P&T Committee Meeting Minutes
(GHP Family/GHP Healthy Connect Business)
September 15, 2015

Present:	**Absent:**
Bret Yarczower, MD, MBA – Chair	Keith Boell, DO
Kristen Bender, Pharm.D. – via phone	Dean Christian, MD
Beverly Blaisure, MD – via phone	John Flaherty, Pharm.D.
Holly Bones, Pharm.D. – via phone	Phillip Krebs, R.EEG T.
Kimberly Clark, Pharm.D.	Jonas Pearson, MS, RPh
Jamie Dodson, RPh	James Schuster, MD
Tricia Heitzman, Pharm.D. – via phone	William Seavey, Pharm.D.
Michelle Holt-Macey, Pharm.D. – via phone	Elaine Tino, CRNP
Jonathan Hoot, Pharmacy Student	Steve Tracy, Pharm.D.
Kristi Juskiewicz, Pharm. D. – via phone	
Steven Kheloussi, Pharm.D.	
Lisa Mazonkey, RPh – via phone	
Perry Meadows, MD	
Thomas Morland, MD	
Mariette Njei, Pharm.D., Pharmacy Resident	
Kristen Scheib, Pharm. D. – via phone	
Richard Silbert, MD – via phone	
Michael Spishock RPh – via phone	
Todd Sponenberg, Pharm.D., RPh	
Kevin Szczecina, RPh	
Shantha Venugopal, Pharmacy Student	
Lori Zaleski, RPh – via phone	

Call To Order:
Bret Yarczower called the meeting to order at 1:00 p.m., Tuesday September 15, 2015

Review and Approval of Minutes:
Bret Yarczower for a motion or approval to accept the July 21, 2015 minutes as written. Jamie Dodson accepted the motion and Steven Kheloussi seconded the motion. None were opposed.

Bret Yarczower for a motion or approval to accept the August 24, 2015 minutes as written. Jamie Dodson accepted the motion and Steven Kheloussi seconded the motion. None were opposed

DRUG REVIEWS:

Cresemba **Steven Kheloussi**
(isavuconazonium sulfate)

Steven Kheloussi provided a review of Cresemba to the committee for consideration as a pharmacy or medical benefit. Cresemba is an azole antifungal indicated for the treatment of invasive aspergillosis and for the treatment of invasive mucormycosis in patients 18 years of age and older.

Specimens for fungal culture and other relevant laboratory studies (including histopathology) to isolate and identify causative organism(s) should be obtained prior to initiating antifungal therapy. Therapy may be instituted before the results of the cultures and other laboratory studies are known. However, once these results become available, antifungal therapy should be adjusted accordingly.

Formulary alternatives: itraconazole*, voriconazole (susp)*, voriconazole (tab)*^ (*pa required)

Proposed Clinical Recommendations: Cresmba IV will be a medical benefit and should not be added to the GHP Family Formulary at this time. Given the limited experience with this agent, it is recommended that Cresemba capsules also not be added to the GHP Family formulary at this time. Request for both IV and oral Cresmba should require prior authorization with the following criteria:

- Medical record documentation that the patient it 18 years of age or older AND
- Medical record documentation that Cresmba is being used for the treatment of invasive aspergillosis OR for the treatment of invasive mucormycosis

Clinical Discussion: FDA Approved Indications, Pharmacology/MOA, Clinical Evidence of Safety and Efficacy, Adverse Reactions, Dosing Schedule, Monitoring, Safety Profile, Black Box Warnings, Contraindications, Warnings and Precautions, Drug Interactions, Patent Life, Unique Therapeutic Features, Recommendations of National Agencies and Organizations, and Special Population Precautions were discussed.

Clinical Outcome: Dr. Perry Meadows made a motion to accept the recommendation as written. Kimberly Clark seconded the motion. None were opposed.

Proposed Financial Recommendations: Cresemba IV will be a medical benefit and should not be added to the GHP Family formulary. Cresemba capsules should also not be added to the GHP Family formulary. The following additional criteria should apply:

- For invasive aspergillosis (oral and IV [pharmacy and medical policies]): Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to itraconazole and voriconazole tablets or suspension
- For IV Cresemba (medical) for invasive mucormycosis: Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to amphotericin B
- For oral Cresmba (pharmacy) for invasive mucormycosis: No further criteria should apply

QUANTITY LIMIT: 2 capsules/day

AUTHORIZATION DURATION: 3 months. Reauthorization will be based on the following criteria:

- Medical record documentation of a culture and sensitivity showing the isolates are susceptible to Cresema

- Medical record documentation that the appropriate dose is being prescribed (1 vial/day or 2 capsules/day)

Financial Discussion: The continuation of Cresemba following hospital discharge was discussed. It was noted that this has not yet been reviewed by the System Formulary Steering Committee or Antimicrobial Subcommittee. A decision was made to table any additional criteria requiring failure of prior agents until such a time as we have received input from the System. The quantity limit was updated to read 6 capsules per day for 2 days, then 2 capsules per day. A quantity limit was also added to the IV formulation of 1 vial per day. The authorization duration was approved as written.

Financial Outcome: Kim Clark made a motion to accept the recommendations as amended. Todd Sponenberg seconded the motion. None were opposed.

Approved Recommendations: Cresemba IV will be covered under the medical benefit. Cresemba capsules will not be added to the GHP Family formulary. The following criteria will apply to prior authorization requests:

- Medical record documentation that the patient it 18 years of age or older AND
- Medical record documentation that Cresmba is being used for the treatment of invasive aspergillosis OR for the treatment of invasive mucormycosis

QUANTITY LIMIT:

- Capsules: 2 capsules per day

AUTHORIZATION DURATION: 3 months. Reauthorization will be based on the following criteria:

- Medical record documentation of a culture and sensitivity showing the isolates are susceptible to Cresema
- Medical record documentation that the appropriate dose is being prescribed (1 vial/day or 2 capsules/day)

Cholbam **Kimberly Clark**
(cholic acid)

Kimberly Clark provided a review of Cholbam to the committee for consideration as a pharmacy benefit. Cholbam is a bile acide indicated for:

- Treatment of bile acid synthesis disorders due to single enzyme defects (SEDs).
- Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatohhea, or complications from decreased fat soluble vitamin absorption

Formulary alternatives: none

Proposed Clinical Recommendations: As a first in class therapy it is recommended that Cholbam is added to the GHP Family formulary. In order to ensure appropriate utilization the following prior authorization criteria should apply:

- Medical record documentation of one of the following:

o Bile acid synthesis disorders due to a single enzyme defect (SEDs) OR
o Peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatorrhea, or complication from decreased fat soluble vitamin absorption
• Medical record documentation that diagnosis has been confirmed with an abnormal urinary bile acid by Fast Atom Bombardment ionization – Mass Spectrometry (FAB-MS) analysis AND
• Prescription written by a gastroenterologist, hepatologist, or metabolic specialist with experience in the diagnosis and treatment of bile acid synthesis and peroxisomal disorders AND
• For the treatment of peroxisomal disorders: medical record documentation that Cholbam will be used as adjunctive therapy AND
• Medical record documentation of baseline ALT/AST, total bilirubin, and body weight

AUTHORIZATION DURATION: 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 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of a response to therapy, defined as the following:
• Member must meet at least two of the following laboratory criteria OR one laboratory criterion and the clinical weight criterion
o Laboratory Criteria:
- ALT or AST values reduced to less than 50 U/L, or baseline levels reduced by 80%
- Total bilirubin values reduced to less than or equal to 1 mg/dL; and
- No evidence of cholestasis on liver biopsy

o Clinical Criteria
- Body weight increased by 10% or stable at greater than the 50th percentile

Clinical Discussion: FDA Approved Indications, Pharmacology/MOA, Clinical Evidence of Safety and Efficacy, Adverse Reactions, Dosing Schedule, Monitoring, Safety Profile, Black Box Warnings, Contraindications, Warnings and Precautions, Drug Interactions, Patent Life, Unique Therapeutic Features, Recommendations of National Agencies and Organizations, and Special Population Precautions were discussed. A specialtist from CHOP was contacted for input related to Cholbam. She stated that she doesn't have any experience with Cholbam to date, but has worked with compounded cholic acid in the past and has found it to be beneficial with no real alternative.

Clinical Outcome: Todd Sponenberg made a motion to accept the recommendations as written. Kevin Szczecin seconded the motion. None were opposed.

Proposed Financial Recommendations: It is recommended that Cholbam be added to the GHP Family formulary requiring prior authorization.

Financial Discussion: No questions or comments.

Financial Outcome: Dr. Meadows made a motion to accept the recommendations as amended. Kevin Szczecin seconded the motion. None were opposed.

Approved Recommendations: Cholbam will be added to the GHP Family formulary. The following criteria will apply:

- Medical record documentation of one of the following:
  - Bile acid synthesis disorders due to a single enzyme defect (SEDs) **OR**

    - Peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatorrhea, or complication from decreased fat soluble vitamin absorption
- Medical record documentation that diagnosis has been confirmed with an abnormal urinary bile acid by Fast Atom Bombardment ionization – Mass Spectrometry (FAB-MS) analysis **AND**
- Prescription written by a gastroenterologist, hepatologist, or metabolic specialist with experience in the diagnosis and treatment of bile acid synthesis and peroxisomal disorders **AND**
- For the treatment of peroxisomal disorders: medical record documentation that Cholbam will be used as adjunctive therapy **AND**
- Medical record documentation of baseline ALT/AST, total bilirubin, and body weight

AUTHORIZATION DURATION: 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 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of a response to therapy, defined as the following:

- Member must meet at least two of the following laboratory criteria **OR** one laboratory criterion and the clinical weight criterion
    - Laboratory Criteria:
        - ALT or AST values reduced to less than 50 U/L, or baseline levels reduced by 80%
        - Total bilirubin values reduced to less than or equal to 1 mg/dL; and
        - No evidence of cholestasis on liver biopsy

    - Clinical Criteria
        - Body weight increased by 10% or stable at greater than the 50th percentile; and

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Unituxim **Steven Kheloussi**
(dinutuximab)

Steven Kheloussi provided a review of Unituxin to the committee for consideration as a medical benefit. Unituxin is indiacted, in combination with granulocyte-macrophage colony-stimulating factor (GM-CSF), interleukin-2 (IL-2), and 13-cis-retinoic acid (RA), for the treatment of pediatric patients with high risk neuroblastoma who achieve at least a partial response to prior first-line multiagent, multimodality therapy.
Formulary alternatives: none

Proposed Clinical Recommendations: Unituxin will be a medical benefit. It should not be added to the GHP Family formulary at this time and should require prior authorization as a medical benefit with the following criteria:

- Medical record documentation that Unituxin is being use for the treatment of pediatric patients with high-risk neuroblastoma who achieve at least a partial response to prior first-line multiagent, multimodality therapy **AND**
- Medical record documentation that Unituxin is being prescribed in combination with granulocyte-macrophage coloncy-stimulating facors (GM-CSF), interleukin-2 (IL-2), and 13-cis-retinoic acid (isotretinoin)

QUANTITY LIMIT: A one-time authorization for a quantity of 20 doses (4 doses per cycle, 5 cycles per lifetime) should apply.

Clinical Discussion: FDA Approved Indications, Pharmacology/MOA, Clinical Evidence of Safety and Efficacy, Adverse Reactions, Dosing Schedule, Monitoring, Safety Profile, Black Box Warnings, Contraindications, Warnings and Precautions, Drug Interactions, Patent Life, Unique Therapeutic Features, Recommendations of National Agencies and Organizations, and Special Population Precautions were discussed. It was discussed that this product is limited in distribution to a single pharmacy provider.

Clinical Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Dr. Perry Meadows seconded the motion. None were opposed.

Proposed Financial Recommendations: Unitixin should be covered under the medical benefit requiring a prior authorization. No additional criteria should apply.

Financial Discussion: As this is a single use vial, the cost per cycle is actually estimated to be double the intial estimate. The estimated cost per cycle is $7,200.00

Financial Outcome: Dr. Meadows made a motion to accept the recommendations as written. Kim Clark seconded the motion. None were opposed.

Approved Recommendations: Unituxin will be covered as a medical benefit requiring prior authorization. The following criteria will apply to requests:

- Medical record documentation that Unituxin is being use for the treatment of pediatric patients with high-risk neuroblastoma who achieve at least a partial response to prior first-line multiagent, multimodality therapy **AND**
- Medical record documentation that Unituxin is being prescribed in combination with granulocyte-macrophage coloncy-stimulating facors (GM-CSF), interleukin-2 (IL-2), and 13-cis-retinoic acid (isotretinoin)

QUANTITY LIMIT: A one-time authorization for a quantity of 20 doses (4 doses per cycle, 5 cycles per lifetime) should apply.

Rexulti **Steven Kheloussi**
(brexpiprazole)

Steven Kheloussi provided a review of Rexulti to the committee for consideration as a pharmacy benefit. Rexulti is approved for the treatment of schizophrenia and as adjunctive therapy to antidepressants for the treatment of major depressive disorder (MDD).

Formulary alternatives: aripiprazole*, clozapine, olanpazine, quetiapine, risperidone, ziprasidone, Abilify* (* requires prior authorization)

Proposed Clinical Recommendations: It is recommended that Rexulti is not added to the GHP Family formulary at this time. Requests for Rexulti should require prior authorization with the following criteria:

- Medical record documentation that patient is ≥ 18 years of age
  AND

- Medical record documentation of:
    - A diagnosis of schizophrenia **OR**
    - A diagnosis of major depressive disorder (MDD) **AND** medical record documentation that the patients is using Rexulti as adjunctive therapy

Clinical Discussion: FDA Approved Indications, Pharmacology/MOA, Clinical Evidence of Safety and Efficacy, Adverse Reactions, Dosing Schedule, Monitoring, Safety Profile, Black Box Warnings, Contraindications, Warnings and Precautions, Drug Interactions, Patent Life, Unique Therapeutic Features, Recommendations of National Agencies and Organizations, and Special Population Precautions were discussed.

Clinical Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Dr. Meadows seconded the motion. None were opposed.

Proposed Financial Recommendations: Rexulti should not be added to the GHP Family formulary at this time. The following additional criteria should apply:

- For MDD:
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least a 4 week trial of combination antidepressant therapy (such as an SSRI and bupropion or an SNRI and bupropion) **OR**
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least a 4 week trial of an antidepressant with augmentation therapy (including, but not limited to lithium, valproate, carbamazepine and lamotrigine)
- For schizophrenia: Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to three generic, formulary atypical antipsychotics.

Financial Discussion: Given the availability of generic aripiprazole which is similar in structure and mechanism, it was recommended that failure of aripiprazole in combination with antidepressant therapy be required for MDD and failure of aripiprazole for schizophrenia

Financial Outcome: Dr. Meadows made a motion to accept the recommendations as ammended. Kevin Szczecina seconded the motion. None were opposed.

Approved Recommendations: Rexulti will not be added to the GHP Family formulary. The following criteria will apply:

- Medical record documentation that patient is $\geq$ 18 years of age

AND

- Medical record documentation of:
    - a diagnosis of schizophrenia **OR**
    - a diagnosis of major depressive disorder (MDD) **AND** medical record documentation that the patient is using Rexulti as adjunctive therapy **AND**
- For MDD:
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least a 4 week trial of combination therapy with aripiprazole* and an antidepressant
- For schizophrenia:

- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to aripiprazole*.

QL: 1 tablet daily

Simponi Aria (golimumab) **Mariette Njei**

Mariette Njei provided a review of Simponi Aria to the committee for consideration as a medical benefit. Simponi Aria is indicated for the treatment of adult pateints with moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate.
Formulary alternatives: Kineret*, Orencia*, Actemra SC*, Humira*, Enbrel*, Cimzia*(*PA Required)

Proposed Clinical Recommendations: Simponi Aria will be a medical benefit. It is recommended that Simponi Aria not be added to the GHP Family formulary. Simponi Aria should require a prior authorization on the medical benefit with the following criteria:

- Prescription must be written by a rheumatologist AND
- Patient must be at least 18 years of age AND
- Medical record documentation of a diagnosis of moderate to severe rheumatoid arthritis (made in accordance with the American College of Rheumatology Criteria for the Classification of Diagnosis of Rheumatoid Arthritis) AND
- Medical record documentation of concomitant methotrexate use

Clinical Discussion: FDA Approved Indications, Pharmacology/MOA, Clinical Evidence of Safety and Efficacy, Adverse Reactions, Dosing Schedule, Monitoring, Safety Profile, Black Box Warnings, Contraindications, Warnings and Precautions, Drug Interactions, Patent Life, Unique Therapeutic Features, Recommendations of National Agencies and Organizations, and Special Population Precautions were discussed. It was noted that joint count has been removed from the standard biologic PA criteria, as we would like to move towards a more subjective measure of disease activity.

Clinical Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Dr. Meadows seconded the motion. None were opposed.

Proposed Financial Recommendations: Simponi Aria will be a medical benefit. It is recommended that Simponi Aria is not added to the GHP Family formulary. Simponi should require prior authorization on the medical benefit with the following additional criteria:

- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to a minimum 3 month trial of Humira* **AND** Enbrel*

AUTHORIZATION DURATION: Approval will be given for an initial duration of six (6) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in signs and symptoms of rheumatoid arthritis on six (6) months of Simponi Aria therapy is required.

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

Financial Discussion: No questions or comments.

Financial Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Dr. Meadows seconded the motion. None were opposed.

Approved Recommendations: Simponi Aria will be covered under the medical benefit. The following prior authorization criteria will apply to requests for Simponi Aria:

- Prescription must be written by a rheumatologist **AND**
- Patient must be at least 18 years of age **AND**
- Medical record documentation of a diagnosis of moderate to severe rheumatoid arthritis (made in accordance with the American College of Rheumatology Criteria for the Classification of Diagnosis of Rheumatoid Arthritis) **AND**
- Medical record documentation of concomitant methotrexate use **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to a minimum 3 month trial of Humira* **AND** Enbrel*

AUTHORIZATION DURATION: Approval will be given for an initial duration of six (6) months. For continuation of coverage, medical record documentation of clinical improvement or lack of progression in signs and symptoms of rheumatoid arthritis on six (6) months of Simponi Aria therapy is required.

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

Stiolto Respimat **Steven Kheloussi**
(tiotropium bromide and olodaterol)

Steven Kheloussi provided a review of Stiolto Respimat to the committee for consideration as a pharmacy benefit. Stiolto Respimat is indicated for long-term, once daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD), including bronchitis and/or emphysema.

Formulary alternatives: Anoro Ellipta, Serevent Diskus, Spiriva Respimat, Spiriva, Advair Diskus*, Advair HFA*, Breo Ellipta (*PA Required)

Proposed Clinical Recommendations: It is recommended that Stiolto Respimat not be added to the GHP Family formulary at this time. Requests for Stiolto Respimat should require prior authorization with the following criteria:

- Medical record documentation of a diagnosis of COPD **AND**
- Medical record documentation that patient is > 18 years of age

Clinical Discussion: FDA Approved Indications, Pharmacology/MOA, Clinical Evidence of Safety and Efficacy, Adverse Reactions, Dosing Schedule, Monitoring, Safety Profile, Black Box Warnings, Contraindications, Warnings and Precautions, Drug Interactions, Patent Life, Unique Therapeutic Features, Recommendations of National Agencies and Organizations, and Special Population Precautions were discussed.

Clinical Outcome: Kim Clark made a motion to accept the recommendations as written. Todd Sponenberg seconded the motion. None were opposed.

Proposed Financial Recommendations: It is recommended that Stiolto Respimat not be added to the GHP Family formulary at this time. The following additional prior authorization criteria should apply:

- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to Anoro Ellipta

Financial Discussion: No questions or comments.

Financial Outcome: Todd Sponenberg made a motion to accept the recommendations as amended. Kevin Szczecina seconded the motion. None were opposed.

Approved Recommendations: Stiolto Respimat will not be added to the GHP Family formulary. The following criteria will apply to requests for Namzaric:

- Medical record documentation of a diagnosis of COPD AND
- Medical record documentation that patient is > 18 years of age AND
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to Anoro Ellipta

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Afrezza (insulin human) **Steven Kheloussi**

Steven Kheloussi provided a review of Afrezza to the committee for consideration as a pharmacy benefit. Afrezza is a rapid-acting inhaled insulin indicated to improve glycemic control in adult patients with diabetes mellitus.

Formulary alternatives: Novolog

Proposed Clinical Recommendations: It is recommended that Afrezza not be added to the GHP Family formulary at this time. The following prior authorization criteria should apply:

- Medical record documentation of a diagnosis of diabetes mellitus **AND**
- Medical record documentation that the patient does not have asthma or COPD **AND**
- Medical record documentation that the patient is at least 18 years of age

Clinical Discussion: FDA Approved Indications, Pharmacology/MOA, Clinical Evidence of Safety and Efficacy, Adverse Reactions, Dosing Schedule, Monitoring, Safety Profile, Black Box Warnings, Contraindications, Warnings and Precautions, Drug Interactions, Patent Life, Unique Therapeutic Features, Recommendations of National Agencies and Organizations, and Special Population Precautions were discussed. The fact that this product was previously available under the brand name Exubra was discussed. This new inhaler appears to be a similar technology in a smaller device. There was also concern that the chronic lung disease contraindication may be overlooked, hence it was included in the PA criteria.

Clinical Outcome: Kimberly Clark made a motion to accept the recommendations as written. Kevin Szczecina seconded the motion. None were opposed.

Proposed Financial Recommendations: Afrezza should not be added to the GHP Family formulary at

this time. The following additional prior authorization criteria should apply:

- 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, contraindication to, or intolerance to Novolog.

***** Fear of needles is not considered a clinically justifiable reason for not using subcutaneous insulin.

Financial Discussion: The per unit cost of Afrezza is higher than that of subcutaneous insulin

Financial Outcome: Dr. Meadows made a motion to accept the recommendations as amended. Todd Sponenberg seconded the motion. None were opposed.

Approved Recommendations: Afrezza will not be added to the GHP Family Formulary. The following criteria will apply to requests for Corlanor:

- Medical record documentation of a diagnosis of diabetes mellitus **AND**
- Medical record documentation that the patient does not have asthma or COPD **AND**
- Medical record documentation that the patient is at least 18 years of age **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, contraindication to, or intolerance to Novolog.

***** Fear of needles is not considered a clinically justifiable reason for not using subcutaneous insulin.

Suprep **Kimberly Clark**
(sodium sulfate, potassium sulfate, & magnesium sulfate)

Kimberly Clark provided a review of Suprep to the committee for consideration as a pharmacy benefit. Suprep Bowel Prep Kit is an osmotic laxative indicated for cleansing of the colon in preparation for colonoscopy in adults

Formulary Alternatives: Gavilyte-H & Bisacodyl, PEG-3350 & Electrolytes, Gavilyte-G, Gavilyte-C, Polyethylene Glycol 3350, PEG -3350 with flavor packs, Gavilyte-N, Trilyte with flavor packs

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Proposed Clinical Recommendations: It is recommended that Suprep not be added to the GHP Family formulary at this time.

Clinical Discussion: FDA Approved Indications, Pharmacology/MOA, Clinical Evidence of Safety and Efficacy, Adverse Reactions, Dosing Schedule, Monitoring, Safety Profile, Black Box Warnings, Contraindications, Warnings and Precautions, Drug Interactions, Patent Life, Unique Therapeutic Features, Recommendations of National Agencies and Organizations, and Special Population Precautions were discussed.

Clinical Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Jamie Dodson seconded the motion. None were opposed.

Proposed Financial Recommendations: It is recommended that Suprep not be added to the GHP Family/Healthy Connect Formulary. The following criteria should apply:

1. Medical record documentation that the member is scheduled for a gastroenterological procedure.
2. Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to PEG + electrolytes.

Financial Discussion: No questions or comments

Financial Outcome: Dr. Meadows made a motion to accept the recommendations as amended. Kevin Szczecina seconded the motion. None were opposed.

Approved Recommendations: Suprep will not be added to the GHP Family Formulary. The following criteria will apply:
1. Medical record documentation that the member is scheduled for a gastroenterological procedure.
2. Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to PEG + electrolytes.

Invega Trinza **Todd Sponenberg**
(paliperidone palmitate)

Todd Sponenberg provided a review of Invega Trinza to the committee for consideration as a medical benefit. Invega Trinza is indicated for the treatment of schizophrenia in patients after they have been adequately treated with Invega Sustenna for at least four months.

Formulary Alternatives: aripiprazole*, clozapine, olanpazine, quetiapine, risperidone, ziprasidone, Abilify* (*PA Required)

Proposed Clinical Recommendations: It is recommended that Invega Trinza be covered under medical benefit for the GHP Family formulary. Requests for Invega Trinza should require prior authorization with the following criteria:

- Medical record documentation of a diagnosis of schizophrenia AND have been adequately treated with Invega Sustenna for at least four months AND
- Medical record documentation that patient is > 18 years of age AND
- Documented history of poor adherence to oral medications and documentation that education to improve adherence has been attempted

QUANTITY LIMIT: 1 syringe every 3 months

Clinical Discussion: FDA Approved Indications, Pharmacology/MOA, Clinical Evidence of Safety and Efficacy, Adverse Reactions, Dosing Schedule, Monitoring, Safety Profile, Black Box Warnings, Contraindications, Warnings and Precautions, Drug Interactions, Patent Life, Unique Therapeutic Features, Recommendations of National Agencies and Organizations, and Special Population Precautions were discussed.

Clinical Outcome: Dr. Meadows made a motion to accept the recommendations as written. Kevin Szczecina seconded the motion. None were opposed.

Proposed Financial Recommendations: It is recommended that Invega Trinza be covered under medical benefit for GHP Family. The following additional criteria should apply:

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Risperdal Consta* and Zyprexa Relprevv*

Financial Discussion: There was a lengthy discussion regarding how to handle members who are new to the plan and are currently stable on their existing therapy. Kimberly Clark and Holly Bones will begin working on a review of this class in its entirety for an upcoming P&T meeting. In the meantime, it was recommended that the criteria be approved as proposed.

Financial Outcome: Kim Clark made a motion to accept the recommendations as amended. Kevin Szczecina seconded the motion. None were opposed.

Approved Recommendations: Invega Trinza will be covered under the medical benefit. The following criteria will apply to requests for Invega Trinza:

- Medical record documentation of a diagnosis of schizophrenia AND have been adequately treated with Invega Sustenna for at least four months AND
- Medical record documentation that patient is > 18 years of age AND
- Documented history of poor adherence to oral medications and documentation that education to improve adherence has been attempted AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Risperdal Consta* and Zyprexa Relprevv*

QUANTITY LIMIT: 1 syringe every 3 months

FAST FACTS:

Eylea **Steven Kheloussi**
(aflibercept**)**

New Indication: Eyelea is now indicated for the treatment of diabetic retinopathy in patients with diabetic macular edema.

Recommendation: It is recommended that the following language be added to the medical policy for Eylea:

- Medical record documentation of a diagnosis of diabetic retinopathy in patients with diabetic macular edema

Discussion: No questions or comments

Outcome: Jamie Dodson made a motion to accept the recommendations as written. Kevin Szczecina seconded the motion. None were opposed.

Botox **Steven Kheloussi**
(Onabotulinumtoxin A)

New Indication: Botox is now indicated for the treatment of upper limb spasticity in adult patients to decrease the severity of increased muscle tone in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris), finger flexors (flexor digitorum profundus and flexor digitorum sublimis), and thumb flexors (adductor pollicis and flexor pollicis longus).

Limitation of Use: Safety and effectiveness of Botox have not been established for the treatment of other upper limb muscle groups, or for the treatment of lower limb spasticity. The safety and effectiveness have not been established in the treatment of upper limb spasticity in pediatric patients. Botox has not been shown to improve upper extremity functional abilities, or range of motion at a joint affected by a fixed contracture. Treatment with Botox is not intended to substitute for usual standard of care rehabilitation regimens.

Recommendation: It is recommended that the new indication is added to the existing Botulinum Toxin and Derivatives medical and Medicare pharmacy policies with the following wording:

- Medical record documentation that Botox is being used for the treatment of upper limb spasticity in the following muscles: elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris), finger flexors (flexor digitorum profundus and flexor digitorum sublimis), and thumb flexors (adductor pollicis and flexor pollicis longus) AND
- Documentation that the patient is at least 18 years of age

Discussion: No questions or comments

Outcome: Jamie Dodson made a motion to accept the recommendations as written. Tricia Heitzman seconded the motion. None were opposed.

Astepro (azelastine) **Steven Kheloussi**

- **New Indication:** Astepro is now indicated for the relief of the symptoms of:
    - Seasonal allergic rhinitis in patients 2 years of age and older.
    - Perennial allergic rhinitis in patients 6 months of age and older.
- In the past it was indicated for both seasonal and perennial allergic rhinitis in patients 6 years of age and older.

Recommendation: It is recommended for all lines that the following criteria be added:

- For seasonal allergic rhinitis: Medical record documentation that patient is $\geq$ 2 years of age.
- For perennial allergic rhinitis: Medical record documentation that patient is $\geq$ 6 months of age.

Discussion: No questions or comments

Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Dr. Meadows seconded the motion. None were opposed.

Treximet **Steven Kheloussi**
(sumatgriptan and naproxen sodium**)**

New Indication: Treximet is now indicated for the acute treatment of migraine with or without aura in adults and pediatric patients 12 years and older.

Recommendation: It is recommended that the following wording is added to the existing Treximet policies (underlined sections are new additions):

- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to (two) formulary triptans (one of which must be sumatriptan**) with concurrent use of naproxen **OR** <u>if member is 12 to < 18 years of age, medical record documentation of a therapeutic failure on, intolerance to, or contraindication to rizatriptan with concurrent use of naproxen.</u>

Discussion: The difference in formulary alternatives between adults and pediatrics was discussed. This difference is due to the FDA approved indications of the alternatives.

Outcome: Kevin Szczecina made a motion to accept the recommendations as written. Todd Speonenberg seconded the motion. None were opposed.

Kyprolis **Kristen Scheib**
(carfilzomab**)**

New Indication: Kyprolis is now indicated for use as combination therapy with lenalidomide and dexamethasone for the treatment of patients with relapsed multiple myeloma who have received one to three prior lines of therapy.

Recommendation: It is recommended that clarification be added to the existing criteria in policy to indicate that it is to be used only when Kyprolis is used for single agent therapy.

Addition of the following criteria to the medical benefit policy to reflect the new indication:
For use in combination with lenalidomide and dexamethasone:

- Kyprolis (carfilzomib) is prescribed by a hematologist/oncologist **AND**
- Documenation of a diagnosis of multiple myeloma relapse **AND**
- Medical record documentation of treatment with at least 1 prior therapy **AND**
- Medical record documentation of use in combination with lenalidomide and low-dose dexamethasone

Discussion: No questions or comments

Outcome: Kim Clark made a motion to accept the recommendations as written. Jamie Dodson seconded the motion. None were opposed.

Fycompa **Steven Kheloussi**
(perampanel**)**

New Indication: In additiona to its previously approved indication as adjunctive tehrapt for partial-onset seizures with or without secondary generalized seizures, Fycompa is now indicated as adjunctive therapy for primary generalize tonic-clonic seizures in patients with epilepsy 12 years of age and older.

Recommendation: It is recommended that the diagnosis wording of the existing policies be updated to read (the underlined portion is the recommended addition):

- Medical record documentation of a diagnosis or partial onset seizures **OR** primary generalized tonic-clonic seizures **AND**…

Discussion: No questions or comments

Outcome: Jamie Dodson made a motion to accept the recommendations as written. Kevin Szczecina seconded the motion. None were opposed.

Xifaxan (riaximin**)** — **Steven Kheloussi**

New Indication: Xifaxan is now indicated for the treatment of irritable bowel syndrome with diarrhea (IBS-D) in adults.

Recommendation: The following wording should be added to the existing criteria for all lines of business:

- Medical record documentation of a diagnosis of moderate to severe IBS with diarrhea **AND**
- Medical record documentation that the member is at least 18 years of age **AND**
- Medical record documentation that the correct FDA approved strength/dosing is being prescribed (550 mg three times daily for 14 days) **AND**
- Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to dicyclomine **AND** loperamide

Approved requests should be for a one-time fill of 42 tablets for a 14 day supply. Reauthorization should require the following:

- Medical record documentation that the patient is having a recurrence of symptoms related to IBS-D **AND**
- Medical record documentation that the patients has not receiving more than two courses of Xifaxan treatment for IBS-D

Discussion: It was recommended that the language regarding prior course of Xifaxan be updated to the following: "the patients has not received more that two previous courses."

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

CLASS REVIEWS:

Antihemophilic Factors — **Steven Kheloussi**

Steven Kheloussi provided a review of the antihemophilic agent class to include the following products:

Classic Hemophilia A				Hemophilia B			VWD	
Control and prevention of bleeding episodes	Perioperative management	Routine prophylaxis to prevent or reduce the frequency of bleeding	To reduce the risk of joint damage in children without pre-existing joint damage	Control and prevention of bleeding episodes	Perioperative management	Routine prophylaxis to prevent or reduce the frequency of bleeding	Prevention of excessive bleeding during and after surgery	Treatment of spontaneous and trauma-induced bleeding episodes
X[a]	X	X						
X	X	X						
X[a]	X	X[b]	X					
X								
X	X							
X[a]	X	X[b]	X					
X[c]	X[b]							
X	X	X						
X[b,d]								
X	X							
X	X							
				X				
				X	X	X		
				X[b]				
				X	X			
				X (≥12 y.o.)	X (≥12 y.o.)			
				X				
				X				
				X	X	X		
X							X[e,f]	
X[b]							X[g]	X[h]
								X[e,h]

For the control of spontaneous bleeding episodes or to cover surgical interventions in hemophilia A and hemophilia B patients with inhibitors.

Treatment of bleeding episodes and perioperative management in adults and children with hemophilia A or B with inhibitors, congenital Factor VII deficiency, and Glanzmann's thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets. Also indicated for treatment of bleeding episodes and perioperative management in adults with acquired hemophilia.

Treatment of patients with hereditary antithrombin III deficiency in connection with surgical or obstetrical procedures or when they suffer from thromboembolism.

Prevention of perioperative and peri-partum thromboembolic events in hereditary antithrombin deficient patients.[i]

Recommendations: Based on the variety of agents available and the variable response based on the patient, it is not recommended that a specific antihemophilic factor is preferred. The new factors products NovoEight, Obizur, and Ixinity should be covered in a similar fashion to those products which are already available. This would include coverage under the medical benefit for emergent situations and coverage under the pharmacy benefit on the brand non-preferred tier or the specialty tier for members with that benefit. A prior authorization shoud continue to be required on the pharmacy benefit while no authorization is necessary on the medical benefit.

Discussion: Specific complications related to hemophilia were discussed, specifically the increased risk of bleeding. Complications due to replacement therapy were also discussed, primarily the formation of IgG antibodies (also referred to as inhibitors). The formation of inhibitors neutralizes the clotting factors and leads to failure to respond to therapy. If inhitors are formed the most common treatment involves increasing the dose of the antihemophilic factor to increase levels above those suppressed by the inhibitors. Other options include the use of a bypassing agent, lowering plasma inhibitor levels via exchange plasmapheresis, or immune tolerance induction.

The use of plasma derived products vs. recombinant products was also discussed. The use of plasma products lead to the emergence and transmission of HIV, hepatitis B, and hepatitis C virus and ultimately high mortality of people with hemophelia in the 1980s and early 1990s. The implementation of purification methods (cryoprecipitation, ion exchange, gel permeation or monoclonal antibody immunoaffinity chromatography), and of viral inactivation (solvent detergent, heat treatment/pasteurization) or removal (ultrafiltration) techniques for the production of plasma-derived factor concentrates, as well as the adoption of new methods to screen viruses in blood donations (i.e., nucleic acid testing [NAT]), greatly improved the safety of plasma-derived products, as shown by the fact that blood-borne transmissions of hepatitis viruses or HIV have no longer occurred in the last 25 years. However, the greatest advance in this field was the development of recombinant factor products. Recombinant factor concentrates have been adopted over the past two decades, particularly in developed countries. Recombinant products have contributed significantly to infection risk reduction. While plasma-derived products have been free of viral transmission for many years, there remain concerns of a potential risk of transmission of blood borne diseases that must be specifically understood by patients and caregivers. Many hemophilia specialists consider recombinant concentrates the first-choice products, particularly in children, economic restraints notwithstanding. While recombinant products are the preferred treatment, there remain patients for whom plasma-derived products are preferred or appropriate based upon a variety of issues pertinent to the patient in question.

The choice of antihemophilic agent relys on many patient specific factors and there is no one preferred or superior product.

GHP specific utilization data was discussed prior to the close of the discussion. We are estimated to have around 14 patients with hemophilic disorders, most of which are members of GHP Family.

Outcome: Kimberly Clark made a motion to accept the recommendations as written. Dr. Perry Meadows seconded the motion. None were opposed

POLICY UPDATES:

Oral PPI Update **Kimberly Clark**

Currently Nexium (now available generically as esomeprazole) and Dexilant are reviewed as follows:

- Esomeprazole: Medical record documentation of a contraindication to, intolerance to, or therapeutic failure on the maximal doses of omeprazole, pantoprazole, lansoprazole, rabeprazole, and Dexilant* .
- Dexilant: Medical record documentation of a contraindication to, intolerance to, or therapeutic failure on the maximal doses of omeprazole, pantoprazole, lansoprazole, and rabeprazole.

Recommendation: With the availability of generic esomeprazole, it is recommended that the prior authorization criteria for Dexilant and esomeprazole are updated as follows:

- Esomeprazole: Medical record documentation of a contraindication to, intolerance to, or therapeutic failure on the maximal doses of omeprazole, pantoprazole, lansoprazole, and rabeprazole.
- Dexilant: Medical record documentation of a contraindication to, intolerance to, or therapeutic failure on the maximal doses of omeprazole, pantoprazole, lansoprazole, rabeprazole, and esomeprazole*.

Discussion: No questions or comments

Outcome: Steven Kheloussi made a motion to accept the recommendations as written. Dr. Perry Meadows seconded the motion. None were opposed.

Astepro **Steven Kheloussi**

At the July P&T meeting, it was recommended and approved that an age-related criterion be added to the policy. However, the indicated age is below some of the formulary alternatives. The criteria should be updated to reflect this.

Recommendations: It is recommended that the existing policies be updated as follows:

- For Seasonal Allergic Rhinitis –
  - Documentation that patient is $\geq$ 2 years of age to < 6 years of age **AND** medical record documentation of therapeutic failure on, intolerance to, or contraindication to azelastine 0.1% nasal spray **AND** triamcinolone acetonide **OR**
  - Documentation that patient is $\geq$ 6 years of age **AND** medical record documentation of therapeutic failure on, intolerance to, or contraindication to azelastine 0.1% nasal spray, flunisolide, **AND** triamcinolone acetonide
- For Perennial Allergic Rhinitis –
  - Documentation that patient is $\geq$ 6 months of age to < 2 years of age **OR**
  - Documentation that patient is $\geq$ 2 years of age to < 4 years of age **AND** medical record documentation of therapeutic failure on, intolerance to, or contraindication to triamcinolone acetonide **OR**
  - Documentation that patient is $\geq$ 4 years of age to < 6 years of age **AND** medical record documentation of therapeutic failure on, intolerance to, or contraindication to fluticasone propionate **AND** triamcinolone acetonide **OR**

- Documentation that patient is ≥ 6 years of age **AND** medical record documentation of therapeutic failure on, intolerance to, or contraindication to three formulary alternatives

Discussion: No questions or comments

Outcome: Kimberly clark made a motion to accept the recommendations as written. Kevin Szczecina seconded the motion. None were opposed.

Biologic Updates **Steven Kheloussi**

One area that we are receiving a large number of overturns on initially upheld appeals is related to joint counts on the biologic agents for RA, psoriatic arthritis (PsA), and polyarticular juvenile idiopathic arthritis (PJIA). Currently, we require a joint count upon initial approval for biologic agents for RA, PsA, and PJIA in order to get a baseline of disease severity. Reauthorization is also based on an improved joint count in addition to overall disease improvement.

Reccomendation: It is recommended that joint count is removed from the biologic policies to reduce the number of overturned cases by Maximus. Joint count should be removed from the initial and reauthorization criteria of the following policies:

Drug Name	Policy Number	Medical Policy
Actemra IV	-	MBP076.0
Actemra SC	121.0F	-
Cimzia	903.0F	MBP074.0
Enbrel	1007.0F	-
Humira	1014.0F	-
Kineret	1011.0F	-
Orencia IV	-	MBP040.0
Orencia SC	1105.0F	-
Otezla	1271.0F	-
Remicade	-	MBP005.0
Rituxan	-	MBP048.0
Simponi Aria	-	MBP112.0
Simponi SC	1137.0F	-
Stelara	1245.0F	MBP075.0
Xeljanz	1201.0F	-

Discussion: No questions or comments

Outcome: Kimberly Clark made a motion to accept the recommendations as written. Dr. Perry Meadows seconded the motion. None were opposed.

Hepatitis C Policy Update **Kevin Szczecina**

Recommendation: The following changes were requested by DHS. It is recommended that the P&T Committee approve the changes:

1246.0F Sovaldi

- Removed "medical record documentation of urine drug screen (UDS) correctly corresponding with medication fill history"
- Removed "medical record documentation that member is compliant with treatment if currently being treated for substance dependency"
- Removed "medical record documentation that the member has not had an incomplete course of treatment with the same direct acting antiviral that is being requested and/or has not failed a treatment regimen of an alternative protease inhibitor"
- Changed "is prescribed by a board certified gastroenterologist, hepatologist, infectious disease specialist or transplant specialist" to "is prescribed by a board certified gastroenterology, hepatology, infectious disease or transplant specialist"
- Changed Genotype 1 indication from "concurrent therapy with peginterferon alfa and ribavirin OR concurrent therapy with ribavirin if peginterferon ineligible* and having a history of previous failed therapy with a HCV protease inhibitor OR concurrent therapy with simeprevir (Olysio) (requires prior authorization) if peginterferon ineligible and not having a history of previous failed therapy with an HCV protease inhibitor" to "concurrent therapy with ribavirin and having a history of previous failed therapy with a HCV protease inhibitor OR concurrent therapy with simeprevir (Olysio) (requires prior authorization)"

1247.0F Olysio

- Removed "medical record documentation of urine drug screen (UDS) correctly corresponding with medication fill history"
- Removed "medical record documentation that member is compliant with treatment if currently being treated for substance dependency"
- Removed "medical record documentation that the member has not had an incomplete course of treatment with the same direct acting antiviral that is being requested and/or has not failed a treatment regimen of an alternative protease inhibitor"
- Changed "is prescribed by a board certified gastroenterologist, hepatologist, infectious disease specialist or transplant specialist" to "is prescribed by a board certified gastroenterology, hepatology, infectious disease or transplant specialist"
- Changed Genotype 1 indication from "concurrent therapy with ribavirin and peginterferon alfa OR concurrent therapy with sofosbuvir (Sovaldi) if peginterferon ineligible and not having a history of previous failed therapy with an HCV protease inhibitor" to "concurrent therapy with sofosbuvir (Sovaldi)

1248.0F Hepatitis C DAAs, 1284.0F Harvoni, 1292.0F Viekira Pak

- Removed "medical record documentation of urine drug screen (UDS) correctly corresponding with medication fill history"
- Removed "medical record documentation that member is compliant with treatment if currently being treated for substance dependency"
- Removed "medical record documentation that the member has not had an incomplete course of treatment with the same direct acting antiviral that is being requested and/or has not failed a treatment regimen of an alternative protease inhibitor"

- Changed “is prescribed by a board certified gastroenterologist, hepatologist, infectious disease specialist or transplant specialist” to “is prescribed by a board certified gastroenterology, hepatology, infectious disease or transplant specialist”

Discussion: No questions or comments

Outcome: Todd Sponenberg made a motion to accept the recommendations as written. Jamie Dodson seconded the motion. Dr. Bret Yarczower was opposed.

GHP Family Policy Updates **Kevin Szczecina**

Recommendation: Formulary stimulants require prior authorization for members over age 21 for GHP Family. It is recommended a policy with the following criteria be created:

For dexmethylphenidate, amphetamine-dextroamphetamine ER and methylphenidate ER:

- Medical record documentation of a diagnosis of attention deficit disorder (ADD) **OR** attention deficit hyperactivity disorder (ADHD)

For dextroamphetamine, amphetamine-dextroamphetamine IR and methylphenidate IR:

- Medical record documentation of attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD) **OR** narcolepsy

Discussion: No questions or comments

Outcome: Kimberly Clark made a motion to accept the recommendations as written. Steven Kheloussi seconded the motion. None were opposed.

Recommendation: Bystolic is a beta-adrenergic blocking agent indicated for hypertension. It requires prior authorization for GHP Family. It is recommended a policy with the following criterion be created:

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to, 2 formulary beta blocker agents.

Formulary alternatives: atenolol, metoprolol succinate, propranolol sa, bisoprolol

Discussion: No questions or comments

Outcome: Todd Sponenberg made a motion to accept the recommendations as written. Steven Kheloussi seconded the motion. None were opposed.

Recommendation: The following addition and deletions to the GHP Family Formulary are recommended:

- Add over-the-counter Omega-3 Fatty Acids/Fish Oil to the formulary as an alternative to prescription Omega-3 products

- Remove Evista as raloxifene is formulary
- Remove Cymbalta as duloxetine is formulary
- Remove Celebrex as celecoxib is formulary.
- Remove Lidoderm as lidocaine patch is formulary.

Discussion: No questions or comments

Outcome: Todd Sponenberg made a motion to accept the recommendations as written. Jamie Dodson seconded the motion. None were opposed.

Additional evidence of the criteria used to make these decisions can be found in the reviews presented to the committee.

Finished meeting at 3:58 pm.

Future Scheduled Meetings

November 17, 2015 at 1:00 HCSRLL Conference room

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