveness information including LDL-C values. The efficacy of Evkeeza was evaluated in 6 patients aged 1 to less than 5 years with HoFH. Patients received 15mg/kg Evkeeza every 4 weeks for up to 98 weeks. Administration of Evkeeza resulted in a reduction of LDL-C [mean (standard deviation changed at Week 40 of -60% (16.8)].

Summary of Updated Safety Considerations[1]: No new safety considerations. The safety profile of Evkeeza in pediatric patients aged 1 to 11 years was similar to the safety profile in adults and pediatric patients aged 12 years and older.

Current Formulary Status: Evkeeza is on the Medicare pharmacy at the specialty tier requiring a prior authorization.

Recommendation: There are no changes recommended to the formulary placement or authorization duration for Evkeeza. The following changes are recommended to the prior authorization criteria in Medical benefit policy 242.0:

- Medical record documentation of a diagnosis of homozygous familial hypercholesterolemia (HoFH) **AND**
- Medical record documentation of one of the following:
    - Genetic testing to confirm diagnosis showing a mutation in the low-density lipoprotein (LDL) receptor (LDLr) gene, apolipoprotein B (ApoB) gene, proprotein convertase subtilisin/kexin type 9 (PCSK9) gene, or LDL protein receptor adaptor 1 (LDLRAP1) gene **OR**
    - Diagnosis made based on history of an untreated low-density lipoprotein cholesterol (LDL-C) greater than 500 mg/dL **AND** either xanthoma before 10 years of age OR evidence of heterozygous familial hypercholesterolemia (HeFH in both parents)

AND

- Medical record documentation that Evkeeza is prescribed by a lipidologist or cardiologist **AND**
- Medical record documentation of age greater than or equal to 1 year ~~5 years~~ **AND**
- Medical record documentation of failure to adequately control low-density lipoprotein (LDL) levels with combination of maximum tolerated statin dose AND ezetimibe defined as:
    - Greater than or equal to 130 mg/dL in pediatric patients greater than or equal to 1 year ~~5 years~~ of age and less than 18 years of age OR
    - Greater than or equal to 100 mg/dL in adult patients without cardiovascular disease OR
    - Greater than or equal to 70 mg/dL in adult patients with established cardiovascular disease

AND

- Medical record documentation of Evkeeza to be used in adjunct with maximum tolerated statin dose **AND**
- For members greater than or equal to 10 years of age, medical record documentation of therapeutic failure on, intolerance to, or contraindication to one formulary proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor **AND**
- If the request is for use in combination with Juxtapid:
    - Medical record documentation of failure to adequately control low-density lipoprotein (LDL) levels with a minimum 6-month trial of maximum tolerated Juxtapid dose without the concomitant use of Evkeeza

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

GAZYVA (obinutuzumab)

Clinical Summary: Gazyva (obinutuzumab) is an anti-CD20 monoclonal antibody. The CD20 antigen is expressed on the surface of pre B- and mature B-lymphocytes; upon binding to CD20, obinutuzumab activates complement-dependent cytotoxicity, antibody-dependent cellular cytotoxicity and antibody-dependent cellular phagocytosis, resulting in cell death. Gazyva was previously FDA approved for treatment of chronic lymphocytic leukemia (CLL) and follicular lymphoma (FL).

Updated Indication: Gazyva gained FDA approval for treatment of adult patients with active lupus nephritis (LN) who are receiving standard therapy on 10/20/2025, expanding its indications outside of oncology. With this new indication Gazyva became the only anti-CD20 monoclonal antibody to demonstrate a complete renal response benefit in lupus nephritis in a randomized phase III study.

Lupus nephritis affects more than 1.7 million people worldwide, predominantly women of color and childbearing age, with up to one-third of patients progressing to end-stage kidney disease. LN is a kidney disease that results as a complication of SLE and affects approximately 50% of people at the time of SLE diagnosis. Around 10-20% of patients will develop LN during the first 10 years of an SLE diagnosis. About 10% of patients with LN will develop ESRD. All patients with SLE should be evaluated for LN at the time of initial diagnosis and then at least annually or upon an SLE flare. Proteinuria is usually the first sign leading to an LN diagnosis.

Elevated anti-double-stranded-DNA titers and low complement (C3 and C4) levels often indicate active SLE, particularly LN, although this can differ among patients. The diagnosis is confirmed by a kidney biopsy which establishes the classification to guide treatment. Immunosuppressive therapy is used to treat active class III, class IV, or class V. It is usually not used to treat class I, class II, or class VI. Class I (minimal mesangial) and Class II (mesangial proliferative) generally do not require specific therapy. Class III (focal) and Class IV (diffuse) are active, chronic classifications at high risk of developing ESRD and will require pharmacologic therapies. Class V (membranous) presents similar to nephrotic syndrome with subendothelial deposits. Patients with Class III or IV disease may also have these deposits and can be classified as Class III or IV in combination with Class V. Class VI have sclerosing lesions and generally do not respond to immunosuppressive therapy; treatment for this population requires dialysis and/or kidney transplant.

Updated Dosing for New indication: The recommended dosage for active lupus nephritis is 1,000 mg at the initial infusion, week 2, 24, 26, and every 6 months thereafter. Gazyva should only be administered by a healthcare professional to manage severe infusion-related reactions that can be fatal if they occur. The FDA approval also allows for a shorter infusion time of 90 minutes after the first infusion in select patients after the initial infusion. The initial dose should be administered at a rate of 50 mg/hr and escalated in 50 mg/hr increments every 30 minutes to a maximum of 400 mg/hr. Subsequent doses should be administered at a rate of 100 mg/hr and escalated at a rate of 100 mg/hr to a maximum of 400 mg/hr. Patients who do not experience Grade 3 or above infusion related reactions (IRR) during the first infusion may receive GAZYVA over approximately 90 minutes from Dose 2 onward using an infusion rate of 100 mg/hr for 30 minutes and then 900 mg/hr for approximately 60 minutes. Premedication with an intravenous glucocorticoid, acetaminophen, and an antihistamine are required for all patients to minimize infusion related reactions regardless of dose or rate of infusion.

Summary of Updated Clinical Studies: The efficacy of GAZYVA was evaluated in REGENCY (NCT04221477), a Phase III, randomized, double-blind, placebo-controlled, parallel-group, multicenter study in 271 patients with Class III or IV, with or without concomitant Class V lupus nephritis (LN), treated with standard therapy consisting of mycophenolate mofetil (MMF) and corticosteroids. Inclusion criteria were active or active/chronic Class III or IV, with or without concomitant Class V proliferative LN determined by kidney biopsy, current or past positive antinuclear antibody (ANA), urine protein-to-creatinine ratio (UPCR) ≥ 1 g/g, and had received at least one dose of pulse intravenous (IV) methylprednisolone (≥ 250 mg) or equivalent treatment for LN during the 6 months prior to screening or during screening. Exclusion criteria were estimated glomerular filtration rate (eGFR) <30 ml/min/1.73 m2 or in need of dialysis or transplantation, with sclerosis in > 50% of glomeruli on kidney biopsy, presence of

rapidly progressive glomerulonephritis, evidence of active infection, receipt of anti-CD20 therapy < 9 months before or during screening, or receipt of cyclophosphamide, tacrolimus, ciclosporin, or voclosporin within 2 months of or during screening. Patients were randomized 1:1 to receive GAZYVA 1,000 mg (N=135) or placebo (N=136) intravenously, in combination with MMF 2-2.5 g/day and a tapering course of corticosteroids and were evaluated over 76 weeks. Patients randomized to receive GAZYVA were further randomized in a 1:1 ratio to receive either GAZYVA 1,000 mg IV on Day 1, Weeks 2, 24, 26, 50, and 52 (Arm 1), or GAZYVA 1,000 mg IV on Day 1, Weeks 2, 24, 26, and 52 (Arm 2). All patients received oral prednisone 0.5 mg/kg/day (maximum 60 mg/day) and remained at this dose until Week 2. Beginning on Day 15, prednisone was tapered to achieve a target dose of 5 mg/day by Week 24. Prednisone was maintained at a low dose (5 mg/day) from Week 24 until Week 80.

The primary endpoint measure was proportion of patients who achieved complete renal response (CRR) at Week 76, defined as meeting all of the following criteria: UPCR < 0.5 g/g; eGFR ≥ 85% of baseline, with no occurrence of the following intercurrent events: rescue therapy, treatment failure, death or early study withdrawal. Key secondary endpoint measures included: proportion of patients who achieved CRR with successful prednisone taper at Week 76 (defined as achievement of CRR at Week 76 without receiving prednisone > 7.5 mg/day or equivalent from Week 64 through Week 76), proportion of patients who achieved a proteinuric response at Week 76 (defined as achievement of UPCR < 0.8g/g and no occurrence of the following intercurrent events: rescue therapy, treatment failure, death or early study withdrawal) and proportion of patients who experience “renal-related events or deaths” through Week 76 (defined as occurrence of death, treatment failure, ≥ 50% increase in UPCR to a value ≥ 3 g/g and/or ≥ 30% decrease in eGFR to < 60 ml/min/1.73 m2).

The proportion of patients achieving CRR at Week 76 was significantly greater in patients treated with GAZYVA in combination with standard therapy compared to patients who received placebo plus standard therapy (46.4 % vs 33.1%). There were also a higher proportion of patients who achieved CRR with successful prednisone taper at Week 76 (42.7% vs 30.9%) and proteinuric response at Week 76 (55.5% vs 41.9%) in the GAZYVA plus standard therapy arm compared to the placebo plus standard therapy arm. Patients who received GAZYVA were less likely to experience the outcome of “renal-related event or death” compared with placebo (17.8% vs 33.8%). Subgroup analysis examining the primary endpoint was examined based on 24-hour UPCR at baseline (< 3 g/g or ≥ 3 g/g), lupus nephritis class at baseline (Class III or IV), and concomitant Class V at baseline all favored Gazyva treatment group vs placebo.

Summary of Efficacy Results in Adult Patients with Active Lupus Nephritis (REGENCY Trial)

	Gazyva + Standard Therapy (n=135)	**Placebo + Standard Therapy** (n=136)	**Adjusted Difference (95% CI)**
Primary Endpoint:			
Complete Renal Response (CRR) at Week 76 - % (95% CI) p-value: 0.02	46.6 (38.0-54.9)	33.1 (25.2-41.0)	13.4 (2.0-24.8)
Secondary Endpoints:			
CRR at week 76 with prednisone taper to <= 7.5 mg/day between weeks 64-76- % (95% CI) p-value: 0.04	42.7 (34.3 – 51.1)	30.9 (23.1-38.7)	11.9 (06-23.2)
UPCR < 0.8 at week 76 with no intercurrent event - % (95% CI) p-value: 0.02	55.5 (47.1 – 64.0)	41.9 (33.6-50.2)	13.7 (2.0-25.4)

Summary of Updated Safety Considerations: No new or unexpected safety issues were identified during the REGENCY trial, the trial reaffirmed Gazyva's existing safety profile from oncology use and prior clinical experiences.

Current Formulary Status: Medical Benefit requiring prior authorization

Recommendation: There are no changes recommended to the formulary placement of Gazyva. It is recommended to change the prior authorization criteria and authorization duration for MBP 113.0.

1. **Chronic Lymphocytic Leukemia (CLL)**
    - Prescribed by a hematologist/oncologist AND
    - Medical record documentation of previously untreated chronic lymphocytic leukemia AND
    - Medical record documentation that Gazyva will be used in combination with chlorambucil

AUTHORIZATION DURATION for CLL: 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.

2. **Follicular Lymphoma**
    - Medical record documentation of a diagnosis of follicular lymphoma AND
    - For first line therapy:
        - Medical record documentation of previously untreated stage II bulky, III or IV follicular lymphoma AND
        - Medical record documentation that Gazyva will be used in combination with chemotherapy

    OR

        - Medical record documentation that the patient has achieved at least a partial remission of stage II bulky, III, or IV follicular lymphoma if previously treated with at least 6 cycles of Gazyva in combination with chemotherapy AND
        - Medical record documentation that Gazyva will be used as monotherapy

    - For second line or subsequent therapy:
        - Medical record documentation that the patient has relapsed after, or is refractory to, a rituximab-containing regimen AND
        - Medical record documentation that Gazyva is being used in combination with bendamustine

        OR

        - Medical record documentation that the patient achieved a complete response, partial response, or has stable disease after at least 6 cycles of Gazyva in combination with bendamustine AND
        - Medical record documentation that Gazyva will be used as monotherapy.

*Note: In clinical trials for the treatment of stage II bulky, III or IV follicular lymphoma chemotherapy was defined as: CHOP (cyclophosphamide, doxorubicin, vincristine and prednisone); CVP (cyclophosphamide, vincristine and prednisone); or bendamustine

AUTHORIZATION DURATION for follicular lymphoma: Initial approval will be 6 months for this indication. The following criteria should apply to reauthorization requests for Gazyva:

- Medical record documentation that the patient achieved a complete response, partial response, or has stable disease after 6 cycles of Gazyva + bendamustine therapy OR after 6 cycles of Gazyva + chemotherapy AND
- Documentation that Gazyva will be used as monotherapy.

Subsequent authorization duration should be 24 months as data does not extend past this point.

3. Active Lupus Nephritis

- Medical record documentation of age greater than or equal to 18 years **AND**
- Physician provided documentation of a diagnosis of active lupus nephritis, Class III, IV, V alone or in combination, confirmed by a kidney biopsy **AND**
- Gazyva will be prescribed in combination with standard therapy (e.g. mycophenolate mofetil (MMF), corticosteroids, cyclophosphamide, azathioprine) **AND**
- Prescription written by or in consultation with a rheumatologist or nephrologist **AND**
- Medical record documentation of a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Rationale: This policy closely mimics the policy for use of Benlysta for treatment of active Lupus Nephritis and aligns with FDA approved indication found on Gazyva label. Limitation to class III, IV, and V is based on current treatment guidelines along with standard therapy.

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 Gazyva (e.g. improvement/stabilization in UPCR, eGFR, renal-related events) **AND**
- Medical record documentation that Gazyva will be prescribed in combination with standard therapy (e.g. mycophenolate mofetil (MMF), corticosteroids, cyclophosphamide, azathioprine) **AND**
- Medical record documentation of a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

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

IMFINZI (durvalumab)

Clinical Summary: Imfinzi is now indicated for use in combination with fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) chemotherapy as neoadjuvant and adjuvant treatment, followed by single agent IMFINZI, for the treatment of adult patients with resectable gastric or gastroesophageal junction adenocarcinoma (GC/GEJC).

Updated Dosing for New indication: Resectable GC/GEJC: Weight ≥ 30 kg: Neoadjuvant: IMFINZI 1,500 mg in combination with FLOT chemotherapy every 4 weeks for up to 2 cycles prior to surgery. Adjuvant: IMFINZI 1,500 mg in combination with FLOT chemotherapy, every 4 weeks for up to 2 cycles and then 1,500 mg as a single agent every 4 weeks for up to 10 cycles, for a total of up to 12 cycles after surgery. Weight < 30 kg: Neoadjuvant: IMFINZI 20 mg/kg in combination with FLOT chemotherapy every 4 weeks for up to 2 cycles prior to surgery. Adjuvant: IMFINZI 20 mg/kg in combination with FLOT chemotherapy, every 4 weeks for up to 2 cycles and then 20 mg/kg as a single agent every 4 weeks for up to 10 cycles, for a total of up to 12 cycles after surgery.

Current Formulary Status: Medical benefit medication requiring prior authorization

Recommendation: Recommend adding the following prior authorization criteria to MBP policy 156.0 for the new indication of use in combination with fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) chemotherapy as neoadjuvant and adjuvant treatment, followed by single agent IMFINZI, for the treatment of adult patients with resectable gastric or gastroesophageal junction adenocarcinoma (GC/GEJC).

9. Neoadjunctive/Adjunctive Resectable Gastric/Gastroesophageal Junction Adenocarcinoma (GC/GEJC)

• Medical record documentation that Imfinzi 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 resectable gastric or gastroesophageal adenocarcinoma (GC/GEJC) AND

• Medical record documentation that Imfinzi is being used in the neoadjuvant setting in combination with fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) chemotherapy for 2 cycles prior to and 2 cycles after surgery, then Imfinzi is being continued as a single agent in the adjuvant setting for up to 10 cycles.

AUTHORIZATION DURATION: Neoadjunctive/Adjunctive Resectable Gastric/Gastroesophageal Junction Adenocarcinoma (GC/GEJC): One approval for 18 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 Imfinzi for the neoadjuvant treatment of GC/GEJC should not exceed the FDA-approved maximum treatment duration of 14 cycles (2 cycles of neoadjuvant treatment prior to surgery and 12 cycles as adjuvant treatment after surgery). 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.

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

KEYTRUDA AND KEYTRUDA QLEX (pembrolizumab; pembrolizumab/berahyaluronidase)

Clinical Summary: Keytruda (pembrolizumab) and Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) are now indicated in combination with Padcev (enfortumab vedotin), as neoadjuvant treatment, and then continued after cystectomy as adjuvant treatment of adult patients with muscle invasive bladder cancer (MIBC) who are ineligible for cisplatin-containing chemotherapy.

Updated Dosing: There are no changes to the recommended dosage of Keytruda for the change in indication. The recommended dosage of Keytruda when given in combination with Padcev for urothelial carcinoma is 200 mg IV once every 3 weeks **or** 400 mg IV once every 6 weeks; continue until disease progression, unacceptable toxicity, or (in patients without disease progression) for up to 24 months

Summary of Updated Clinical Studies: These approvals are based on data from the Phase 3 KEYNOTE-905 trial, an open-label, multicenter, randomized, active-controlled trial that evaluated perioperative Keytruda, with or without Padcev, versus surgery alone in patients with MIBC who were either not eligible for or declined cisplatin-based chemotherapy. The trial enrolled 344 patients who were randomized 1:1 to receive either:

- Neoadjuvant Keytruda 200 mg over 30 minutes as an intravenous infusion on Day 1 and Padcev 1.25 mg/kg as an intravenous infusion on Days 1 and 8 of each 21 day cycle for 3 cycles prior to surgery, followed by adjuvant Keytruda 200 mg over 30 minutes on Day 1 of each 21 day cycle for 14 cycles and Padcev 1.25 mg/kg on Days 1 and 8 of each 21 day cycle for 6 cycles (n=170).
- Immediate radical cystectomy (RC) and pelvic lymph node dissection (PLND) alone (n=174).

Treatment continued until completion of study medications, disease progression, not undergoing or refusal of RC and PLND, disease recurrence in the adjuvant phase, or unacceptable toxicity. Assessment

of tumor status was performed at baseline, within 5 weeks prior to RC and PLND, and at 6 weeks post radical cystectomy. Following RC and PLND, assessment of tumor status was performed every 12 weeks up to 2 years, and every 24 weeks thereafter. The trial was not designed to isolate the effect of Keytruda in each phase (neoadjuvant or adjuvant) of treatment.

The major efficacy outcome measure of this trial was event-free survival (EFS), defined as the time from randomization to the first of: disease progression preventing curative surgery, failure to undergo surgery for participants with muscle invasive residual disease, incomplete surgical resection, local or distant recurrence after surgery, or death. Additional outcome measures were overall survival (OS) and pathologic complete response (pCR) rate as assessed by blinded independent pathology review.

Results showed that after a median follow-up of 25.6 months, Keytruda plus Padcev, as perioperative treatment, demonstrated a statistically significant 60% reduction in the risk of event-free survival (EFS) events versus surgery alone in patients with MIBC who are not eligible for or declined cisplatin-based chemotherapy (HR=0.40 [95% CI, 0.28-0.57]; p<0.0001; 48/170 [28%] versus 95/174 [55%]; median EFS not reached [NR] [95% CI, 37.3-NR] versus 15.7 months [95% CI, 10.3-20.5]).

Keytruda plus Padcev also demonstrated a statistically significant 50% improvement in overall survival (OS) versus surgery alone (HR=0.50 [95% CI, 0.33-0.74]; p=0.0002; 38/170 [22%] versus 68/174 [39%]; median OS NR [95% CI, NR-NR] vs 41.7 [95% CI, 31.8-NR]). The trial demonstrated a statistically significant difference in pathologic complete response (pCR) rate (57.1% [95% CI: 49.3, 64.6] vs. 8.6% [95% CI: 4.9, 13.8]; p<0.0001).

The effectiveness of Keytruda Qlex for its approved indications has been established based upon evidence from the adequate and well-controlled studies conducted with Keytruda and additional data from MK-3475A-D77 comparing the pharmacokinetic, efficacy, and safety profiles of Keytruda Qlex and Keytruda.

Current Formulary Status: Medical Benefit, PA required, MBP 119.0, When processed at Specialty Pharmacy, processes at Specialty tier or Brand NP tier for members with a three-tier benefit

Recommendation: No changes are recommended for the formulary placement of Keytruda or Keytruda Qlex.

For Keytruda, the following additional criteria is recommended for the “urothelial carcinoma” portion of MBP 119.0.

For Keytruda Qlex, the same additional criteria recommended for the “urothelial carcinoma” portion of MBP 119.0 will be recommended for the Keytruda Qlex medical benefit policy 375.0.

MBP 119.0

Urothelial Carcinoma

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is ≥ 18 years of age **AND**
- Medical record documentation of one of the following:
  - Medical record documentation of locally advanced or metastatic urothelial carcinoma **AND**
  - Medical record documentation of one of the following:
    - Disease progression during or following platinum-containing chemotherapy **OR**
    - Disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy **OR**
    - Patient is not eligible for any platinum-containing chemotherapy **OR**
    - ~~Patient has high-risk, non-muscle invasive bladder cancer (NMIBC)** **AND**~~

- ~~Patient's disease is unresponsive to an adequate trial of Bacillus Calmette-Guerin (BCG) therapy** **AND**~~
- ~~Patient is ineligible for or has elected not to undergo cystectomy~~

  OR
- Keytruda is being used in combination with Padcev

OR

- Medical record documentation of muscle invasive bladder cancer (MIBC) **AND**
- Medical record documentation that Keytruda will be prescribed in combination with Padcev **AND**
- Medical record documentation of use in the neoadjuvant setting and then continued after cystectomy as adjuvant treatment **AND**
- Medical record documentation that member is ineligible for cisplatin-containing chemotherapy

OR

- Patient has high-risk, non-muscle invasive bladder cancer (NMIBC)** **AND**
- Patient's disease is unresponsive to an adequate trial of Bacillus Calmette-Guerin (BCG) therapy** **AND**
- Patient is ineligible for or has elected not to undergo cystectomy

**Note:
- BCG-unresponsive high-risk NMIBC is defined as persistent disease despite adequate BCG therapy, disease recurrence after an initial tumor-free state following adequate BCG therapy, or T1 disease following a single induction course of BCG.
- Adequate BCG therapy was defined as administration of at least five of six doses of an initial induction course plus either of: at least two of three doses of maintenance therapy or at least two of six doses of a second induction course.

MBP 357.0

Urothelial Carcinoma

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is ≥ 18 years of age **AND**
- Medical record documentation of one of the following:
  - Medical record documentation of locally advanced or metastatic urothelial carcinoma **AND**
  - Medical record documentation of one of the following:
    - Disease progression during or following platinum-containing chemotherapy

      OR
    - Disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy

      OR
    - Patient is not eligible for any platinum-containing chemotherapy

      OR
    - Keytruda is being used in combination with Padcev

OR

- Medical record documentation of muscle invasive bladder cancer (MIBC) **AND**
- Medical record documentation that Keytruda will be prescribed in combination with Padcev **AND**
- Medical record documentation of use in the neoadjuvant setting and then continued after cystectomy as adjuvant treatment **AND**
- Medical record documentation that member is ineligible for cisplatin-containing chemotherapy

OR

- Patient has high-risk, non-muscle invasive bladder cancer (NMIBC)** **AND**
- Patient's disease is unresponsive to an adequate trial of Bacillus Calmette-Guerin (BCG) therapy** **AND**
- Patient is ineligible for or has elected not to undergo cystectomy

**Note:
- BCG-unresponsive high-risk NMIBC is defined as persistent disease despite adequate BCG therapy, disease recurrence after an initial tumor-free state following adequate BCG therapy, or T1 disease following a single induction course of BCG.
- Adequate BCG therapy was defined as administration of at least five of six doses of an initial induction course plus either of: at least two of three doses of maintenance therapy or at least two of six doses of a second induction course.

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

KOSELUGO (selumetinib)

Clinical Summary:
Updated Indication: Koselugo is a kinase inhibitor that was indicated for the treatment of adult and pediatric patients 2 years of age and older with neurofibromatosis type 1 (NF1) who have symptomatic, inoperable plexiform neurofibromas (PN). It is now indicated for adult and pediatrics patients 1 year of age and older.

Updated Dosing: The recommended dosage is 25mg/m^2 taken orally twice daily. Koselugo is available as 10mg and 25mg oral capsules, as well as 5mg and 7.5mg oral granules to be sprinkled onto or mixed with soft food. Oral granules are intended for patients who have difficulty swallowing whole capsules.

Table 1: Recommended Dosage: Koselugo Capsules

Body Surface Area*	KOSELUGO Capsules
0.55 – 0.69 m^2	20 mg in the morning and 10 mg in the evening
0.70 – 0.89 m^2	20 mg twice daily
0.90 – 1.09 m^2	25 mg twice daily
1.10 – 1.29 m^2	30 mg twice daily
1.30 – 1.49 m^2	35 mg twice daily
1.50 – 1.69 m^2	40 mg twice daily
1.70 – 1.89 m^2	45 mg twice daily
≥ 1.90 m^2	50 mg twice daily

* The recommended dosage of KOSELUGO capsules for patients with a BSA less than 0.55 m^2 has not been established.

Table 2: Recommended Dosage: Koselugo Oral Granules

Body Surface Area*	KOSELUGO Oral Granules
0.40 – 0.59 m^2	12.5 mg twice daily
0.60 – 0.69 m^2	15 mg twice daily
0.70 – 0.89 m^2	20 mg twice daily
0.90 – 1.09 m^2	25 mg twice daily
1.10 – 1.29 m^2	30 mg twice daily
1.30 – 1.49 m^2	35 mg twice daily
1.50 – 1.69 m^2	40 mg twice daily
1.70 – 1.89 m^2	45 mg twice daily
≥ 1.90 m^2	50 mg twice daily

* The recommended dosage of KOSELUGO oral granules for patients with a BSA less than 0.40 m^2 has not been established.

Summary of Updated Clinical Studies[1]: The safety of Koselugo oral granules was evaluated in SPRINKLE (NCT05309668), a dose-finding and activity estimating, single-arm, multicenter study in 36 pediatric patients ages 1 year to less than 7 years with a clinical diagnosis of NF1-related symptomatic inoperable PN. The study evaluated the pharmacokinetics (PK), safety, efficacy, and tolerability of Koselugo oral granules. Study patients were to receive Koselugo oral granules for 25 cycles at a dose equivalent to 25mg/m^2 BSA twice daily until disease progression or unacceptable toxicity. In the sprinkle study, the median duration of Koselugo oral granules treatment in pediatric patients with NF1 PN was 11 months. The observed safety profile of Koselugo oral granules in the Sprinkle study was consistent with the known safety profile of Koselugo capsules. Similar exposure between the formulations supports extrapolation of efficacy from pediatric patients greater than or equal to 2 years of age to greater than or equal to 1 year of age.

Summary of Updated Safety Considerations: There are no new safety considerations

Current Formulary Status: Brand non preferred tier requiring a prior auth for new starts only
Gold: Specialty tier requiring a prior auth for new starts only

Recommendation: There are no changes to formulary status, quantity limits, or authorization duration at this time. It is recommended to update Commercial policy 691.0 to include the new FDA approved age range.

- Medical record documentation that Koselugo is prescribed by or in consultation with an oncologist, neurologist, or geneticist **AND**
- Medical record documentation that member is 1 year of age or older ~~age greater than or equal to 1 year and less than or equal to 18 years~~ **AND**
- Medical record documentation of neurofibromatosis type 1 as defined by:
    a. At least two (2) of the following from section (c), diagnostic criteria points (i) through (vii) if the individual does **NOT** have a parent with neurofibromatosis type 1 (NF1) **OR**
    b. At least one (1) of the following from section (c), diagnostic criteria points (i) through (vii) if the individual **DOES** have a parent with neurofibromatosis type 1 (NF1)
    c. Diagnostic Criteria Points:
        i. Six (6) or more café-au-lait macules > 5 mm in diameter in prepuberal and > 15 mm in diameter in postpuberal individuals (longest diameter measure for each lesion)
        ii. Two (2) or more neurofibromas **OR** one (1) plexiform neurofibroma (PN)
        iii. Freckling in the axillary or inguinal region
        iv. Optic pathway glioma
        v. Two (2) or more Lisch nodules (iris hamartomas) or two (2) or more choroidal abnormalities

vi. A distinctive bony lesion (example: sphenoid dysplasia), anterolateral bowing of the tibia, or long bone pseudoarthritis
vii. A heterozygous pathogenic NF1 variant with variant allele fraction of 50% in apparently normal tissue

- Medical record documentation that member has symptomatic plexiform neurofibromas (PN) not amenable to complete resection

***NOTE:** In clinical trials, inoperable PN was defined as a PN that could not be completely removed without risk for substantial morbidity due to encasement of, or close proximity to, vital structures, invasiveness, or high vascularity of the PN.

MEDISPAN AUTHORIZATION LEVEL: GPI-10, number of claims authorized = 1, enter for one month duration

QUANTITY LIMIT: No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.

- **QL FOR LETTER ONLY:**
  - 10 mg capsules: 8 capsules per day, 30 day supply per fill
  - 25 mg capsules: 4 capsules per day, 30 day supply per fill
  - 5 mg oral granules: 20 oral granules per day, 30 day supply per fill
  - 7.5 mg oral granules: 12 oral granules per day, 30 day supply per fill

RE-AUTHORIZATION CRITERIA: 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 the member experiences unacceptable toxicity or worsening of disease.

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

OPZELURA (ruxolitinib)

Clinical Summary:
Updated Indication: Opzelura is now indicated for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in non-immunocompromised pediatric patients 2 years of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Previously, it was approved for that same indication in patients 12 years of age and older as well as the treatment of nonsegmental vitiligo in adult and pediatric patients 12 years of age and older.

Updated Dosing for New indication: The maximum dosage for children 2 to <12 years of age is 60g every 2 weeks. The dosing for patients ≥12 years of age is 60g every week or 100g every 2 weeks.

Summary of Updated Clinical Studies: A double-blind, randomized, vehicle-controlled trial enrolled a total of 330 pediatric patients aged 2 to 11 years who were treated twice daily for 8 weeks. Subjects had affected BSA of 3 to 20% and an IGA score of 2 (mild) to 3 (moderate) on a severity scale of 0 to 4. At baseline, subjects had a mean affected BSA of 10% and 76% of subjects had a score of 3.

The primary endpoint was the proportion of subjects at Week 8 achieving IGA treatment success defined as a score of 0 (clear) or 1 (almost clear) with ≥ 2 grade improvement from baseline.

Table 1: Efficacy Results at Week 8 in Pediatric Subjects 2 to 11 Years of Age

	OPZELURA (N = 131)	Vehicle (N = 65)	Treatment Difference and 95% Confidence Interval
IGA-TS[a]	56.5%	10.8%	45.7% (34.7%, 56.8%)

[a] Defined as an IGA score of 0 or 1 with a ≥ 2-grade improvement from baseline.

Summary of Updated Safety Considerations: There is an updated warning for cytopenias. Thrombocytopenia, anemia, neutropenia, lymphopenia, and leukopenia were reported in the clinical trials with Opzelura. Consider risks and benefits for patients who have a history of these events prior to starting therapy. Perform CBC monitoring as indicated. Discontinue Opzelura if signs/symptoms associated with clinically significant decreases in laboratory values occur.

Current Formulary Status: Non-formulary requiring prior authorization.

Recommendation: No formulary placement changes are recommended but it is recommended to update the prior authorization criteria.

Atopic Dermatitis

- Medical record documentation that Opzelura is prescribed by or in consultation with a dermatologist, allergist, or immunologist AND
- Medical record documentation of a diagnosis of mild to moderate atopic dermatitis AND
- Medical record documentation of age greater than or equal to 2 years AND
- Medical record documentation that member is immunocompetent AND
- Medical record documentation of Body Surface Area (BSA) less than or equal to 20% AND
- Medical record documentation that Opzelura is NOT being used in combination with therapeutic biologics, other Janus-associated kinase (JAK) inhibitors or potent immunosuppressants such as azathioprine or cyclosporine AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to ALL of the following:
    - One formulary topical calcineurin inhibitor AND
    - One formulary topical corticosteroid unless deemed inadvisable due to potential risks such as (a) use on sensitive skin areas (face, axillae, or groin) OR (b) member is less than 15 years of age AND
    - Eucrisa

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

OTEZLA/OTEZLA XR (apremilast)

Clinical Summary: Otezla is now available in an extended release formulation, Otezla XR. Otezla XR shares the indications of Otezla as follow:

Adult patients with:

- Active psoriatic arthritis
- Plaque psoriasis who are candidates for phototherapy or systemic therapy
- Oral ulcers associated with Behçet's Disease

Pediatric patients 6 years of age and older with:

- Active psoriatic arthritis
- Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy

In the pediatric population, Otezla is indicated for patients weighing at least 20 kg, and Otezla XR is indicated for patients weighing at least 50 kg.

The recommended dosage of Otezla/Otezla XR for the treatment of adults with psoriatic arthritis, plaque psoriasis, or Behcet's disease are an initial dosage titration from Day 1 to Day 5 (Table 1), followed by a maintenance dosage of Otezla 30 mg twice daily or Otezla XR 75 mg once daily starting on Day 6.

Table 1. Recommended titration scheduled for adult patients with PsA, PP, or Behcet's disease

OTEZLA Dosage Titration[a]									**OTEZLA/OTEZLA XR Maintenance Dosage**
Day 1	**Day 2**		**Day 3**		**Day 4**		**Day 5**		**Day 6 & thereafter**
AM	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	
10 mg	10 mg	10 mg	10 mg	20 mg	20 mg	20 mg	20 mg	30 mg	OTEZLA 30 mg BID **OR** OTEZLA XR 75 mg QD

For pediatric patients, with PsA or moderate to severe PP, the initial Otezla dosage titration (Table 2.) is followed by the recommended maintenance dosage of Otezla 30 mg twice daily or Otezla XR 75 mg once daily in pediatric patients weighing at least 50 kg. For patients weighing 20 kg to less than 50 kg, the recommended maintenance dosage is 20 mg twice daily.

Table 2. Recommended pediatric dosage of Otezla/Otezla XR

	OTEZLA Dosage Titration[a]									**OTEZLA/OTEZLA XR Maintenance Dosage**
Body Weight	**Day 1**	**Day 2**		**Day 3**		**Day 4**		**Day 5**		**Day 6 & thereafter**
	AM	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	
50 kg or more	10 mg	10 mg	10 mg	10 mg	20 mg	20 mg	20 mg	20 mg	30 mg	OTEZLA 30 mg BID **OR** OTEZLA XR 75 mg QD
20 kg to less than 50 kg	10 mg	10 mg	10 mg	10 mg	20 mg	20 mg	20 mg	20 mg	20 mg	OTEZLA 20 mg BID

Patients may switch to Otezla XR 75 mg once daily the day following the last dose of Otezla 30 mg or vice versa. Otezla XR is not recommended for adult or pediatric patients with severe renal impairment; the appropriate dosage for these patients has not been determined.

No new clinical trials were performed to evaluated the efficacy of Otezla XR. Otezla XR demonstrated bioequivalence to the bid formulation and no new safety signals were identified during pharmacokinetic studies.

Otezla and Otezla XR are supplied as follows:

Package Configuration	Tablet Strength	NDC
Otezla 30 mg bid dosing		
28-day treatment initiation pack	55-tablet blister pack including tablets for titration and maintenance dosage: 4 tablets (10 mg each), 4 tablets (20 mg each), and 47 tablets (30 mg each)	55513-369-55
60-count bottle	30 mg	55513-137-60
Otezla 20 mg bid dosing		
28-day treatment initiation pack	55-tablet blister pack including tablets for titration and maintenance dosage: 4 tablets (10 mg each) and 51 tablets (20 mg each)	55513-508-55
60-count bottle	20 mg	55513-497-60
Otezla XR Package Configurations		
28-day treatment initiation pack	41-tablet blister titration pack including tablets for titration and maintenance dosage: • Otezla 4 tablets (10 mg each), 4 tablets (20 mg each), and 19 tablets (30 mg each) and • Otezla XR: 14 tablets (75 mg each)	55513-516-41
30- count bottle	Otezla XR 75 mg	55513-519-30

Current Formulary Status: Otezla 30 mg bid titration pack & Otezla 30 mg tablets, PA NSO Required

2 Tier/CHIP	**3 Tier**	**4 Tier**	**ACA**
Tier 2 – Brand	Tier 3 – Brand NP	Tier 4 – Specialty tier	Tier 6 – Specialty tier

30 mg bid titration pack: QL: 55 tablets per 28 days

30 mg tablets: 60 tablets / 30 days

Recommendation: Otezla 10- 20 mg bid titration pack, Otezla 20 mg tablets, Otezla XR Titration Pack and Otezla XR 75 mg tablets should be added to the following tiers:

2 Tier/CHIP	**3 Tier**	**4 Tier**	**ACA**
Tier 2 – Brand	Tier 3 – Brand NP	Tier 4 – Specialty tier	Tier 6 – Specialty tier

They will require a prior authorization for new starts only. They should be reviewed with Otezla Commercial Policy 336.0 with the following changes:

For Adult Psoriatic Arthritis:

- Medical record documentation that Otezla/Otezla XR is prescribed by a rheumatologist or dermatologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of moderately to severely active psoriatic arthritis which must include documentation of either active psoriatic lesions or a documented history of psoriasis **AND**
- Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on one conventional/non-biologic agent

MEDISPAN AUTHORIZATION LEVEL: GPI-10, number of claims authorized = 1, enter for one month duration

QUANTITY LIMIT: *No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.*

- Otezla 30 mg tablets: QL FOR LETTER ONLY: 2 tablets per day, 30 day supply per fill
- Otezla 10-20-30 Titration Pack QL FOR LETTER ONLY: 55 tablets per 180 days
- Otezla XR 75 mg tablets: QL FOR LETTER ONLY: 1 tablet per day, 30 day supply per fill
- Otexla XR 28 Day Titration Pack: QL FOR LETTER ONLY: 41 tablets per 180 days

RE-AUTHORIZATION CRITERIA: Otezla/Otezla XR is configured as a prior authorization for new starts only. Otezla/Otezla XR 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

For Pediatric Psoriatic Arthritis:

- Medical record documentation that Otezla/Otezla XR is prescribed by a rheumatologist or dermatologist AND
- Medical record documentation that member is 6 to 17 years of age **AND**
- Medical record documentation of one of the following:
  - If the request is for Otezla tablets: Medical record documentation of weight of at least 20 kilograms **AND**
  - If the request is for Otezla XR tablets: Medical record documentation of weight of at least 50 kilograms **AND**
- Medical record documentation that Otezla/Otezla XR dosing is appropriate based on member's weight **AND**
- Medical record documentation of a diagnosis of moderately to severely active psoriatic arthritis which must include documentation of either active psoriatic lesions or a documented history of psoriasis **AND**
- Medical record documentation of an intolerance to, contraindication to, or therapeutic failure on one conventional/non-biologic agent

MEDISPAN AUTHORIZATION LEVEL: GPI-10, number of claims authorized = 1, enter for one month duration

QUANTITY LIMIT: *No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.*

- Otezla 20 mg tablets: QL FOR LETTER ONLY: 2 tablets per day, 30 day supply per fill
- Otezla 10 – 20 Titration Pack: Pack QL FOR LETTER ONLY: 55 tablets per 180 days
- Otezla 30 mg tablets: QL FOR LETTER ONLY: 2 tablets per day, 30 day supply per fill
- Otezla 10-20-30 Titration Pack QL FOR LETTER ONLY: 55 tablets per 180 days
- Otezla XR 75 mg tablets: QL FOR LETTER ONLY: 1 tablet per day, 30 day supply per fill
- Otexla XR 28 Day Titration Pack: QL FOR LETTER ONLY: 41 tablets per 180 days

RE-AUTHORIZATION CRITERIA: Otezla/Otezla XR is configured as a prior authorization for new starts only. Otezla/Otezla XR 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

For Adult Plaque Psoriasis:

- Medical record documentation that Otezla/Otezla XR is prescribed by a dermatologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- For mild disease:
  - Medical record documentation of a diagnosis of mild to moderate plaque psoriasis characterized by less than 3% of body surface area involved **AND**
  - Medical record documentation of an intolerance to, contraindication to, or therapeutic failure of one topical therapy **OR** phototherapy
- For moderate-severe disease:
  - Medical record documentation of a diagnosis of moderate to severe plaque psoriasis characterized by greater than 3% of body surface area involved or disease involving crucial body areas such as the hands, feet, face, or genitals **AND**
  - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to one topical corticosteroid **OR** one systemic therapy **OR** phototherapy

MEDISPAN AUTHORIZATION LEVEL: GPI-10, number of claims authorized = 1, enter for one month duration

QUANTITY LIMIT: *No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.*

- Otezla 30 mg tablets: QL FOR LETTER ONLY: 2 tablets per day, 30 day supply per fill
- Otezla 10-20-30 Titration Pack QL FOR LETTER ONLY: 55 tablets per 180 days
- Otezla XR 75 mg tablets: QL FOR LETTER ONLY: 1 tablet per day, 30 day supply per fill
- Otexla XR 28 Day Titration Pack: QL FOR LETTER ONLY: 41 tablets per 180 days

RE-AUTHORIZATION CRITERIA: Otezla/Otezla XR is configured as a prior authorization for new starts only. Otezla/Otezla XR 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

For Pediatric Plaque Psoriasis:

- Medical record documentation that Otezla/Otezla XR is prescribed by a dermatologist **AND**
- Medical record documentation of age 6 to 17 years **AND**
- Medical record documentation of one of the following:
  - If the request is for Otezla tablets: Medical record documentation of weight of at least 20 kilograms **AND**
  - If the request is for Otezla XR tablets: Medical record documentation of weight of at least 50 kilograms **AND**
- Medical record documentation of a diagnosis of moderate to severe plaque psoriasis characterized by greater than 3% of body surface area or disease involving crucial body areas such as the hands, feet, face, or genitals **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to one topical corticosteroid **OR** one systemic therapy **OR** phototherapy
- Medical record documentation that Otezla/Otezla XR dosing is appropriate based on patient's weight

Dosage Titration Schedule for Pediatric Patients 6 years of Age and Older and Weighing at Least 20 kg with Moderate to Severe Plaque Psoriasis

	OTEZLA Dosage Titration[a]									OTEZLA/OTEZLA XR Maintenance Dosage
Body Weight	**Day 1**	**Day 2**		**Day 3**		**Day 4**		**Day 5**		**Day 6 & thereafter**
	AM	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	
50 kg or more	10 mg	10 mg	10 mg	10 mg	20 mg	20 mg	20 mg	20 mg	30 mg	OTEZLA 30 mg BID **OR** OTEZLA XR 75 mg QD
20 kg to less than 50 kg	10 mg	10 mg	10 mg	10 mg	20 mg	20 mg	20 mg	20 mg	20 mg	OTEZLA 20 mg BID

MEDISPAN AUTHORIZATION LEVEL: GPI-10, number of claims authorized = 1, enter for one month duration

QUANTITY LIMIT: *No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.*

- Otezla 20 mg tablets: QL FOR LETTER ONLY: 2 tablets per day, 30 day supply per fill
- Otezla 10 – 20 Titration Pack: Pack QL FOR LETTER ONLY: 55 tablets per 180 days
- Otezla 30 mg tablets: QL FOR LETTER ONLY: 2 tablets per day, 30 day supply per fill
- Otezla 10-20-30 Titration Pack QL FOR LETTER ONLY: 55 tablets per 180 days
- Otezla XR 75 mg tablets: QL FOR LETTER ONLY: 1 tablet per day, 30 day supply per fill
- Otexla XR 28 Day Titration Pack: QL FOR LETTER ONLY: 41 tablets per 180 days

RE-AUTHORIZATION CRITERIA: Otezla/Otezla XR is configured as a prior authorization for new starts only. Otezla/Otezla XR 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

For Behçet's Disease

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

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

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

MEDISPAN AUTHORIZATION LEVEL: GPI-10, number of claims authorized = 1, enter for one month duration

QUANTITY LIMIT: *No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.*

- Otezla 30 mg tablets: QL FOR LETTER ONLY: 2 tablets per day, 30 day supply per fill
- Otezla 10-20-30 Titration Pack QL FOR LETTER ONLY: 55 tablets per 180 days
- Otezla XR 75 mg tablets: QL FOR LETTER ONLY: 1 tablet per day, 30 day supply per fill
- Otexla XR 28 Day Titration Pack: QL FOR LETTER ONLY: 41 tablets per 180 days

RE-AUTHORIZATION CRITERIA: Otezla/Otezla XR is configured as a prior authorization for new starts only. Otezla/Otezla XR 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.

PADCEV (enfortumab vedotin)

Clinical Summary: Padcev (enfortumab vedotin) received approval for use in combination with Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph), as neoadjuvant treatment and then continued after cystectomy as adjuvant treatment, for the treatment of adult patients with muscle invasive bladder cancer (MIBC) who are ineligible for cisplatin-containing chemotherapy.

Updated Dosing: There are no changes to the recommended dosage of Padcev for the change in indication. The recommended dosage of Padcev when given in combination with Keytruda or Keytruda Qlex is 1.25 mg/kg (up to a maximum of 125 mg) administered as an intravenous infusion on Days 1 and 8 of a 21 day cycle; continue for 3 cycles or until disease progression that precludes curative intent cystectomy or unacceptable toxicity.

Summary of Updated Clinical Studies: This approval is based on data from the Phase 3 KEYNOTE-905 trial, an open-label, multicenter, randomized, active-controlled trial that evaluated perioperative Keytruda, with or without Padcev, versus surgery alone in patients with MIBC who were either not eligible for or declined cisplatin-based chemotherapy. The trial enrolled 344 patients who were randomized 1:1 to receive either:

- Neoadjuvant Keytruda 200 mg over 30 minutes as an intravenous infusion on Day 1 and Padcev 1.25 mg/kg as an intravenous infusion on Days 1 and 8 of each 21 day cycle for 3 cycles prior to surgery, followed by adjuvant Keytruda 200 mg over 30 minutes on Day 1 of each 21 day cycle for 14 cycles and Padcev 1.25 mg/kg on Days 1 and 8 of each 21 day cycle for 6 cycles (n=170).
- Immediate radical cystectomy (RC) and pelvic lymph node dissection (PLND) alone (n=174).

Treatment continued until completion of study medications, disease progression, not undergoing or refusal of RC and PLND, disease recurrence in the adjuvant phase, or unacceptable toxicity. Assessment of tumor status was performed at baseline, within 5 weeks prior to RC and PLND, and at 6 weeks post radical cystectomy. Following RC and PLND, assessment of tumor status was performed every 12 weeks up to 2 years, and every 24 weeks thereafter. The trial was not designed to isolate the effect of Keytruda in each phase (neoadjuvant or adjuvant) of treatment.

The major efficacy outcome measure of this trial was event-free survival (EFS), defined as the time from randomization to the first of: disease progression preventing curative surgery, failure to undergo surgery for participants with muscle invasive residual disease, incomplete surgical resection, local or distant

recurrence after surgery, or death. Additional outcome measures were overall survival (OS) and pathologic complete response (pCR) rate as assessed by blinded independent pathology review.

Results showed that after a median follow-up of 25.6 months, Keytruda plus Padcev, as perioperative treatment, demonstrated a statistically significant 60% reduction in the risk of event-free survival (EFS) events versus surgery alone in patients with MIBC who are not eligible for or declined cisplatin-based chemotherapy (HR=0.40 [95% CI, 0.28-0.57]; p<0.0001; 48/170 [28%] versus 95/174 [55%]; median EFS not reached [NR] [95% CI, 37.3-NR] versus 15.7 months [95% CI, 10.3-20.5]).

Keytruda plus Padcev also demonstrated a statistically significant 50% improvement in overall survival (OS) versus surgery alone (HR=0.50 [95% CI, 0.33-0.74]; p=0.0002; 38/170 [22%] versus 68/174 [39%]; median OS NR [95% CI, NR-NR] vs 41.7 [95% CI, 31.8-NR]). The trial demonstrated a statistically significant difference in pathologic complete response (pCR) rate (57.1% [95% CI: 49.3, 64.6] vs. 8.6% [95% CI: 4.9, 13.8]; p<0.0001).

The most common adverse reactions (≥20%) occurring in cisplatin-ineligible patients with MIBC treated with Keytruda in combination with Padcev (n =167) were rash (54%), pruritus (47%), fatigue (47%), peripheral neuropathy (39%), alopecia (35%), dysgeusia (35%), diarrhea (34%), constipation (28%), decreased appetite (28%), nausea (26%), urinary tract infection (24%), dry eye (21%), and weight loss (20%).

Current Formulary Status: Medical Benefit, PA required for new starts only. When processed at a specialty pharmacy, processes as Specialty tier or Brand NP tier for members with a 3-tier benefit

Recommendation: There are no changes recommended for the formulary placement or authorization duration of Padcev. The following changes are recommended to Medical Benefit Policy 209.0:

MBP 209.0

- Medical record documentation that prescription is written by a hematologist or oncologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of one of the following:
  - Medical record documentation of locally advanced or metastatic urothelial cancer **AND**
  - Medical record documentation of one of the following:
    - Medical record documentation that member has received a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and platinum-containing chemotherapy **OR**
    - Medical record documentation that member has received at least one prior line of therapy and is ineligible for cisplatin-containing chemotherapy* **OR**
    - Medical record documentation that Padcev will be prescribed in combination with Keytruda or Keytruda Qlex

    OR
  - Medical record documentation of muscle invasive bladder cancer (MIBC) **AND**
  - Medical record documentation that Padcev will be prescribed in combination with Keytruda or Keytruda Qlex **AND**
  - Medical record documentation of use in the neoadjuvant setting and then continued after cystectomy as adjuvant treatment **AND**
  - Medical record documentation that member is ineligible for cisplatin-containing chemotherapy

*Note to reviewer: In clinical trials, patients who were not considered cisplatin-eligible had one or more of the following characteristics: baseline creatinine clearance of 30 – 59 mL/min, ECOG performance status of 2, or Grade 2 or greater hearing loss.

AUTHORIZATION DURATION: Initial approval will be for 12 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of

continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

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

RYBELSUS (semaglutide)

Clinical Summary: Rybelsus is now FDA approved for an additional indication – to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) [MACE] in adults with type 2 diabetes mellitus who are at high risk for these events.

The recommended dosage for Rybelsus for the new indication based on the formulation. For Rybelsus (formulation R1), starting dosage is 3 mg orally once daily for 30 days (this dosage is not effective for glycemic control). Increase the dosage to 7 mg orally once daily. If no additional glycemic control is needed after day 60, maintain the dosage at 7 mg orally once daily. If additional glycemic control is needed after day 60, increase the dosage to 14 mg orally once daily. For Rybelsus (formulation R1), starting dosage is 1.5 mg orally once daily for 30 days (this dosage is not effective for glycemic control). Increase the dosage to 4 mg orally once daily. If no additional glycemic control is needed after day 60, maintain the dosage at 4 mg orally once daily. If additional glycemic control is needed after day 60, increase the dosage to 9 mg orally once daily.

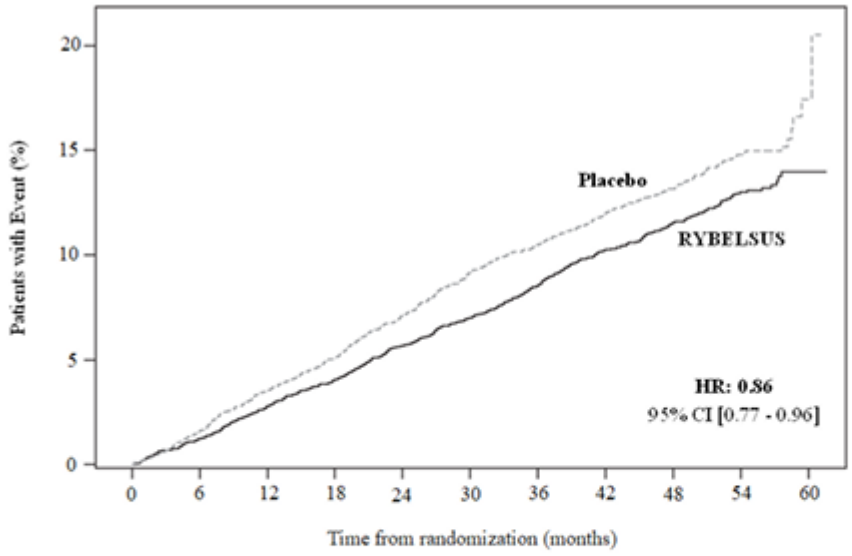
The efficacy of Rybelsus to reduce MACE was evaluated in a randomized, double-blind, parallel-group, placebo-controlled trial (Trial 7). In this trial, 9,650 patients with type 2 diabetes mellitus and established cardiovascular (CV) disease and/or chronic kidney disease (CKD) (defined as eGFR <60 mL/min/1.73 m2), were randomized to either once daily oral Rybelsus 14 mg or placebo, in addition to standard of care. The primary endpoint, major adverse cardiovascular events (MACE), was the time to first occurrence of a three-part composite outcome which included CV death, non-fatal myocardial infarction (MI) and non-fatal stroke. Patients eligible to enter the trial were: 50 years of age or older and with established CV disease or CKD. In total, 5,468 patients (56.7%) had established CV disease without CKD, 1,241 (13%) had CKD only, and 2,620 (27%) had both CV disease and CKD. Most patients (97%) were treated with one or more glucose lowering medications at baseline: metformin (76%), insulin (51%), SGLT-2 inhibitor (27%), sulfonylurea (29%), and DPP-4 inhibitor (23%). At baseline, CV disease and risk factors were managed with lipid-lowering medications (89%), plateletaggregation inhibitors including aspirin (77%), angiotensin converting enzyme inhibitors or angiotensin II receptor blockers (79%), and beta blockers (64%). The mean duration of diabetes was 15.4 years, the mean BMI was 31.1 kg/m2, the mean HbA1c was 8%, and the mean eGFR was 73.8 mL/min/1.73 m2. Concomitant diseases included heart failure (23%), hypertension (91%), previous ischemic stroke (12%), previous MI (40%), and peripheral artery disease (16%). In total, 98.4% patients completed the trial, and the vital status was known at the end of the trial for 99.5%. Rybelsus significantly reduced the occurrence of MACE. The estimated hazard ratio for time to first MACE was 0.86 (95% CI: 0.77, 0.96) over the median follow-up duration of 49.6 months and 49.4 months for patients randomized to Rybelsus and placebo, respectively. Refer to the table and chart below for results.

Trial 7 Treatment Effect for MACE and its Components

	PLACEBO N=4,825	RYBELSUS 14 mg N=4,825	Hazard ratio vs Placebo (95% CI)
Primary composite endpoint			
MACE: Composite of CV death, non-fatal MI, non-fatal stroke (time to first occurrence)	668 (13.8%)	579 (12.0%)	0.86 (0.77, 0.96)
CV Death	320 (6.6%)	301 (6.2%)	0.93 (0.80, 1.09)
Non-fatal MI	253 (5.2%)	191 (4.0%)	0.74 (0.61, 0.89)
Non-fatal Stroke	161 (3.3%)	144 (3.0%)	0.88 (0.70, 1.11)

Note: Data from the in-trial period based on full analysis set defined as all randomized patients.
Time from randomization to each endpoint was analyzed using a Cox proportional hazards model with treatment as categorical fixed factor. Subjects without events of interest were censored at the end of their in-trial period. For the primary endpoint the hazard ratio and CI were adjusted for the group sequential design using likelihood ratio ordering. CV death, non-fatal MI and non-fatal stroke are listed descriptively for supportive purpose. CV death includes both CV death and undetermined cause of death.
N=number of patients; %: percentage of participants in the full analysis set with at least one event; CI: confidence interval

Time to First Occurrence of a MACE in Trial 7



Patients at risk											
RYBELSUS	4825	4743	4635	4542	4438	4346	4239	3831	2555	1346	47
Placebo	4825	4718	4583	4455	4322	4194	4101	3727	2517	1346	38

Data from the in-trial period based on full analysis set defined as all randomized patients. Cumulative incidence estimates are based on time from randomization to first EAC-confirmed MACE with non-CV death modeled as competing risk using the Aalen-Johansen estimator. Patients without events of interest were censored at the end of their in-trial observation period. Time from randomization to first MACE was analyzed using a Cox proportional hazards model with treatment as categorical fixed factor. The hazard ratio and confidence interval are adjusted for the group sequential design using the likelihood ratio ordering. HR: Hazard ratio; CI: confidence interval.

Warnings and precautions for Rybelsus regarding severe gastrointestinal adverse reactions has been updated to include severe gastrointestinal adverse reactions have also been reported postmarketing with GLP-1 receptor agonists.

Current Formulary Status: Rybelsus is a pharmacy benefit requiring prior authorization. Quantity limits apply. It is on the preferred brand tier.

Recommendation: No changes to formulary placement are recommended. No changes are recommended to the pharmacy benefit policy 732.0 Preferred GLP-1 Agonists And Mounjaro as the new indication still requires the adult patient have a diagnosis of type 2 diabetes.

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

SIMPONI (golimumab)

Clinical Summary: Updated Indication: Simponi (golimumab) has received a new indication for the treatment of children with moderately to severely active ulcerative colitis weighing at least 15 kilograms. The previous indication was for adults 18 years of age and older.

Updated Dosing for New indication:
Ulcerative colitis
Children ≥4 years of age and adolescents
Simponi (prefilled syringe)
Weight 15 to <40 kg
Induction
100 mg SUBQ at week 0, then 50 mg at week 2.
Maintenance (begin at week 6)
50 mg SUBQ every 4 weeks.
Weight ≥40 kg
Induction
200 mg SUBQ at week 0, then 100 mg at week 2.
Maintenance (begin at week 6)
100 mg SUBQ every 4 weeks.

Summary of Updated Clinical Studies: The PURSUIT 2 trial was a Phase 3 Randomized, Open-Label Study to Assess the Efficacy, Safety, and Pharmacokinetics of Golimumab Treatment, a Human Anti-TNFα Monoclonal Antibody, Administered Subcutaneously in Pediatric Participants with Moderately to Severely Active Ulcerative Colitis who were naïve to biologic therapy.

The efficacy and safety of SIMPONI was evaluated in a multi-center, open-label pediatric study of 69 patients. Efficacy was assessed in 66 patients weighing at least 15 kg with moderately to severely active ulcerative colitis defined as a Mayo score of 6 to 12 with an endoscopy subscore of ≥2 who had an inadequate response to corticosteroids, 6-mercaptopurine (6-MP), or azathioprine (AZA), or who were intolerant to or had medical contraindications for such therapies. Patients with prior exposure to TNF blockers were ineligible. Of the 66 subjects assessed for efficacy, the mean age was 13.4 years (range 4 to 17 years), the median weight was 51 kg, and 53% were female. Twenty-four percent identified as Hispanic or Latino; 71% identified as White, 18% as Asian, 3% as American Indian or Alaskan Native, 3% as Black, and 2% identified as part of multiple racial subgroups.

Patients weighing 15 to less than 45 kg received SIMPONI subcutaneously at 120 mg/m2 at dosages of 120 mg/m2 at Week 0, 60 mg/m2 at Week 2 and 60 mg/m2 every 4 weeks from Week 6 onward.

Patients weighing at least 45 kg received SIMPONI 200 mg at Week 0, 100 mg at Week 2 and 100 mg every 4 weeks from Week 6 onward.

At weeks 6, and 54, efficacy was assessed by the Mayo score.

Efficacy Endpoints Week 6: The results of the primary endpoint of clinical remission at Week 6 and secondary endpoint of clinical response at Week 6, both assessed by Mayo score are shown in the table below.

Endpoint	Simponi n (%) [90% CI] N = 66
Clinical remission at Week 6	21 (32%) [22%, 41%]
Clinical response at Week 6	38 (58%) [48%, 68%]

Additional Secondary Endpoints Of the 38 pediatric subjects with clinical response at Week 6, 13 subjects (34%) were in clinical remission and 15 subjects (39%) had endoscopic improvement, defined as an endoscopy subscore of 0 or 1 based on local endoscopy, at Week 54. Of the 21 subjects in clinical remission at Week 6, 12 subjects (57%) maintained clinical remission at Week 54.

- Summary of Updated Safety Considerations
  The safety and effectiveness of SIMPONI for the treatment of moderately to severely active ulcerative colitis have been established in pediatric patients weighing at least 15 kg. Use of SIMPONI for this indication is supported by evidence from adequate and well-controlled studies in adults with additional safety and efficacy data from an open-label, study in 69 pediatric patients (4 to 17 years of age). The adverse reaction profile in these pediatric patients was similar to adults. Additionally, headache (17%) and pyrexia (10%) were reported in at least 10% of pediatric patients in the trial.

The safety and effectiveness of SIMPONI for the treatment of moderately to severely active ulcerative colitis have not been established in pediatric patients weighing less than 15 kg.

Current Formulary Status: Simponi is a pharmacy benefit that is on the specialty tier with a prior authorization required.

Recommendation: No changes recommended to the formulary placement of Simponi at this time. It would remain on the specialty tier with a prior authorization required. An update to the Simponi Commercial Drug Policy 198.0 with the new pediatric indication is recommended below:

For Ulcerative Colitis:
An exception for coverage of Simponi (which is self-administered) may be made for members who meet ALL of the following criteria:

- Medical record documentation that Simponi is prescribed by a gastroenterologist **AND**
- Medical record documentation of a diagnosis of moderate to severe ulcerative colitis **AND**
- Medical record documentation of age greater than or equal to ~~18~~ 4 years old and weighing ≥ 15kg **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to adalimumab* **AND**
- Medical record documentation that Simponi is not being used concurrently with a tumor necrosis factor (TNF) blocker or other biologic agent

MEDISPAN AUTHORIZATION LEVEL: GPI-12 (must enter 6627004000E5 & 6627004000D5), number of claims authorized = 1, enter for one month duration

QUANTITY LIMIT –

1. In PA Hub: Add PA, OQL, DS, max quantity dispensed 3, min day supply 28, max day supply 28, number of claims authorized = 1, with a duration of one month
   - QL FOR LETTER: Loading dose: 3 mL per 28 days; Maintenance dose: 1 mL per 28 days

RE-AUTHORIZATION CRITERIA: Simponi is configured as a prior authorization for new starts only. Simponi 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

FORMULARY ALTERNATIVES:

Amjevita*

*prior authorization required

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

TECENTRIQ (atezolizumab)

Clinical Summary: Tecentriq is now FDA approved in combination with lurbinectedin (Zepzelca) for the maintenance treatment of adult patients with extensive stage-small cell lung cancer (ES-SCLC) whose disease has not progressed after first-line induction therapy with Tecentriq or atezolizumab and hyalurinidase-tqjs (Tecentriq Hybreza), carboplatin and etoposide. This new indication is the second approved for ES-SCLC.

The recommended dosing is 840 mg every 2 weeks, 1200 mg every 3 weeks, or 1680 mg every 4 weeks. This dosing is consistent with the dosing for the prior approved indication for ES-SCLC. Tecentriq should be administered prior to chemotherapy when given on the same day. The duration of therapy is until disease progression or unacceptable toxicity.

The efficacy of Tecentriq in combination with lurbinectedin as maintenance treatment was evaluated in IMforte (NCT05091567), a randomized, multicenter, open-label study in patients with ES-SCLC. Patients were eligible if their disease had not progressed after completion of four cycles of Tecentriq, carboplatin and etoposide (induction treatment) and they had an ECOG performance status of 0 or 1. The trial excluded patients with CNS metastases, history of autoimmune disease, or administration of systemic immunosuppressive medications within 1 week prior to enrollment. Unless contraindicated, primary prophylaxis with granulocyte colony-stimulating factor (G-CSF) was mandated for patients assigned to the Tecentriq with lurbinectedin arm.

The trial randomized 483 patients who had not experienced disease progression following the completion of four cycles of Tecentriq with carboplatin and etoposide to one of the following two treatment arms:

- Tecentriq 1200 mg IV in combination with lurbinectedin 3.2 mg/m^2 IV once every 3 weeks until disease progression or unacceptable toxicity, or
- Tecentriq 1200 mg IV once every 3 weeks until disease progression or unacceptable toxicity

The major efficacy outcome measures were Overall Survival (OS) and Progression-Free Survival

(PFS). Efficacy results are presented in Table 1 below.

Table 1: Efficacy Results from IMforte

	TECENTRIQ with Lurbinectedin N=242	TECENTRIQ N=241
Overall Survival [1]		
Deaths (%)	113 (47%)	136 (56%)
Median, months (95% CI)	13.2 (11.9, 16.4)	10.6 (9.5, 12.2)
Hazard ratio[2] (95% CI)	0.73 (0.57, 0.95)	
p-value[3, 6]	0.0174	
Progression-Free Survival [1, 4, 5]		
Number of events (%)	174 (72%)	202 (84%)
Median, months (95% CI)	5.4 (4.2, 5.8)	2.1 (1.6, 2.7)
Hazard ratio[2] (95% CI)	0.54 (0.43, 0.67)	
p-value[3, 7]	<0.0001	

[1]Measured from the time of randomization
[2]Stratified by ECOG performance status, LDH level, presence of liver metastases and prior receipt of prophylactic cranial irradiation
[3]Based on the stratified log-rank test
[4]As determined by an IRF
[5]per RECIST v1.1 (Response Evaluation Criteria in Solid Tumors v1.1)
[6]Compared to the allocated alpha of 0.0313 (two-sided) for this interim OS analysis.
[7]Compared to the allocated alpha of 0.001 (two- sided) for this final PFS analysis.
CI=confidence interval

Serious adverse reactions occurred in 31% of patients receiving Tecentriq with lurbinectedin in the IMforte trial. Serious adverse reactions in > 2% of patients were pneumonia (2.5%), respiratory tract infection (2.1%), dyspnea (2.1%), and decreased platelet count (2.1%). Fatal adverse reactions occurred in 5% of patients receiving Tecentriq with lurbinectedin including pneumonia (3 patients), sepsis (3 patients), cardio-respiratory arrest (2 patients), myocardial infarction (2 patients) and febrile neutropenia (1 patient)

Current Formulary Status: Tecentriq is a medical benefit requiring prior authorization.

Recommendation: It is recommended that the medical benefit policy (MBP 144.0) for Tecentriq be updated to account for the new indication. See below for the recommended highlighted changes.

Medical Benefit Policy 144.0 Tecentriq

Small Cell Lung Cancer (SCLC):

- Prescription written by an oncologist **AND**
- Medical record documentation of a diagnosis of extensive stage small cell lung cancer (ES-SCLC) **AND**
- Medical record documentation that Tecentriq will be used in combination with carboplatin and etoposide AND
- Medical record documentation of use as first-line treatment of extensive-stage disease

OR

- Prescription written by an oncologist **AND**
- Medical record documentation of a diagnosis of extensive stage small cell lung cancer (ES-SCLC) **AND**
- Medical record documentation that Tecentriq will be used in combination with lurbinectedin **AND**

- Medical record documentation that the disease has not progressed after first-line induction therapy with Tecentriq or atezolizumab and hyaluronidase-tqjs, carboplatin and etoposide

AUTHORIZATION DURATION:
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.

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

VYJUVEK (beremagene geperpavec-svdt)

Clinical Summary:
Updated Indication: Vyjuvek (beremagene geperpavec-svdt) is a herpes-simplex virus type 1 (HSV-1) vector-based gene therapy indicated for the treatment of wounds in adult and pediatric patients with dystrophic epidermolysis bullosa with mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene. Vyjuvek was previously approved only in patients 6 months of age and older.

Updated Dosing for New indication: Vyjuvek is for topical application only. Vyjuvek gel is applied to the selected wound(s) in droplets spaced evenly within the wound and approximately 1cm-by-1cm apart. Dose application is determined by approximate size of wound. Vyjuvek gel is applied to wounds once weekly by a healthcare professional, patient, or caregiver either in a healthcare setting or home. Previously Vyjuvek was only applied by a healthcare professional. Vyjuvek may now be administered during routine at-home bandage changes by patient or caregiver.

Wound Area (cm^2)	Dose (PFU)	Volume (mL)
< 20	$4x10^8$	0.2
20 to < 40	$8x10^8$	0.4
40 to 60	$1.2x10^9$	0.6

PFU = plaque forming unit; mL = milliliter, cm = centimeter

For wound area > 60cm^2, recommend calculating the total dose based on the above tablet until the maximum weekly dose is reached.

Age Range	Maximum Weekly Dose (PFU)	Maximum Weekly Volume (mL)*
< 3 years old	$2x10^9$	1
≥ 3 years old	$4x10^9$	2

PFU = plaque forming unit; mL = milliliter

*Maximum weekly volume is the volume after mixing Vyjuvek biological suspension with excipient gel.

Vyjuvek biological suspension is supplied as a 1 mL extractable volume in a single-use vial at a nominal concentration of $5x10^9$ PFU/mL. The excipient gel is supplied as a 1.5 mL fill volume in a separate single-use vial. Vyjuvek biological suspension is mixed into the excipient gel vial prior to administration.

Summary of Updated Clinical and Safety Studies:
The efficacy and safety of Vyjuvek is based on one randomized, double-blind, intra-patient placebo-controlled study (GEM-3 (NCT04491604)). The study population included 31 patients (19 pediatric patients aged 1 to 16 years) with dystrophic epidermolysis bullosa (DEB) with confirmed mutation(s) in the *COL7A1* gene and who had two cutaneous wounds with similar size, appearance, and anatomical location. In each patient, two comparable wounds were selected and randomized to receive application of Vyjuvek gel or placebo (excipient gel) weekly for 26 weeks. The primary efficacy outcome was improved wound healing defined as the difference in the proportion of complete (100%) wound closure at 24 Weeks confirmed at two consecutive study visits 2 weeks apart. Wounds were assessed at Weeks 22 and 24 or Weeks 24 and 26. The difference in the proportion of complete wound closure was also assessed at Weeks 8 and 10 or at Weeks 10 and 12.

Wound Closure Assessment Timepoints	Complete Wound Closure n (%) Vyjuvek gel (N=31)	Complete Wound Closure n (%) Placebo gel (N=31)	Treatment Difference (95% CI)	p value
Weeks 22 & 24 or Weeks 24 & 26	20 (65)	8 (26)	39% (14, 63)	0.012
Weeks 8 & 10 or Weeks 10 & 12	21 (68)	7 (23)	45% (22, 69)	0.003

The expanded age indication to now include patients under 6 months of age (0 to 16 years of age) is supported by efficacy and safety data from GEM-3, which included pediatric patients aged 1 to 19 years, as well as an open-label study, which included two infants aged 6 and 7 months. The open-label study itself has not been published as a standalone manuscript or registered clinical trial, and specific details such as treatment duration, wound characteristics, healing outcomes, or individual adverse event profiles for the two infants are not available in accessible medical literature. The evidence supporting the age expansion from ≥6 months to birth (0 years) is incorporated directly into the FDA labeling based on regulatory submission data rather than peer-reviewed publication.

Current Formulary Status: Vyjuvek is a medical benefit only requiring prior authorization. Vyjuvek is currently non-formulary for pharmacy.

Recommendation: Vyjuvek is a medical or pharmacy benefit and will require prior authorization. Vyjuvek should not be added to the Commercial/Marketplace/CHIP formularies.

- Medical record documentation that Vyjuvek is prescribed by or in consultation with a dermatologist who specializes in epidermolysis bullosa (EB) management AND
- ~~Medical record documentation of age greater than or equal to 6 months AND~~
- Medical record documentation of diagnosis of dystrophic epidermolysis bullosa (DEB) AND
- Medical record documentation of genetic testing confirming mutation(s) in the COL7A1 gene AND
- Medical record documentation of at least one open dystrophic epidermolysis bullosa (DEB) wound AND

- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

No changes are recommended for the following: GPI level, Facets Rx Count, Authorization Duration, Quantity Limit, Reauthorization Info, and RPH Sign Off.

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

ZORYVE CREAM 0.05% (roflumilast)

Clinical Summary: Zoryve cream 0.05% (new strength) approved for use in the treatment of mild to moderate atopic dermatitis in pediatric patients 2 to 5 years of age.

Previous approvals: Zoryve cream 0.3%: plaque psoriasis in ages 6 years and older
Zoryve cream 0.15%: mild to moderate atopic dermatitis in ages 6 years old and above.

Dosing: once daily dosing to affected areas which is the same for all indications and ages

Summary of Updated Clinical Studies: A multicenter, randomized, double-blind, vehicle-controlled trial (INTEGUMENT-PED [NCT04845620]) enrolled a total of 652 pediatric subjects 2 to 5 years of age with mild to moderate atopic dermatitis.

Subjects were randomized 2:1 to receive ZORYVE cream, 0.05%, or vehicle cream applied once daily for 4 weeks. The median age of the trial population was 3 years (range 2 to 5 years of age).

The trial population was 52% male; 69.1% were White, 15.4% Black or African American, 8.3% Asian, 1.8% other races, 4.9% more than one race, and 0.5% American Indian or Alaska Native. For ethnicity, 82.2% of subjects identified as Not Hispanic or Latino, 17.4% identified as Hispanic or Latino, and 0.5% were unknown.

At baseline, subjects had a mean affected BSA of 22% (range of 3% to 82%), and 53% had facial involvement. At baseline, 22% of subjects had a validated Investigator Global Assessment for Atopic Dermatitis (vIGA-AD) score of 2 (mild), and 78% had a vIGA-AD score of 3 (moderate).

The primary endpoint was the proportion of subjects who achieved vIGA-AD treatment success at Week 4 (Table 7). Success was defined as a score of “Clear” (0) or “Almost Clear” (1), plus a 2-grade improvement from baseline. Secondary endpoints included the proportion of subjects that achieved vIGA-AD success at Weeks 1 and 2 (Figure 4)

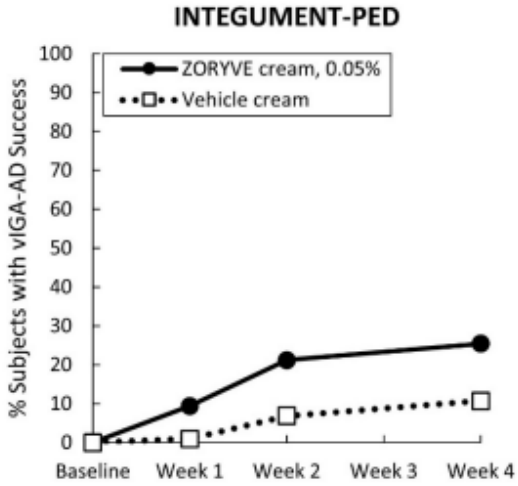
Table 7: vIGA-AD Success* at Week 4 in Pediatric Subjects 2 to 5 Years of Age with Mild to Moderate Atopic Dermatitis in Trial INTEGUMENT-PED

	INTEGUMENT-PED	
	ZORYVE Cream, 0.05%	**Vehicle Cream**
Subjects randomized	**N=436**	**N=215**
vIGA-AD success	25.4%	10.7%
Difference from vehicle (95% CI)†	14.9% (9.04%, 20.79%)	

Abbreviations: CI = Confidence Interval
*vIGA-AD success was defined as a vIGA-AD score of “Clear” (0) or “Almost Clear” (1), plus a 2-grade vIGA-AD score improvement from baseline at Week 4 (Multiple Imputation).

†The difference in percent and related 95% CIs are Mantel-Haenszel estimates stratified by pooled study site and vIGA-AD randomization strata.

Figure 4: vIGA-AD Success* Over Time in Pediatric Subjects 2 to 5 Years of Age with Mild to Moderate Atopic Dermatitis in Trial INTEGUMENT-PED



*vIGA-AD success was defined as a vIGA-AD score of "Clear" (0) or "Almost Clear" (1), plus a 2-grade vIGA-AD score improvement from baseline at Week 4 (Multiple Imputation).

Summary of Safety Considerations Adverse reactions for this dose and population: upper respiratory tract infections, diarrhea, vomiting, stuffy or runny nose, red or swollen eyes (like "pink eye"), headache

Current Formulary Status: non-formulary

Recommendation: It is recommended to add criteria for this diagnosis and age to Commercial/Marketplace/CHIP policy 744.0 AND remove the highlighted criteria from Commercial policy under 0.15% cream

Age 12 Years and Above

- Medical record documentation that Zoryve is prescribed by or in consultation with a dermatologist **AND**
- Medical record documentation of age greater than or equal to 12 years **AND**
- Medical record documentation of a diagnosis of chronic plaque psoriasis **AND**
- Medical record documentation of BSA involvement less than or equal to 20% **AND**
- Medical record documentation of therapeutic failure, intolerance, or contraindication to at least one of the following:
    - A high- to ultrahigh-potency TCS used concurrently with a generic topical calcipotriene product **OR**
    - A generic calcipotriene/betamethasone combination product **OR**
    - A high- to ultrahigh-potency TCS used concurrently with generic tazarotene 0.1%

Age 6 to 11 Years

- Medical record documentation that Zoryve is prescribed by or in consultation with a dermatologist **AND**
- Medical record documentation of age 6 to 11 years **AND**
- Medical record documentation of a diagnosis of chronic plaque psoriasis **AND**
- Medical record documentation of BSA involvement less than or equal to 20% **AND**

- Medical record documentation of therapeutic failure, intolerance, or contraindication to a medium to high-potency topical corticosteroid used concurrently with a generic topical calcipotriene product [calcipotriene should be avoided on the face, genitalia, intertriginous areas/flexures]

An exception for coverage of **Zoryve 0.3% topical foam** may be made for members who meet the following criteria:

Seborrheic Dermatitis

- Medical record documentation that Zoryve topical foam is prescribed by or in consultation with a dermatologist **AND**
- Medical record documentation of age greater than or equal to 9 years **AND**
- Medical record documentation of a diagnosis of seborrheic dermatitis **AND**
- Medical record documentation of therapeutic failure, intolerance, or contraindication to:
    - At least one low- to high-potency topical corticosteroid **AND**
    - At least one topical antifungal

Plaque Psoriasis

- Medical record documentation that Zoryve topical foam is prescribed by or in consultation with a dermatologist **AND**
- Medical record documentation of age greater than or equal to 12 years **AND**
- Medical record documentation of a diagnosis of plaque psoriasis **AND**
- Medical record documentation of therapeutic failure, intolerance, or contraindication to at least one of the following:
    - A high- to ultrahigh-potency topical corticosteroid used concurrently with a generic topical calcipotriene product **OR**
    - A generic calcipotriene/betamethasone combination product **OR**
    - A high- to ultrahigh-potency topical corticosteroid used concurrently with generic tazarotene 0.1%

An exception for coverage of **Zoryve 0.15% topical cream** may be made for members who meet the following criteria:

- Medical record documentation that Zoryve 0.15% cream is prescribed by or in consultation with a dermatologist, allergist, or immunologist **AND**
- Medical record documentation of a diagnosis of mild to moderate atopic dermatitis **AND**
- Medical record documentation of age greater than or equal to 6 years **AND**
- ~~Medical record documentation that member is immunocompetent **AND**~~
- Medical record documentation of Body Surface Area (BSA) less than or equal to 20% **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to ALL of the following:
    - One formulary topical calcineurin inhibitor (tacrolimus ointment) **AND**
    - One formulary topical corticosteroid unless deemed inadvisable due to potential risks such as (a) use on sensitive skin areas (face, axillae, or groin)

An exception for coverage of **Zoryve 0.05 % topical cream** may be made for members who meet the following criteria:

- Medical record documentation that Zoryve 0.05 % cream is prescribed by or in consultation with a dermatologist, allergist, or immunologist **AND**
- Medical record documentation of a diagnosis of mild to moderate atopic dermatitis **AND**
- Medical record documentation of age 2 to 5 years **AND**
- Medical record documentation of Body Surface Area (BSA) less than or equal to 20% **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to ALL of the following:
    - One formulary topical calcineurin inhibitor (tacrolimus ointment) **AND**
    - One formulary topical corticosteroid unless deemed inadvisable due to potential risks such as (a) use on sensitive skin areas (face, axillae, or groin)

MEDISPAN AUTHORIZATION LEVEL: GPI-12

QUANTITY LIMIT: *No QLs need to be entered within the authorization unless the requested quantity exceeds the QL.*

- QL FOR LETTER ONLY: 60 grams (1 tube) every 30 days

AUTHORIZATION DURATION: Initial approval will be for 6 months. Subsequent approvals will be for an additional 12 months and will require medical record documentation of the following:

- For Zoryve 0.3% topical cream: Medical record documentation of clinical improvement based on signs and symptoms of plaque psoriasis **OR**
- For Zoryve 0.3% topical foam: Medical record documentation of clinical improvements based on signs and symptoms of seborrheic dermatitis or plaque psoriasis **OR**
- For Zoryve 0.15% or 0.05% topical cream: Medical record documentation of clinical improvement based on signs and symptoms of atopic dermatitis

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

UPDATES

ACTEMRA POLICY UPDATE

Background: Actemra has been removed from the Commercial, Exchange, and CHIP formularies with the availability of biosimilar competitors. Due to this formulary removal, it is necessary to update policy 321.0 Actemra and Tyenne Self-Injectable.

Specifically:

- The authorization duration for Actemra approvals requires update since Actemra is no longer a prior authorization for new starts only.
- The GPI level for Actemra and Tyenne approvals requires update to GPI-10 due to the availability of additional formulations:
    - Actemra: ActPen (auto-injector) and pre-filled syringe
    - Tyenne: auto-injector and pre-filled syringe

Of note, Actemra and Tyenne share all FDA approved indications with the exception of systemic sclerosis-associated interstitial lung disease for which only Actemra is approved.

Current Policy: The following authorization duration and GPI approval restrictions apply:

Systemic sclerosis-associated interstitial lung disease:

MEDISPAN AUTHORIZATION LEVEL: GPI-14, number of claims authorized = 1, enter for one month duration

RE-AUTHORIZATION CRITERIA: Actemra self-injectable is configured as a prior authorization for new starts only. Actemra self-injectable 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

All Other Indications:

MEDISPAN AUTHORIZATION LEVEL: GPI-14, number of claims authorized = 1, enter for one month duration

RE-AUTHORIZATION CRITERIA: Actemra and Tyenne self-injectable are configured as a prior authorization for new starts only. Actemra or Tyenne self-injectable 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

Recommendations: The authorization duration and GPI should be updated as follows:

Systemic sclerosis-associated interstitial lung disease:

MEDISPAN AUTHORIZATION LEVEL: GPI-10 ~~14 number of claims authorized = 1, enter for one month duration.~~

RE-AUTHORIZATION CRITERIA: Approval will be given for a duration of twelve (12) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in signs and symptoms of systemic sclerosis-associated interstitial lung disease rheumatoid arthritis on Actemra therapy is required. ~~Actemra self-injectable is configured as a prior authorization for new starts only. Actemra self-injectable 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~~

All Other Indications:

MEDISPAN AUTHORIZATION LEVEL: GPI-~~14~~10.
If request is for Tyenne: number of claims authorized = 1, enter for one month duration.

TYENNE RE-AUTHORIZATION CRITERIA: ~~Actemra and~~ Tyenne self-injectable are configured as a prior authorization for new starts only. ~~Actemra or~~ Tyenne self-injectable 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

ACTEMRA RE-AUTHORIZATION CRITERIA: Approval will be given for a duration of twelve (12) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in signs and symptoms of *insert diagnosis* on Actemra therapy is required.

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.

COMMERCIAL OPIOID USE POLICY 488.0 UPDATES

Background/Recommendations: The following updates are recommended to the commercial opioid use policy 488.0 in alignment with the recent 2022 update to the CDC guidelines:

CURRENT CRITERIA 1: The prescriber will conduct urine drug screening (UDS), which includes testing for the prescribed opioid per the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain – United States 2016

PROPOSED UPDATE 1: The prescriber will conduct urine drug screening (UDS), which includes testing for the prescribed opioid per the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain – United States 2022

Rationale: 2022 CDC Guidelines continue to recommend that clinicians prescribing opioids for subacute or chronic pain consider the benefits and risks of toxicology testing to assess for use of controlled substances

CURRENT CRITERIA 2: Provider has evaluated member for risk of opioid use disorder using CAGE-AID, Opioid Risk Tool or a similar screening tool upon initiation of opioids and every 3 months or as needed

PROPOSED UPDATE 2: Provider has established a risk mitigation plan and evaluated member for risk of opioid use disorder/misuse disorder at least once every 12 months during treatment.
Note to reviewer: This plan may include use of validated risk tool (such as ORT, CAGE-AID, etc), regularly scheduled provider follow-up, review of family/social history, and/or co-management by pharmacist trained in chronic pain management.

Rationale: The CDC guidelines recommend screening or risk assessment tools to identify patients at high risk for opioid misuse/use disorder. It is recommended that this be completed upon initiation and periodically during treatment. The available tools have demonstrated limited

and variable accuracy and per the guidelines if the tools are used, they should be supplemented with other assessments. The CDC guidelines recommend an overall strategy & plan to mitigate risk of overdose.

CURRENT CRITERIA 3: Medical record documentation that the member or parent/guardian has been educated on the potential adverse effects of opioid analgesics, including the risk for misuse, abuse and addiction **AND** the member will receive a prescription for naloxone if dose of opioid is 120 MEDs (50MEDs for minors) or greater and member is not being treated for end of life **OR** if the prescriber determine the member is at risk for an overdose at any MED

PROPOSED UPDATE 3: Medical record documentation that the member or parent/guardian has been educated on the potential adverse effects of opioid analgesics, including the risk for misuse, abuse and addiction **AND** has been educated about how to obtain naloxone as part of a risk mitigation plan, unless member is being treated for end-of-life care.

Rationale: Access to Naloxone is an important part of a risk mitigation plan for any patient receiving chronic opioid therapy. Given the availability of Naloxone over the counter and through community outreach programs, recommend removing prescription requirement and documenting education regarding Naloxone and avenues to obtain.

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.

INSULIN POLICY UPDATES

Background/Recommendations:

Policy 96.0 Lilly Insulin

Due to formulary changes in the rapid acting insulin category it is necessary to update policy 96.0 Lilly Insulin. This policy currently requires failure of a Novo brand insulin, but these products are no longer covered on the formulary.

Drug	Formulary Status	
	Commercial	Exchange
Kirsty	Brand Preferred Tier	Brand Preferred Tier
Merilog	Brand Preferred Tier	Brand Preferred Tier
Fiasp	Non-Formulary	Non-Formulary
Admelog	Non-Formulary	Non-Formulary
Apidra	Non-Formulary	Non-Formulary
Humalog	Non-Formulary	Non-Formulary
Insulin Lispro	Non-Formulary	Non-Formulary
Novolog	Non-Formulary	Brand Preferred Tier
Insulin Aspart	Non-Formulary	Generic Non-Preferred Tier
Lyumjev	Non-Formulary	Non-Formulary

Current Policy:

A formulary exception for coverage of Lilly Insulin may be made for members who meet the following criteria:

- Medical record documentation that the requested insulin requires dilution **OR**
- Medical record documentation of a therapeutic failure on, contraindication to, or intolerance to comparable Novo Nordisk brand insulin **(with the exception of Fiasp)**

Recommendations: It is recommended that this policy is updated to include all non-formulary, injectable, rapid acting insulins. Policy 509.0 Fiasp will be retired. The prior authorization criteria should be updated as follows:

- ~~Medical record documentation that the requested insulin requires dilution **OR**~~
- ~~Medical record documentation of a therapeutic failure on, contraindication to, or intolerance to comparable Novo Nordisk brand insulin **(with the exception of Fiasp)**~~
- Medical record documentation of therapeutic failure on, contraindication to, or intolerance to Kirsty **OR** Merilog

---

Policy 390.0 Afrezza

Due to formulary changes in the rapid acting insulin category it is necessary to update policy 390.0 Afrezza. This policy currently requires failure of Novolog, but this product is no longer covered on the formulary.

Recommendations: It is recommended that this policy is updated to require failure of formulary rapid acting insulins:

- Medical record documentation of a diagnosis of diabetes mellitus **AND**
- Medical record documentation that the patient does not have asthma or chronic obstructive pulmonary disease (COPD) **AND**
- Medical record documentation that the patient is 18 years of age or older **AND**
- Medical record documentation that the patient is unable to use subcutaneous insulin due to a clinically justifiable reason (i.e., patient is unable to hold/maneuver syringes/pens*) **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to ~~Novolog~~ Kirsty **OR** Merilog

---

Policy 474.0 Basaglar, Semglee, and Rezvoglar

Due to formulary changes in the long-acting insulin category it is necessary to update policy 474.0 Basaglar, Semglee, and Rezvoglar. This policy currently requires failure of Lantus or insulin glargine.

Drug	Formulary Status	
	Commercial	Exchange
Insulin Glargine-yfgn	Brand Preferred Tier	Brand Preferred Tier
Insulin Glargine Max Solostar	Brand Preferred Tier	Brand Preferred Tier
Insulin Glargine Solostar	Brand Preferred Tier	Brand Preferred Tier
Basaglar	Non-Formulary	Brand Preferred Tier
Lantus	Non-Formulary	Brand Preferred Tier
Rezvoglar	Non-Formulary	Non-Formulary
Semglee	Non-Formulary	Non-Formulary
Toujeo	Non-Formulary	Non-Formulary

Current Policy:

A formulary exception for coverage of Basaglar, Semglee, or Rezvoglar may be made for members who meet the following criteria:

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Lantus **OR** insulin glargine

Recommendations: It is recommended that this policy is updated to remove failure of Lantus from the criteria and clarify that failure will be of insulin glargine-yfgn. Additionally, Lantus and Toujeo should be added to policy 474.0. The prior authorization criteria should be updated as follows:

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to ~~Lantus **OR**~~ insulin glargine-yfgn

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.

Medical Benefit policy updates

Background/Recommendations:

Nucala Update

Discussion: In the clinical trials demonstrating efficacy of Nucala in COPD (MATINEE and METREX) listed in the prescribing information, the efficacy population included patients who had a blood eosinophil count ≥150 cell/mcL at screening or ≥300 cell/mcL in the previous 12 months.

Recommendations: It is recommended to update the prior authorization criteria of MBP 141.0 Nucala (mepolizumab) to include blood eosinophil counts of 300 cells/mcL. Within 12 months of starting therapy and 150 cells/mcL within 3 months of starting therapy.

MBP 141.0 Nucala (mepolizumab)

Nucala (mepolizumab) will be considered medically necessary for the commercial, exchange, and CHIP lines of business when all of the following criteria are met:

Moderate to Severe Eosinophilic Chronic Obstructive Pulmonary Disease (COPD)

- Documentation of patient age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of moderate to severe eosinophilic chronic obstructive pulmonary disease (COPD) **AND**
- Medical record documentation that Nucala is being used as add-on maintenance treatment **AND**
- Prescription written by an allergist or pulmonologist **AND**
- Medical record documentation of a blood eosinophil count of either ~~>~~ ≥ 300 cells/mcL (0.30 K/µl) during the 12-month period before screening and/or ~~>~~ ≥ 150 cells/mcL (0.15 K/µl) within 3 months of the start of therapy **AND**
- Medical record documentation of one severe or two moderate exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, antibiotics, emergency department or urgent care visits, or hospitalization) despite current therapy or intolerance to triple therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) **AND**
- Insured individual must be adherent with current therapeutic regimen and must demonstrate appropriate inhaler technique **AND**
- Medical record documentation that the medication will not be used in combination with another biologic medication indicated for COPD treatment (e.g. Dupixent (dupilumab))

Nucala (mepolizumab) will be considered medically necessary for the Medicare line of business when all of the following criteria are met:

Moderate to Severe Eosinophilic Chronic Obstructive Pulmonary Disease (COPD)

- Documentation of patient age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of moderate to severe eosinophilic chronic obstructive pulmonary disease (COPD) **AND**
- Medical record documentation that Nucala is being used as add-on maintenance treatment **AND**
- Prescription written by an allergist or pulmonologist **AND**

- Medical record documentation of a blood eosinophil count of either ~~>~~ ≥ 300 cells/mcL (0.30 K/µl) during the 12-month period before screening and/or ~~>~~ ≥ 150 cells/mcL (0.15 K/µl) within 3 months of the start of therapy **AND**
- Medical record documentation of one severe or two moderate exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, antibiotics, emergency department or urgent care visits, or hospitalization) despite current therapy or intolerance to triple therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) **AND**
- ~~Insured individual must be adherent with current therapeutic regimen and must demonstrate appropriate inhaler technique **AND**~~
- Medical record documentation that the medication will not be used in combination with another biologic medication indicated for COPD treatment (e.g. Dupixent (dupilumab))

Infliximab Update

Recommendations: It is recommended to update the prior authorization criteria of MBP 5.0 Remicade (infliximab), Inflectra (infliximab-dyyb), Renflexis (infliximab-abda), Avsola (infliximab-axxq) to include unbranded infliximab as a product addressed by the commercial, exchange, and CHIP prior authorization criteria.

MBP 5.0 Remicade (infliximab), Inflectra (infliximab-dyyb), Renflexis (infliximab-abda), Avsola (infliximab-axxq) – Commercial/Exchange/CHIP only

Remicade (infliximab), Inflectra (infliximab-dyyb), Renflexis (infliximab-abda), or Avsola (infliximab-axxq) will be considered medically necessary for the commercial, exchange, and CHIP lines of business when all of the following criteria are met based on indication:

- 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 or unbranded infliximab), medical record documentation of a therapeutic failure on, intolerance to, or contraindication to infliximab-axxq (Avsola) AND infliximab-abda (Renflexis), AND infliximab-dyyb (Inflectra).

Rituximab Update

Recommendations: It is recommended to update the prior authorization criteria of MBP 48.0 Rituxan (rituximab), Truxima (rituximab-abbs), Ruxience (rituximab-pvvr), and Riabni (rituximab-arrx) to have an all-inclusive range of diagnosis codes for MS.

MBP 48.0 Rituxan (rituximab), Truxima (rituximab-abbs), Ruxience (rituximab-pvvr), and Riabni (rituximab-arrx)

8. For Multiple Sclerosis (MS)

Note: Prior authorization is not required for Ruxience, Riabni or Truxima for diagnosis code G35 A-35.D. In the event of a request for the rituximab reference product (i.e. Rituxan), OR in the event a requestor would like a medical necessity review completed, the following criteria would apply:

Imaavy Update

Discussion: Based on PARP review, the below updates were made to the reauthorization criteria of Imaavy. The initial reauthorization verifies initial benefit from treatment. Subsequent reauthorizations verify either continued improvement or sustained initial benefit.

MBP 354.0 Imaavy (nipocalimab-aahu)

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Reauthorization will be for 6 months and will require:

- Medical record documentation that the member is responding positively to therapy as evidenced by an improvement of Myasthenia Gravis-Activities of Daily Living (MG-ADL) total score from baseline.

Subsequent reauthorizations will be for an additional 6 months and will require:

- Medical record documentation of continued disease improvement or lack of disease progression **OR**
- Medical record documentation that the member is responding positively to therapy as evidenced by an improvement of Myasthenia Gravis-Activities of Daily Living (MG-ADL) total score from baseline.

The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Opdivo and Opdivo Qvantig Update

Recommendations: It is recommended to update the prior authorization criteria of MBP 126.0 Opdivo (nivolumab) and MBP 342.0 Opdivo Qvantig (nivolumab-hyaluronidase-nvhy) to include changes recommended by PARP review.

MBP 126.0 Opdivo (nivolumab)

3. *Renal Cell Carcinoma*
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation that patient is ≥ 18 years of age **AND**
     - Medical record documentation of use as a single agent for ~~relapse or for surgically unresectable~~ advanced ~~or metastatic~~ renal cell carcinoma **AND**
     - Medical record documentation of a therapeutic failure on or intolerance to prior anti-angiogenic therapy, including, but not limited to, Sutent (sunitinib), Votrient (pazopanib), Inlyta (axitinib), Nexavar (sorafenib), Avastin (bevacizumab), Afinitor (everolimus), or Torisel (temsirolimus).

MBP 342.0 Opdivo Qvantig (nivolumab-hyaluronidase-nvhy)

1. ***Melanoma***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation that patient is ≥ ~~18 years~~ 12 years of age **AND**
   - Medical record documentation of one of the following:
     - A diagnosis of unresectable or metastatic melanoma **AND**
     - Opdivo Qvantig is being used as a single agent ~~following combination treatment with intravenous nivolumab and ipilimumab~~

     OR
     - A diagnosis of completely resected (no evidence of disease) Stage IIB, Stage IIC, Stage III, or Stage IV melanoma **AND**
     - Opdivo Qvantig is being used in the adjuvant setting **AND**

Opdivo Qvantig is being used as a single agent

2. ***Renal Cell Carcinoma***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation that patient is ≥ 18 years of age **AND**
   - Medical record documentation of use as a single agent ~~for relapse or for surgically unresectable~~ advanced ~~or metastatic~~ renal cell carcinoma **AND**
   - Medical record documentation of a therapeutic failure on or intolerance to prior anti-angiogenic therapy, including, but not limited to, Sutent (sunitinib), Votrient (pazopanib), Inlyta (axitinib), Nexavar (sorafenib), Avastin (bevacizumab), Afinitor (everolimus), or Torisel (temsirolimus).

3. ***Colorectal Cancer***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation that patient is ≥ ~~18 years~~ 12 years of age **AND**
   - Medical record documentation of a diagnosis of metastatic colorectal cancer **AND**

- Medical record documentation of microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease **AND**
- One of the following:
    - Medical record documentation of progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan ~~**AND**~~ as a single agent **OR**
    - Medical record documentation that Opdivo Qvantig is being used ~~as a single agent or~~ as a single agent following combination treatment with intravenous nivolumab and ipilimumab (Yervoy).

4. ***Hepatocellular Carcinoma (HCC)***
    - Prescription written by a hematologist/oncologist **AND**
    - Medical record documentation of a diagnosis of unresectable or metastatic hepatocellular carcinoma **AND**
    - One of the following:
        - Medical record documentation of a therapeutic failure on or intolerance to sorafenib (Nexavar) **AND**
        - Medical record documentation that Opdivo Qvantig will be used as a single-agent following combination treatment with intravenous nivolumab and ipilimumab (Yervoy).

        OR
        - Medical record documentation that Opdivo Qvantig is being used as a single-agent in the first-line setting following combination treatment with intravenous nivolumab and ipilimumab (Yervoy).

Retired Policies Update (Medical benefit only)

Discussion: Per an FDA safety communication released on 12/18/25, postmarketing safety data on Andexxa has led to the conclusion that the risks of the product outweigh the benefits. AstraZeneca submitted a request to voluntarily withdraw the BLA and sales in the United States ended on 12/22/25. As of February 2025, Pfzier announced they are discontinuing Beqvez, ceasing global development and commercialization of the product. As of December 2025, Merck announced they are discontinuing Zinplava, effective 1/31/25.

Recommendations: It is recommended to retire the medical benefit policies listed in the following table for all lines of business. Beqvez will remain on the prior authorization list at this time to indicate a prior authorization is required if the medication is being requested.

Medical Benefit Policy	Lines of business	Recommendation
MBP 332.0 Beqvez (fidanacogene elaparvovec-dzkt)	All LOB's	Retire
MBP 183.0 Andexxa (andexanet alfa)	All LOB's	Retire
MBP 153.0 Zinplava (bezlotoxumab)	Commercial/Exchange/CHIP/ Medicare	Retire

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

ORAL ONCOLOGY UPDATE

Background/Recommendations:
It is recommended to retire the following oral oncology policies and review all of them under the same policy.

BRAND NAME	Policy #
Abiraterone Acetate	257
Abirtega	257
Akeega	783

Alecensa	408
Alunbrig	453
Augtyro	797
Avmapki Fakzynja Co-Pack	865
Ayvakit	611
Balversa	563
Bosulif	263
Braftovi	525
Brukinsa	608
Cabometyx	420
Calquence	480
Caprelsa	229
Cometriq (100 mg Daily Dose)	277
Cometriq (140 mg Daily Dose)	277
Cometriq (60 mg Daily Dose)	277
Copiktra	531
Cotellic	401
Danziten	853
Dasatinib	125
Daurismo	548
Ensacove	869
Erivedge	245
Erleada	498
Erlotinib HCl	292
Everolimus	188
Exkivity	689
Fotivda	663
Fruzaqla	790
Gavreto	645
Gefitinib	99
Gilotrif	307
Gomekli	858
Hernexeos	878
Ibrance	367
Ibtrozi	871
Iclusig	278
IDHIFA	462
Imbruvica	315
Imkeldi	852
Inlyta	246
Inluriyo	884

Inqovi	643
Itovebi	838
Iwilfin	800
Jaypirca	748
Kisqali (200 MG Dose)	447
Kisqali (400 MG Dose)	447
Kisqali (600 MG Dose)	447
Kisqali Femara (200 MG Dose)	447
Kisqali Femara (400 MG Dose)	447
Kisqali Femara (600 MG Dose)	447
Koselugo	621
Krazati	745
Lapatinib Ditosylate	175
Lazcluze	832
Lenalidomide	124
Lenvima (10 MG Daily Dose)	373
Lenvima (12 MG Daily Dose)	373
Lenvima (14 MG Daily Dose)	373
Lenvima (18 MG Daily Dose)	373
Lenvima (20 MG Daily Dose)	373
Lenvima (24 MG Daily Dose)	373
Lenvima (4 MG Daily Dose)	373
Lenvima (8 MG Daily Dose)	373
Lonsurf	396
Lorbrena	539
Lumakras	673
Lynparza	362
Lytgobi (12 MG Daily Dose)	740
Lytgobi (16 MG Daily Dose)	740
Lytgobi (20 MG Daily Dose)	740
Mekinist	304
Mektovi	526
Modeyso	880
Nerlynx	463
Nilotinib HCl	174
Ninlaro	403
Nubeqa	585
Odomzo	397
Ogsiveo	798
Ojemda	821
Onureg	646

Orgovyx	654
PAZOPanib HCl	207
Pemazyre	627
Phyrago	125
Piqray (200 MG Daily Dose)	566
Piqray (250 MG Daily Dose)	566
Piqray (300 MG Daily Dose)	566
Pomalyst	281
Qinlock	631
Retevmo	632
Revuforj	847
Rezlidhia	756
Romvimza	859
Rozlytrek	588
Rubraca	442
Rydapt	454
Scemblix	693
SORAfenib Tosylate	132
Stivarga	269
SUNItinib Malate	133
Tabrecta	634
Tafinlar	304
Tagrisso	405
Talzenna	544
Tasigna	174
Tazverik	613
Tepmetko	658
Tibsovo	528
Torpenz	Admin Policy
Truqap	793
Truseltiq (100MG Daily Dose)	674
Truseltiq (125MG Daily Dose)	674
Truseltiq (50MG Daily Dose)	674
Truseltiq (75MG Daily Dose)	674
Tukysa	635
Turalio	586
Vanflyta	786
Venclexta	417
Venclexta Starting Pack	417
Verzenio	473

Vitrakvi	549
Vizimpro	537
Voranigo	835
Welireg	680
Xalkori	255
Xospata	550
Xtandi	262
Yonsa	519
Zejula	455
Zelboraf	256
Zydelig	343
Zykadia	330

The medications listed above will be consolidated into one oral oncology policy and reviewed with the following criteria.

Prior Authorization Criteria (for all oncology products listed above):

- Medical record documentation that the medication is prescribed by or in consultation with a hematologist, oncologist, or other appropriate specialist AND
- Medical record documentation of a diagnosis that is supported by one of the following:
  - U.S. Food and Drug Administration (FDA)- approved package labeling or
  - The National Comprehensive Cancer Network (NCCN) guidelines or
  - American Society of Clinical Oncology (ASCO)

  AND
- Medical record documentation of an age consistent with FDA approval or medically accepted indication AND
- Medical record documentation that the medication is being prescribed at a dose and duration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature AND
- For a non-preferred product with a therapeutically equivalent generic or biosimilar, medical record documentation of a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent generic or biosimilar

Authorizations will be entered by GPI-12. If the request is for a generic product, please enter generic only on the authorization.

Updates to authorization durations for consistency:

- It is recommended to update the authorization duration for the following medications **to prior authorization for new starts only**. These medications are given until disease progression or unacceptable toxicity. Also, their current reauthorization criteria is just to confirm the member is not having progression, except for Orgovyx. Orgovyx is the only medication that does not have an authorization duration currently.
  - Brukinsa
  - Gomekli
  - Koselugo
  - Ojemda

- Orgovyx
- Revuforj

- It is recommended to update the following authorization durations as indicated to 6 months for consistency with OncoHealth reviews. The updates are highlighted below.
  - **Lynparza:**
    - For first-line maintenance of BRCA-mutated advanced ovarian cancer (failure on first-line platinum-based chemotherapy) and for first-line maintenance of HRD-positive advanced ovarian cancer in combination with bevacizumab: Initial approval will be for ~~12 months~~ 6 months or less if the reviewing provider feels it is medically appropriate. ~~One~~ Three subsequent approvals for Lynparza will be granted ~~for up to an additional 12 months~~ in 6 month increments (total of two years of therapy) and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease. For members requesting approval of treatment beyond two (2) years, medical record documentation will be required showing patient has continued evidence of disease and treating healthcare provider believes member can derive further benefit from continuous treatment. Each additional approval will be for a period of ~~12 months~~ 6 months. Members with complete response at two years, will not be granted additional treatment, per the package labeling.
    - For adjuvant treatment of high-risk early breast cancer: ~~One time authorization for 12 months or less~~ Initial approval will be for 6 months and one subsequent approval will be for 6 months if the reviewing provider feels it is medically appropriate. Authorization of Lynparza for the adjuvant treatment of high-risk early breast cancer should not exceed the FDA-approved treatment duration of 1 year (12 months). 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~~ 6 months or less if the reviewing provider feels it is medical appropriate. Subsequent approvals will be for an additional ~~12 months~~ 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 the member experiences unacceptable toxicity or worsening of disease.
  - Nerllynx
    - Early Stage Breast Cancer: ~~One time, 12 month authorization~~ Initial approval will be for 6 months and one subsequent approval will be for 6 months
    - Advanced or Metastatic Breast Cancer: Initial approval will be for ~~12 months~~ 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional ~~12 months~~ 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 the member experiences unacceptable toxicity or worsening of disease.
  - Tagrisso
    - ADJUVANT TREATMENT OF NSCLC AUTHORIZATION DURATION: Initial approval will be for 6 months. Up to 5 (five) subsequent approvals will each be for an additional ~~5 months or less~~ 6 months if the reviewing provider feels it is medically appropriate to equal a total treatment duration of 3 years and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease. Authorization of Tagrisso for adjuvant treatment of Non-Small Cell Lung Cancer (NSCLC) will not exceed the FDA-approved treatment duration of 3 years (36 months). For

requests exceeding the above limit, documentation will be required of peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration.
        - METASTATIC, LOCALLY ADVANCED, OR UNRESECTABLE NSCLC 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 the member experiences unacceptable toxicity or worsening of disease.
    - Vanflyta
        - Initial approval will be for 6 months. Subsequent approvals will be for 6 months 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.
        - Authorization of Vanflyta for the treatment of FLT3-ITD positive acute myeloid leukemia (AML) should not exceed the FDA-approved treatment duration of 2 cycles of induction, up to 4 cycles of consolidation, and up to 36 cycles as maintenance (3 years and 3 months). 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
    - Verzenio
        - 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~~ Four approvals in 6 months increments 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~~ 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional ~~24 months~~ 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.

Authorization Duration for Oral Oncology Policy: All products (unless listed below) are configured as a prior authorization for new starts only. The medication 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

Other Authorization Durations in Oral Oncology Policy:

- **Lynparza:**

        - For first-line maintenance of BRCA-mutated advanced ovarian cancer (failure on first-line platinum-based chemotherapy) and for first-line maintenance of HRD-positive advanced ovarian cancer in combination with bevacizumab: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Three subsequent approvals for Lynparza will be granted in 6 month increments (total of two years of therapy) and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease. For members requesting approval of treatment beyond two (2) years, medical record documentation will be required showing patient has continued evidence of disease and treating healthcare provider believes member can derive further benefit from continuous treatment. Each additional approval will be for a period of 6 months. Members with complete response at two years, will not be granted additional treatment, per the package labeling.
        - For adjuvant treatment of high-risk early breast cancer: Initial approval will be for 6 months and one subsequent approval will be for 6 months if the reviewing provider feels it is medically appropriate. Authorization of Lynparza for the adjuvant treatment of high-risk early breast cancer should not exceed the FDA-approved treatment duration of 1 year (12 months). 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 6 months or less if the reviewing provider feels it is medical 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 the member experiences unacceptable toxicity or worsening of disease.
    - Nerllynx
        - Early Stage Breast Cancer: Initial approval will be for 6 months and one subsequent approval will be for 6 months
        - Advanced or Metastatic Breast Cancer: 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 the member experiences unacceptable toxicity or worsening of disease.
    - Tafinlar/Mekinist:
        - For Adjuvant Treatment of Melanoma: Approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. The FDA-approved treatment duration is for 6 months only. 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: Each treatment period will be defined as 6 months. Re-review will occur every 6 months. Tafinlar and/or Mekinist will no longer be covered if there is medical record documentation of disease progression.
    - Tagrisso
        - ADJUVANT TREATMENT OF NSCLC AUTHORIZATION DURATION: Initial approval will be for 6 months. Up to 5 (five) subsequent approvals will each be for an additional 6 months or less if the reviewing provider feels it is medically appropriate to equal a total treatment duration of 3 years and will require medical

record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease. Authorization of Tagrisso for adjuvant treatment of Non-Small Cell Lung Cancer (NSCLC) will not exceed the FDA-approved treatment duration of 3 years (36 months). For requests exceeding the above limit, documentation will be required of peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration.
        - METASTATIC, LOCALLY ADVANCED, OR UNRESECTABLE NSCLC 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 the member experiences unacceptable toxicity or worsening of disease.
    - Vanflyta
        - Initial approval will be for 6 months. Subsequent approvals will be for 6 months 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.
        - Authorization of Vanflyta for the treatment of FLT3-ITD positive acute myeloid leukemia (AML) should not exceed the FDA-approved treatment duration of 2 cycles of induction, up to 4 cycles of consolidation, and up to 36 cycles as maintenance (3 years and 3 months). 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
    - Verzenio
        - For adjuvant treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, node positive, early breast cancer: Four approvals in 6 month increments 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 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.

Quantity Limit Recommendations: It is recommended to add a Quantity Limit for Xospata of 3 tablets per day. Xospata is available as 40 mg tablets and the recommended dose is 120 mg once daily for a minimum of 6 months until disease progression or unacceptable toxicity.

Quantity Limits for Oral Oncology Policy:

Drug Name	Quantity Limit
Abiraterone Acetate	QL for letter only: 250 mg tablet: 4 tablets per day, 30 day supply per fill; 500 mg tablets: 2 tablets per day, 30 day supply per fill
Abirtega	QL for letter only: 250 mg tablet: 4 tablets per day, 30 day supply per fill; 500 mg tablets: 2 tablets per day, 30 day supply per fill
Akeega	QL for letter only: 2 tablets per day, 30 day supply per fill
Alecensa	QL for letter only: 8 capsules per day, 30 day supply per fill
Alunbrig	QL for letter only: 30 mg tablet: 2 tablets per day, 30 day supply per fill; 90 mg, 180 mg, and Starter Pack: 1 tablet per day, 30 day supply per fill
Augtyro	QL for letter only: 8 capsules per day, 30 day supply per fill
Avmapki Fakzynja Co-Pack	QL for letter only: 66 tabs per 28 days, 28 day supply per fill
Ayvakit	QL for letter only: 1 tablet per day, 30 day supply per fill
Balversa	QL for letter only: 3 mg tablet : 3 tablets per day, 28 day supply per fill; 4 mg tablet: 2 tablets per day, 28 day supply per fill; 5 mg tablet : 1 tablet per day, 28 day supply per fill
Bosulif	QL for letter only: 100 mg tablets: 3 tablets per day, 30 day supply per fill; 400 mg tablets: 1 tablet per day, 30 day supply per fill; 500 mg tablets: 1 tablet per day, 30 day supply per fill
Braftovi	QL for letter only: Melanoma/NSCLC: 6 tablets per day, 30 day supply per fill; colon cancer: 4 tablets per day, 30 day supply per fill
Brukinsa	QL for letter only: 4 capsules per day, 30 day supply per fill
Cabometyx	QL for letter only: If approved for 20 mg, 40 mg, or 60 mg daily dose: QL 1 per day, 30 day supply per fill; If approved for 80 mg daily, dosed as one 20 mg + one 60 mg tablet: QL 1 per day, 30 day supply per fill; If approved for 80 mg daily, dosed as two 40 mg tablets daily: QL 2 per day, 30 day supply per fill
Calquence	QL for letter only: 2 caps per day, 30 day supply per fill
Caprelsa	QL for letter only: 100 mg tab: 2 tabs per day, 30 day supply per fill; 300 mg tab: 1 tab per day, 30 day supply per fill
Cometriq (100 mg Daily Dose)	QL for letter only: 2 capsules per day, 28 day supply per fill
Cometriq (140 mg Daily Dose)	QL for letter only: 4 capsules per day, 30 day supply per fill
Cometriq (60 mg Daily Dose)	QL for letter only: 3 capsules per day, 28 day supply per fill
Copiktra	QL for letter only: 2 tabs per day, 30 day supply per fill
Cotellic	QL for letter only: 3 tabs per day, 30 day supply per fill
Danziten	QL for letter only: 4 capsules per day, 28 day supply per fill
Dasatinib	QL for letter only: 20 mg tab: 3 tabs per day, 30 day supply per fill; 50/70/80/100/140 mg tabs: 1 tab per day, 30 day supply per fill
Daurismo	QL for letter only: 100 mg tab: 1 tab per day, 30 day supply per fill; 25 mg tab: 2 tabs per day, 30 day supply per fill
Ensacove	QL for letter only: 2 caps per day, 30 day supply per fill
Erivedge	QL for letter only: 1 cap per day, 28 day supply per fill
Erleada	QL for letter only: 4 tabs per day, 30 day supply per fill
Erlotinib HCl	QL for letter only: 100 mg and 150 mg tablets: 1 tablet per day, 30 day supply per fill; 25 mg tablets: 3 tablets per day, 30 day supply per fill
Everolimus	QL for letter: 1 tab per day, 28 day supply per fill
Exkivity	QL for letter only: 4 caps per day, 30 day supply per fill
Fotivda	QL for letter only: 21 tabs per 28 days
Fruzaqla	QL for letter only: 1 mg tabs: 3 tabs per day, 28 day supply per fill; 5 mg tabs: 21 tabs per day 28 days
Gavreto	QL for letter only : 4 capsules per day, 30 day supply per fill
Gefitinib	QL for letter only: 1 tablet per day, 30 day supply per fill

Gilotrif	QL for letter only: 1 tablet per day, 30 day supply per fill
Gomekli	QL for letter only: 1 mg capsule & 1 mg soluble tab: 168 caps/tabs per 28 days; 2 mg cap: 84 caps per 28 days
Hernexeos	QL for letter only: 3 tabs per day, 30 day supply per fill
Ibrance	QL for letter only: 21 caps per 28 days, 28 day supply per fill
Ibtrozi	QL for letter only: 3 caps per day, 30 day supply per fill
Iclusig	QL for letter only: 1 tab per day, 30 day supply per fill
IDHIFA	QL for letter only: 1 tab per day, 30 day supply per fill
Imbruvica	QL for letter only: tabs/caps: 1 tab or cap per day, 28 day supply per fill; oral suspension: 6 mL per day, 36 day supply per fill
Imkeldi	QL for letter only: 10 mL per day, 28 day supply per fill
Inlyta	QL for letter only: 1 mg tab: 6 tabs per day, 30 day supply per fill; 5 mg tab: 4 tabs per day, 30 day supply per fil
Inluriyo	QL for letter only: 2 tabs per day, 30 day supply per fill
Inqovi	QL for letter only: 5 tabs per 28 days
Itovebi	QL for letter only: 3 mg tabs: 2 tabs per day, 30 day supply per fill; 9 mg tabs: 1 tab per day, 30 day supply per fill
Iwilfin	QL for letter only: 8 tabs per day, 30 day supply per fill
Jaypirca	QL for letter only: 50 mg tabs: 1 tab per day, 30 day supply per fill; 100 mg tabs: 2 tabs per day, 30 day supply per fill
Kisqali (200 MG Dose)	QL for letter only : Kisqali 200 mg per day: 21 tablets per 28 days
Kisqali (400 MG Dose)	QL for letter only: Kisqali 400 mg per day: 42 tablets per 28 days
Kisqali (600 MG Dose)	QL for letter only: Kisqali 600 mg per day: 63 tablets per 28 days
Kisqali Femara (200 MG Dose)	QL for letter only: Kisqali/Femara 200 mg per day co-pack: 49 tablets per 28 days
Kisqali Femara (400 MG Dose)	QL for letter only: Kisqali/Femara 400 mg per day co-pack: 70 tablets per 28 days
Kisqali Femara (600 MG Dose)	QL for letter only: Kisqali/Femara 600 mg per day co-pack: 91 tablets per 28 days
Koselugo	QL for letter only: 10 mg capsules: 8 capsules per day, 30 day supply per fill; 25 mg capsules: 4 capsules per day, 30 day supply per fill; 5 mg oral granules: 20 oral granules per day, 30 day supply per fill; 7.5 mg oral granules: 12 oral granules per day, 30 day supply per fill
Krazati	QL for letter only: 6 tablets per day, 30 day suppply per fill
Lapatinib Ditosylate	QL for letter only: 6 tabs per day, 30 day supply per fill
Lazcluze	QL for letter only: 80 mg tabs: 2 tabs per day, 30 day supply per fill; 240 mg tabs: 1 tab per day, 30 day supply per fill
Lenalidomide	QL for letter only: 2.5 mg, 5 mg, 10 mg caps: 1 cap per day, 28 day supply per fill; 15 mg, 20 mg, & 25 mg: 21 caps per 28 days
Lenvima (10 MG Daily Dose)	QL for letter only: 1 capsule per day, 30 days supply per fill
Lenvima (12 MG Daily Dose)	QL for letter only: 3 capsules per day, 30 days supply per fill
Lenvima (14 MG Daily Dose)	QL for letter only: 2 capsules per day, 30 days supply per fill
Lenvima (18 MG Daily Dose)	QL for letter only: 3 capsules per day, 30 days supply per fill
Lenvima (20 MG Daily Dose)	QL for letter only: 2 capsules per day, 30 days supply per fill
Lenvima (24 MG Daily Dose)	QL for letter only: 3 capsules per day, 30 days supply per fill
Lenvima (4 MG Daily Dose)	QL for letter only: 1 capsule per day, 30 days supply per fill
Lenvima (8 MG Daily Dose)	QL for letter only: 2 capsules per day, 30 days supply per fill
Lonsurf	QL for letter only: 15 mg/6.14 mg tablet: 100 tablets per 28 days; 20 mg/8.19 mg tablet: 80 tablets per 28 days
Lorbrena	QL for letter only: 25 mg tab: 3 tabs per day, 30 day supply per fill

Lumakras	QL for letter only: 8 tabs per day, 30 day supply per fill
Lynparza	QL for letter only: 4 tabs per day, 30 day supply per fill
Lytgobi (12 MG Daily Dose)	QL for letter only: Lytgobi 12 mg daily dose: 84 tablets per 28 days
Lytgobi (16 MG Daily Dose)	QL for letter only: Lytgobi 16 mg daily dose: 112 tablets per 28 days
Lytgobi (20 MG Daily Dose)	QL for letter only: Lytgobi 20 mg daily dose: 140 tablets per 28 days
Mekinist	QL for letter only: 1 mg and 2 mg: 1 tablet per day, 30 day supply per fill; 0.5 mg: 3 tablets per day, 30 day supply per fill; oral solution: 40 mL per day, 30 day supply per fill
Mektovi	QL for letter only: 6 tabs per day, 30 day supply per fill
Modeyso	QL for letter only: 20 capsules per 28 days
Nerlynx	QL for letter only: 6 tabs per day, up to a 30 day supply per fill
Nilotinib HCl	QL for letter only: 50 mg capsule: 4 capsules per day, 30 day supply per fill; 150 mg and 200 mg capsule: 4 capsules per day, 28 day supply per fill
Ninlaro	QL for letter only: 3 caps per 28 days
Nubeqa	QL for letter only: 4 tabs per day, 30 day supply per fill
Odomzo	QL for letter only: 1 capsule per day, 30 days supply per fill
Ogsiveo	QL for letter only: 6 tablets per day, 30 day suppply per fill
Ojemda	QL for letter only: Ojemda 100 mg tablet (4 blister cards (4 tablets each)) (NDC 82950-001- 16): 16 tablets per 28 days; Ojemda 100 mg tablets (5 blister cards (4 tablets each)) (NDC 82950-001- 20): 20 tablets per 28 days; Ojemda 100 mg tablets (4 blister cards (6 tablets each)) (NDC 82950-001- 24): 24 tablets per 28 days; Ojemda 25 mg/mL suspension: 96 mL per 28 days
Onureg	QL for letter only: 14 tabs per 28 days
Orgovyx	QL for letter only 64 tabs per 30 days
PAZOPanib HCl	QL for letter only: 4 tabs per day, 30 day supply per fill
Pemazyre	QL for letter only: 1 tab per day
Phyrago	QL for letter only: 20 mg tablet: 3 tablets per day, 30 day supply per fill; 50 mg, 70 mg, 80 mg, 100 mg, and 140 mg tablets: 1 tablet per day, 30 day supply per fill
Piqray (200 MG Daily Dose)	QL for letter only: 200 mg daily dose: 1 tablet per day, 28 day supply per fill
Piqray (250 MG Daily Dose)	QL for letter only: 300 mg or 250 mg daily dose: 2 tablets per day, 28 day supply per fill
Piqray (300 MG Daily Dose)	QL for letter only: 300 mg or 250 mg daily dose: 2 tablets per day, 28 day supply per fill
Pomalyst	QL for letter only : 21 tablets per 28 days
Qinlock	QL for letter only: 90 tabs per 30 days
Retevmo	QL for letter only: 40 mg capsules: 3 capsules per day, 30 day supply per fill; 80 mg capsules: 4 capsules per day, 30 day supply per fill; 40 mg tablets: 3 tablets per day, 30 day supply per fill; 80 mg tablets: 2 tablets per day, 30 day supply per fill; 120 mg tablets: 2 tablets per day, 30 day supply per fill; 160 mg tablets: 2 tablets per day, 30 day supply per fill
Revuforj	QL for letter only: 25 mg tablets: 8 tablets per day, 30 day supply per fill; 110 mg tablets: 4 tablets per day, 30 day supply per fill; 160 mg tablets: 2 tablets per day, 30 day supply per fill
Rezlidhia	QL for letter only: 2 caps per day, 30 day supply per fill
Romvimza	QL for letter only: 8 caps per 28 days, 28 day supply per fill
Rozlytrek	QL for letter only: 100 mg capsules: 1 capsule per day, 30 day supply per fill; 200 mg capsules: 3 capsules per day, 30 day supply per fill; 50 mg packets: 12 packets per day, 30 day supply per fill

Rubraca	QL for letter only: 4 tabs per day, 30 day supply per fill
Rydapt	AML: QL for letter only: 56 caps per 21 days; ASM/SM_AHN/MCL: QL for letter: 224 caps per 28 days
Scemblix	40 mg or 80 mg per day: QL for letter: 2 tabs per day, 30 day supply per fill; 200 mg twice daily (100 mg tabs): QL for letter only: 2 tabs per day. 30 day supply per fill; 160 mg twice daily (40 mg tabs): QL for letter: 8 tabs per day, 30 day supply per fill
SORAfenib Tosylate	QL for letter only: 4 tabs per day, 30 day supply per fill
Stivarga	QL for letter only: 84 tabs per 28 days
SUNItinib Malate	QL for letter only: 1 cap per day, 28 day supply per fill
Tabrecta	QL for letter only: 4 tabs per day, 30 day supply per fill
Tafinlar	QL for letter only: Tafinlar: 4 capsules per day, 30 day supply per fill; Tafinlar Tablets for Oral Suspension: 30 tablets per day, 30 day supply per fill
Tagrisso	QL for letter only: 1 tab per day, 30 day supply per fill
Talzenna	QL for letter only: 1 cap per day, 30 day supply per fill
Tasigna	QL for letter only: 50 mg cap: 4 caps per day, 30 day supply per fill; 150 mg and 200 mg caps: 4 caps per day, 28 day supply per fill
Tazverik	QL for letter only: 8 tabs per day, 30 day supply per fill
Tepmetko	QL for letter only: 2 tabs per day, 30 day supply per fill
Tibsovo	QL for letter only: 2 tabs per day, 30 day supply per fill
Torpenz	QL for letter only: 1 tab per day, 30 day supply per fill
Truqap	QL for letter only: 64 tabs per 28 days
Truseltiq (100MG Daily Dose)	QL for letter only: Truseltiq 100 mg daily dose: 21 capsules per 28 days
Truseltiq (125MG Daily Dose)	QL for letter only: Truseltiq 125 mg daily dose: 42 capsules per 28 days
Truseltiq (50MG Daily Dose)	QL for letter only: Truseltiq 50 mg daily dose: 42 capsules per 28 days
Truseltiq (75MG Daily Dose)	QL for letter only: Truseltiq 75 mg daily dose: 63 capsules per 28 days
Tukysa	QL for letter only: 4 tabs per day, 30 day supply per fill
Turalio	QL for letter only: 4 caps per day, 30 day supply per fill
Vanflyta	QL for letter only: 2 tabs per day, 28 day supply per fill
Venclexta	QL for letter only: 10 mg tablet: 2 tablets per day, 30 day supply per fill; 50 mg tablet: 1 tablet per day, 30 day supply per fill; 100 mg tablet, 6 tablets per day, 30 day supply per fill; starter pack: 42 tablets per 28 days
Venclexta Starting Pack	QL for letter only: 10 mg tablet: 2 tablets per day, 30 day supply per fill; 50 mg tablet: 1 tablet per day, 30 day supply per fill; 100 mg tablet, 6 tablets per day, 30 day supply per fill; starter pack: 42 tablets per 28 days
Verzenio	QL for letter only: 2 tabs per day, 28 day supply per fill
Vitrakvi	QL for letter only: 25 mg capsule: 6 capsules per day, 30 day supply per fill; 100 mg capsule: 2 capsules per day, 30 day supply per fill; 20 mg/mL solution: 10 mL per day, 30 day supply per fill
Vizimpro	QL for letter only: 1 tab per day, 30 day supply per fill
Voranigo	QL for letter only: 10 mg tabs: 2 tabs per day, 30 day supply per fill; 40 mg tabs: 1 tab per day, 30 day supply per fill
Welireg	QL for letter only: 90 tabs per 30 days
Xalkori	QL for letter only: Capsules: 4 capsules per day, 30 day supply per fill; 20 mg & 50 mg Oral Pellets: 4 pellets per day, 30 day supply per fill; 150 mg Oral Pellets: 6 pellets per day, 30 day supply per fill
Xospata	QL for letter only: 3 tabs per day, 30 day supply per fill
Xtandi	QL for letter only: 40 mg capsules: 4 capsules per day, 30 day supply per fill; 40 mg tabs: 4 tabs per day, 30 day supply per fill; 80 mg tabs: 2 tabs per day, 30 day supply per fill

Yonsa	QL for letter only: 4 tabs per day, 30 day supply per fill
Zejula	QL for letter only: 3 tabs per day, 30 day supply per fill
Zelboraf	QL for letter only: 8 tabs per day, 30 day supply per fill
Zydelig	QL for letter only: 2 tabs per day, 30 day supply per fill
Zykadia	QL for letter only: 3 tabs per day, 38 day supply per fill

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.

WEIGHT MANAGEMENT CENTER OF EXCELLENCE CRITERIA

Background/Recommendations:
The below criteria have been reviewed and approved by the Geisinger Health Plan Credentials Committee. These criteria will be utilized for those Commercial members who are eligible for weight loss medication coverage under their prescription drug rider.

Center of Excellence (COE) - a group of licensed physicians who have a shared facility or an entity that:

Criteria	Benchmark
Demonstrates best practices by using clinically proven health care management techniques	Follows evidence-based literature and guidelines and includes contraindication screening
Encompasses a multidisciplinary team including, but not limited to, a board certified specialist, nurse educator, behavioral health, and social worker	
Clinical pharmacist to provide titration support, side effect management, etc.	
Registered dietician providing evidence-based nutritional counseling	
Pharmaceuticals are prescribed by a board-certified specialist who is actively involved in his/her discipline as evidenced through research and clinical enterprises	Pulmonologist, endocrinologist, cardiologist, obesity medicine physician, gastroenterologist
Has the capabilities to, and has historically, managed high volumes of patients	
Has the ability to complete testing/diagnostics on location	• Labs • Weight check • Pregnancy screening if indicated
FOR COE RENEWAL: Has evidence of measured, favorable outcomes	Efficacy: • Percent of patients with a weight reduction of at least 10% at month 6 or greater than 15% by month 12 • Percent of patients with an in-office weight on file within the prior 6 months • Adherence as evidence by PDC
Is authorized as a Center of Excellence by the Geisinger Health Plan Credentialing Committee	

Recommend initial COE approval for a period of 6 months.

Subsequent approvals will be given for a period of 6 months if all conditions are met.

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.

Voting responses were received from 31 of 50 members. The vote was unanimously approved.

The next bi-monthly scheduled meeting will be held on March 10th, 2026 at 1:00 p.m.

Meeting will be held virtually via phone/Microsoft Teams.