Department of Vermont Health Access
Pharmacy Benefits Management Program
DUR Board Meeting
Draft Minutes

June 20, 2023: 6:00 – 8:30 p.m.

Board Members Present:

	Andy Miller, RPH		**Lucy Miller, MD**		**Douglas Franzoni, PharmD**
	Claudia Berger, MD		**Annie Daly, PharmD**		**Katharina Cahill, PharmD**
	Mark Pasanen, MD		**Margot Kagan, PharmD**		

Board Members Absent:

	Joseph Nasca, MD				

DVHA Staff Present:

	Ashley MacWalters		**Carrie Germaine**		**Taylor Robichaud, PharmD**
	Lisa Hurteau, PharmD		**Michael Rapaport, MD**		

Change Healthcare Staff Present:

	Jeffrey Barkin, MD		**Laurie Brady, RPh**		**Michael Ouellette, RPh**

Guests/Members of the Public:

- Jim Pitt, Beth D'Ambrosio, Adam Denman, Alain Nguyen, Annie Guest, Kristin Chopas, Evie Knisely, Lindsey Walter, Melissa Abbott, Michael Gitomer, Nikhil Kacker, Pam Storey, Paul Sparks, Robin Desmarais, Steven Patterson, Edward MacMillan, Sejal Patel, Megan Walsh, Tim McSherry, Erin Booth, Joe Ward

Executive Session:

- An executive session was held from 6:00 p.m. until 6:30 p.m.

Introductions and Approval of DUR Board Minutes:

- Attendance was called and introductions of DVHA and Change Healthcare staff were made.
- The May meeting minutes were accepted as printed. Margot Kagan abstained from voting due to being absent from the last meeting.

DVHA Pharmacy Administration Update: Lisa Hurteau, PharmD, DVHA

- This is the last meeting for Dr. Nasca and Dr. Berger as their final terms expire at the end of August. Lisa thanked them for their expertise and service to the board. DVHA is actively recruiting new board members.

Chief Medical Officer Update: Michael Rapaport, MD, DVHA

- The FY2024 budget has not been passed yet. There are a few pharmacy related changes that are dependent on budget approval, one of which is a change to select over-the-counter coverage in patients 21 years of age and older.
- Weight loss medications are currently not covered according to the State Plan, however, DVHA is exploring non-pharmaceutical modalities.
- DVHA has entered into a pilot project with the University of Vermont comprehensive pain management program. Blue Cross/Blue Shield of Vermont has been participating and has reported a return on investment.

Follow-up Items from Previous Meetings: Laurie Brady, RPH Change Healthcare

- None at this time.

Recommendation: None needed.

Board Decision: None needed.

RetroDUR/ProDUR: Mike Ouellette, RPh and Laurie Brady, RPh, Change Healthcare

- Introduce: "Triple Therapy": Opioids, Benzodiazepines, and Skeletal Muscle Relaxants

The co-prescribing of opioids, benzodiazepines, and muscle relaxants is known to cause significant morbidity and has been shown to increase the likelihood of hospital admissions. A retrospective cohort study was published in 2019 examining data from the Medical Expenditure Panel Survey longitudinal data set and the affiliated Prescribed Medicines Files from 2013-2014, weighted to reflect the actual US population. The results showed that 0.53% of the population took all three classes of medications simultaneously and compared with non-users, the odds ratio of hospitalization was 8.52 in 2013. Respiratory and CNS depression are the primary reasons for hospitalizations and Deaths associated with concurrent use. A study done in Washington State found that opioid users had a 12-fold increased rate of death when also taking a benzodiazepine and muscle relaxant. While the FDA has issued warnings about the combined use of benzodiazepines and opioids, adding a muscle relaxant contributes to the risk of hospitalization and poor outcomes. Short-term use of an opioid and benzodiazepine has been deemed reasonable in specific situations, although the use of triple drug therapy with opioids, benzodiazepines, and muscle relaxants, even in the short-term, is not considered appropriate patient care. FDA Warnings about the co-prescribing of benzodiazepines and opioids has brought attention to the risks, however, short-term overlapping prescriptions are sometimes seen, although less frequently over

the last few years. It is expected that there will be very little overlapping use of these 3 classes of medications in Vermont.

Change Healthcare will use paid, non-reversed Medicaid pharmacy claims from Calendar Year 2022, excluding members with Part D, VMAP and Healthy Vermonters coverage. They will identify members who have been prescribed an opioid, benzodiazepine, and muscle relaxant with overlapping dates of service and determine if the members had the same or different prescribers. This combination presents a dangerous risk, and they will identify all cases where there is overlap, even if short-term.

Board Decision: None at this time.

- Data Presentation: Compliance with Heart Failure Medications

The treatment of heart failure has improved markedly over the last decade as the pathophysiology of heart failure is better understood and drugs with new therapeutic targets have been developed. Compliance with treatment is associated with improved life expectancy and decreased hospitalizations. Management of heart failure has become a specialty within cardiology as treatment has become more complex. Currently, patients with heart failure accompanied by reduced ejection fraction (HFrEF) often take many medications, with the goal of improving cardiac function and reducing associated health risks. These drugs fall into the classes of beta blockers (bisoprolol, metoprolol succinate, carvedilol), angiotensin-converting enzyme (ACE) inhibitors, angiotensin II receptor blocker (ARB) (candesartan, valsartan, losartan), angiotensin receptor-neprilysin (ARNI) inhibitors (sacubitril/valsartan, Entresto), SGLT-2 inhibitors, diuretics, aldosterone antagonists (spironolactone, eplerenone), and If channel blockers (ivabradine). In some cases, hydralazine, statins, and anticoagulants are used adjunctively to improve cardiac function and reduce the risk of potential health complications.

Change Healthcare used paid, non-reversed Medicaid pharmacy and medical claims for adults with a heart failure diagnosis from CY 2022, excluding members with Part D, VMAP and Healthy Vermonters coverage. Only members with continuous Medicaid eligibility were included in the analysis. The classes of drugs Change Healthcare examined were the ACE inhibitors, ARBs, beta-blockers, ARNI antagonists, and aldosterone antagonists. They looked at the medication possession ratio (MPR) for one year following the initial prescription of the selected medication. This analysis identified the number of medications individual members were being prescribed. Finally, this analysis evaluated compliance for each drug class to see if there are classes of medications that have poor adherence.

There were 266 members identified with a heart failure diagnosis. Of those members, there were a total number of 2,453 claims for heart failure medications. 22% of members used ACE Inhibitors, 21% of members used an ARB, 58% of members used a Beta Blocker, 48% of members used an ARNI, and 27% of members used a potassium

sparing diuretic. Patients could have been taking medications from multiple therapeutic categories.

Recommendation: A MPR of 80% or greater is preferred and was used as a benchmark to indicate compliance with a prescribed drug. In general, the MPR of the studied heart failure medications was greater than 80% in two classes, ARNI and beta-blocker drug classes. There were three classes of drugs that resulted in a MPR below 80%, the ACE inhibitors, ARB antagonists, and potassium sparing diuretics. A few of these classes fell just below the 80% benchmark, but all the studied classes were within a 10% deviation of the acceptable adherence benchmark.

Potential limitations in this review include the method for calculation of MPR values. Data from Chart 2 may represent lower numbers than members actual adherence rate. This limitation on MPR values would be due to members starting or stopping therapy at some point in the middle of the study period. Discontinuing a prescribed drug would not negatively impact a MPR value. Because this is claims data evaluating a snapshot in time, the analysis was not able to measure when a prescribed medication was stopped. Average MPR values of all studied members was used to minimize this deviation, but it should be noted that actual MPR values, when interviewing members directly, could potentially be higher..

Education about the MPR results of the three drug classes that were below 80%, including ACE inhibitors, ARB antagonists, and potassium sparing diuretics, to the primary care and cardiology providers may be helpful in improving compliance and prompting better member education about the importance of regularly taking medication.

Board Decision: The Board unanimously agreed that no further action is needed. A board member noted that some success could be due to “transition of care” teams for heart failure patients at UVM Medical Centers. A board member noted that after patients are discharged from the hospital due to heart failure, they are typically very compliant with their prescribed medications.

Clinical Update: Drug Reviews: Jeffrey Barkin, MD Change Healthcare and Laurie Brady RPh, Change Healthcare

Biosimilar Drug Reviews:

- Rezvoglar® (insulin glargine-aglr) (interchangeable with Lantus will be reviewed in Hypoglycemics, Insulin TCR)

Full New Drug Reviews:

- Ermeza® (levothyroxine)

Ermeza® contains synthetic levothyroxine (T4) sodium. Synthetic T4 is chemically identical to that produced in the human thyroid gland and is very slightly soluble in water. Thyroid hormones exert their physiologic actions through control of DNA transcription and protein synthesis. Triiodothyronine (T3) and L-thyroxine (T4) diffuse

into the cell nucleus and bind to thyroid receptor proteins attached to DNA. This hormone nuclear receptor complex activates gene transcription and synthesis of messenger RNA and cytoplasmic proteins. The physiological actions of thyroid hormones are produced mainly by T3, the majority of which (about 80%) is derived from T4 by deiodination in peripheral tissues. Oral levothyroxine sodium is a synthetic T4 hormone that exerts the same physiologic effect as endogenous T4, thus maintaining normal T4 levels when a deficiency is present. It is indicated for Hypothyroidism: As a replacement therapy in primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) congenital or acquired hypothyroidism in adult and pediatric patients, including neonates. Pituitary Thyrotropin (Thyroid-Stimulating Hormone, TSH) Suppression: As an adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer in adult and pediatric patients, including neonates. Limitations of use include: Ermeza® is not indicated for suppression of benign thyroid nodules and nontoxic diffuse goiter in iodine-sufficient patients as there are no clinical benefits and overtreatment with Ermeza® may induce hyperthyroidism. Ermeza® is not indicated for treatment of hypothyroidism during the recovery phase of subacute thyroiditis. There are no clinical trials section for Ermeza®. Synthetic levothyroxine has been able available for many years, both as brand and generic versions. Ermeza® is a new liquid dosage formulation to be administered with an oral syringe that allows for individualized dosing. A prior liquid formulation was FDA approved but at a different dose than Ermeza®. Per the Ermeza® website, it is bioequivalent to Synthroid® tablets. There is no evidence at this time to support that Ermeza® is safer or more effective than the other currently preferred, more cost-effective medications.

Recommendation:

- Add New sub-category Hypothyroid Agents
- Add Armour Thyroid tablet, Euthyrox® (levothyroxine) tablet, Levothyroxine tablet, Levoxyl® (levothyroxine) tablet, Liothyronine (compare to cytomel®) tablet, NP Thyroid® (thyroid) tablet, and Unithroid® (levothyroxine) tablet to preferred.
- Add Cytomel® (liothyronine) tablet, Ermeza™ (levothyroxine) oral solution, Levothyroxine capsule (compare to Tirosint®), Synthroid® (levothyroxine) tablet, Thyquidity™ (levothyroxine) oral solution, Tirosint® (levothyroxine) capsule, Tirosint®-Sol (levothyroxine) oral solution to non-preferred. Current users of Tirosint capsules will be grandfathered.
    - Clinical criteria:
        - Add Ermeza, Thyquidity, Tirosint-Sol: The patient has a medical necessity for a non-solid oral dosage form and the medication cannot be administered by crushing oral tablets AND for approval of Thyquidity, the patient must have a documented intolerance to Ermeza or Tirosint-Sol.

- Add Levothyroxine capsule, Tirosint capsule: patient has had a documented side effect, allergy, or treatment failure to 2 preferred hypothyroid agents.
- Add Cytomel, Synthroid: The patient has a documented intolerance to the generic equivalent.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendations.

- Hemgenix® (etranacogene dezaparvovec-drlb)

Hemgenix® is an adeno-associated viral vector-based gene therapy for IV infusion after dilution. It is an adeno-associated virus serotype 5 (AAV5) based gene therapy designed to deliver a copy of a gene encoding the Padua variant of human coagulation Factor IX (hFIX-Padua). Single IV infusion of Hemgenix® results in cell transduction and increase in circulating Factor IX activity in patients with Hemophilia B. It is indicated for the treatment of adults with Hemophilia B (congenital Factor IX deficiency) who: Currently use Factor IX prophylaxis therapy, or have current or historical life-threatening hemorrhage, or have repeated, serious spontaneous bleeding episodes. The efficacy of Hemgenix® was evaluated in a prospective, open-label, single-dose, single-arm, multinational study that enrolled adult male subjects aged 19 to 75 years of age (N=54) with severe or moderately severe Hemophilia B, who received a single IV dose of 2 X 1013 gc/kg body weight of Hemgenix®, and who entered a follow-up period of 5 years. This study is on-going. Hemgenix® is the first and only FDA-approved gene therapy for hemophilia B.

Recommendation:

- Add new sub-category Gene Therapy.
- Add note that all products require PA.
- Add Hemgenix® (etranacogene dezaparvovec-drlb) to non-preferred.
  - Clinical criteria:
    - Add Hemgenix:
    - Patient is ≥ 18 years of age AND
    - Patient has a diagnosis of severe congenital Factor IX deficiency, as evidenced by < 1% of normal circulating factor IX AND
    - Patient has the following: Current and continuous use of Factor IX prophylaxis therapy for the previous 6 months as evidence by claims history or clinical documentation, without breaks in adherence. (Continuous use is defined as routine prophylaxis with defined frequency. e.g. twice weekly, once every two weeks) AND Current or historical life-threatening hemorrhage despite use of preferred prophylaxis therapy OR

Repeated, serious spontaneous bleeding episodes requiring hospitalization AND
- Patient has been tested and found negative for Factor IX inhibitor titers (if test result is positive, re-test within approximately 2 weeks. If re-test is also positive, Hemgenix should not be administered) AND
- Patient must have a baseline anti-AAV5 antibody titer of less than or equal to 1:678 measured by ELISA AND
- Baseline liver function tests will be completed prior to start of therapy and continued weekly for 3 months following Hemgenix administration AND
- Factor IX activity will be monitored weekly for 3 months AND Factor IX prophylaxis therapy will be discontinued when circulating factor IX levels reach 5%.
- Approval will be granted for a max one-time dose per lifetime and may not be renewed.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendations.

- Sunlenca® (lenacapavir)

Lenacapavir sodium, the active ingredient of Sunlenca®, is an HIV-1 antiretroviral agent. It is a multistage, selective inhibitor of HIV-1 capsid function that directly binds to the interface between capsid protein (p24) subunits in hexamers. Surface plasmon resonance sensorgrams demonstrated dose-dependent and saturable binding of lenacapavir to cross-linked wild-type capsid hexamer. Lenacapavir inhibits HIV-1 replication by interfering with multiple essential steps of the viral lifecycle, including capsid-mediated nuclear uptake of HIV-1 proviral DNA (by blocking nuclear import proteins binding to capsid), virus assembly and release (by interfering with Gag/Gag-Pol functioning, reducing production of capsid protein subunits), and capsid core formation (by disrupting the rate of capsid subunit association, leading to malformed capsids). It is indicated in combination with other antiretroviral(s) for the treatment of HIV-1 infection in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations. The safety and efficacy of Sunlenca® were assessed in a randomized, placebo-controlled, double-blind, multicenter study that included HIV-1 infected, heavily treatment-experienced subjects with multidrug resistance. The primary efficacy endpoint (the proportion in cohort 1 achieving ≥0.5 log10 copies/ml reduction from baseline in HIV-1 RNA at the end of the functional monotherapy period) was achieved by 87.5% of the Sunlenca® group as compared with 16.7% of the placebo group (calculated NNT by CHC of 2). After initial titration, this is a twice-yearly, first-in-class capsid inhibitor for injection to be used in combination with other antiretroviral(s).

Recommendation:

- Add new sub-category Treatment Resistant Therapies.

- Add note that all products require PA.
- Add Sunlenca® (lenacapavir sodium) to non-preferred.
- Move Trogarzo® (ibalizumab-uiyk) with QTY LIMIT: 10 vials (2000 mg) x 1 dose then 4 vials (800 mg) every 14 days thereafter to non-preferred.
- Move Rukobia® (fostemsavir) with QTY LIMIT = 2 tablets per day to non-preferred.
    - Clinical criteria:
        - Update Sunlenca, Rukobia, Trogarzo: The patient must meet ALL of the following criteria:
            - ≥ 18 years of age
            - Prescription is written by or in consultation with an infectious disease specialist.
            - Viral Load is ≥ 1,000 copies/mL (results must be submitted)
            - Patient has been compliant but has had an inadequate response to at least 6 months of treatment with anti-retroviral therapy (ART)
            - Patient has multi-drug resistant HIV-1 infection including documented resistance to at least one medication from each of the following classes: Protease Inhibitor (PI), Nucleoside Reverse Transcriptase Inhibitor (NRTI), Non-nucleoside Reverse Transcriptase Inhibitor (NNRTI)
            - Medication will be used in combination with ART that includes at least one drug to which the individual's virus is susceptible.
            - Initial approval will be granted for 6 months. For continuation of therapy, there must be a decrease in viral load from baseline AND the patient must continue to be compliant with the optimized background regimen of ART.

Public Comment: Alain Nguyen with Gilead highlighted the attributes of Sunlenca®.

Board Decision: The Board unanimously approved the above recommendations.

- Tepezza® (teprotumumab-trbw)

Teprotumumab-trbw, the active ingredient of Tepezza®, is an insulin-like growth factor-1 receptor inhibitor (IGF-1R). It is a fully human IgG1 monoclonal antibody produced in Chinese hamster ovary cells. Its mechanism of action has not been fully characterized, but teprotumumab-trbw binds to IGF-1R and blocks its activation and signaling. It is indicated for the treatment of Thyroid Eye Disease regardless of Thyroid Eye Disease activity or duration. The safety and efficacy of Tepezza® were assessed in 2 randomized, double-masked, placebo-controlled studies that included patients with Thyroid Eye Disease. In 2 clinical trials, Tepezza® improved proptosis (bulging eyes)

responder rates as compared with placebo. (The NNT for proptosis responder rates for study 1 was 2 and for study 2 was 2.) In addition, double vision was also reduced. Per one noted reference source, treatment with teprotumumab or glucocorticoids is suggested as initial treatment for patients with moderate-to-severe orbitopathy. “In the absence of comparative effectiveness trials, the choice of therapy should be individualized based upon the clinical presentation of the patient, shared decision-making, regional expertise, and availability of therapies.

Recommendation:

- Add Tepezza® (teprotumumab-trbw) vial for IV infusion to non-preferred.
  - Clinical criteria:
    - Add: Tepezza: Patient has a diagnosis of Thyroid Eye Disease (TED) related to Graves’ Disease AND
    - Patient has a baseline Clinical Activity Score (CAS) ≥ 4 in the most severely affected eye AND
    - Patient has active TED associated with at least one of the following: Lid retraction ≥ 2 mm, Moderate or severe soft tissue involvement, Exophthalmos ≥ 3 mm above normal for race and gender, Diplopia (double vision).
    - Patient is euthyroid, defined as free triiodothyronine (T3) and thyroxine (T4) levels within the normal limits, OR Patient has free T3 and T4 levels less than 50% above or below the normal limits and is undergoing treatment to correct the hypo- or hyperthyroidism to maintain a euthyroid state AND
    - Patient has had an inadequate response or contraindication to high-dose intravenous glucocorticoid therapy.

Public Comment: Sejal Patel with Horizon Therapeutics highlighted the attributes of Tepezza®. He requested that the board reconsider proposed criteria due to the recent FDA approval updates.

Board Decision: The Board unanimously approved the above recommendations.

- Tzield® (teplizumab-mzwv)

Teplizumab-mzwv, the active ingredient of Tzield®, is a CD3-directed monoclonal antibody (humanized IgG1 kappa) expressed from a recombinant Chinese hamster ovary (CHO) cell line. Teplizumab-mzwv binds to CD3 (a cell surface antigen present on T lymphocytes) and delays the onset of Stage 3 type 1 diabetes in adults and pediatric patients aged 8 years and older with Stage 2 type 1 diabetes. The mechanism may involve partial agonistic signaling and deactivation of pancreatic beta cell autoreactive T lymphocytes. Teplizumab-mzwv leads to an increase in the proportion of regulatory T cells and of exhausted CD8+ T cells in peripheral blood. Cytokine release syndrome (CRS) has been observed in Tzield®-treated patients. In clinical trials, CRS was reported in 5% of Tzield®-treated patients compared to 0.8% of control-treated patients

during the treatment period and through 28 days after the last study drug administration. CRS manifestations (e.g., fever, nausea) typically occurred during the first 5 days of Tzield® treatment. To mitigate CRS:

- Premedicate with antipyretics, antihistamines, and/or antiemetics prior to Tzield® treatment.
- Monitor liver enzymes during treatment. Discontinue Tzield® treatment in patients who develop elevated ALT or AST greater than 5 times the upper limit of normal (ULN) or bilirubin higher than 3 times ULN.
- Treat symptoms of CRS with antipyretics, antihistamines, and/or antiemetics. If severe CRS develops, consider temporarily pausing dosing for 1-2 days (and administer the remaining doses to complete the full 14-day course on consecutive days) or discontinuing treatment.

Bacterial and viral infections have occurred in Tzield®-treated patients. Use of Tzield® is not recommended in patients with active serious infection or chronic infection other than localized skin infections. Monitor patients for signs and symptoms of infection during and after Tzield® treatment. If serious infection develops, treat appropriately, and discontinue Tzield®. In clinical trials, 78% of Tzield®-treated patients developed lymphopenia compared to 11% of control-treated patients. For most Tzield®-treated patients who experienced lymphopenia, lymphocyte levels began to recover after the fifth day of treatment and returned to pre-treatment values within 2 weeks after treatment completion and without dose interruption. Monitor white blood cell counts during the treatment period. If prolonged severe lymphopenia develops, discontinue Tzield®. The safety and efficacy of Tzield® was assessed in a randomized, double-blind, event-driven, placebo-controlled study. The primary efficacy endpoint was the time from randomization to development of Stage 3 type 1 diabetes diagnosis. Results suggested that the median time from randomization to Stage 3 type 1 diabetes diagnosis was 50 months in the Tzield® group and 25 months in the placebo group. With a median follow-up time of 51 months, therapy with Tzield® resulted in a statistically significant delay in the development of Stage 3 type 1 diabetes (HR 0.41, p=0.0066). Tzield® is currently the first and only FDA-approved treatment proven to delay the onset of Stage 3 type 1 diabetes.

Recommendation:

- Add new sub-category CD3 Monoclonal Antibody.
- Add note that all products require PA.
- Add Tzield™ (teplizumab-mzwv) vial for IV infusion to non-preferred.
    - Clinical criteria:
        - Add Tzield: Patient is ≥ 8 years of age
        - Patient has Stage 2 Type 1 Diabetes as documented by the following:

    - Patient has at least 2 positive pancreatic islet cell autoantibodies (Glutamic acid decarboxylase 65 (GAD) autoantibodies, Insulin autoantibody (IAA), Insulinoma-associated antigen 2 autoantibody (IA-2A), Zinc transporter 8 autoantibody (ZnT8A), or Islet cell autoantibody (ICA)
    - Dysglycemia without overt hyperglycemia, as demonstrated by at least one of the following: Fasting plasma glucose 110-125 mg/dL, 2-hour postprandial glucose 140-199 mg/dL, or Postprandial glucose level at 30, 60, or 90 minutes > 200 mg/dL.
  - Patient does not have any of the following: Lymphocyte count less than 1,000 lymphocytes/mcL, Hemoglobin less than 10 g/dL, Platelet count less than 150,000 platelets/mcL, Absolute neutrophil count less than 1,500 neutrophils/mcL, Elevated ALT or AST greater than 2 times the upper limit of normal (ULN), Bilirubin greater than 1.5 times ULN
  - Patient has received all age-appropriate vaccines prior to starting Tzield (Live-attenuated vaccines should be administered at least 8 weeks prior to treatment. Inactivated vaccines or mRNA vaccines should be administered at least 2 weeks prior to treatment).

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendations.

- Xelstrym® (dextroamphetamine patch, extended release)

Dextroamphetamine, the active ingredient of Xelstrym®, is a CNS stimulant and is the dextro isomer of the compound d, l-amphetamine. Amphetamines are non-catecholamine sympathomimetic amines with CNS stimulant activity. The exact mode of therapeutic action in ADHD is not known. Amphetamines block the reuptake of norepinephrine and dopamine into the presynaptic neuron and increase the release of these monoamines into the extra neuronal space. Xelstrym® is a Schedule II controlled substance. CNS stimulants, including Xelstrym®, have a high potential for abuse. Xelstrym® may produce physical dependence and tolerance from continued use. It is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in adults and pediatric patients 6 years and older. Limitation of use includes that pediatric patients younger than 6 years of age experienced more long-term weight loss than patients 6 years and older. The efficacy of Xelstrym® for the treatment of ADHD in pediatric patients 6 to 17 years of age was assessed in a multicenter, randomized, double-blind, placebo-controlled, cross-over design, modified analog classroom study that was conducted in patients who met DSM-IV-TR criteria for ADHD (N=110). Following a 5-week, open-label, dose optimization phase with Xelstrym®, patients were randomized to one of two treatment sequences: Xelstrym® (optimized dose) followed by placebo, each for one week OR placebo followed by Xelstrym® (optimized dose), each

for one week. Efficacy was assessed at the end of each week using the Swanson, Kotkin, Agler, M. Flynn, and Pelham (SKAMP) total score, a validated 13-item rating scale to assess manifestations of ADHD in a classroom setting. Items are specific to place (classroom setting) and time (during a typical classroom period), and the scale is used to assess multiple ratings taken within a day. Efficacy was solely based on data from Period 1, which was the first week of the two-week double-blind, placebo-controlled, crossover treatment phase. Results suggested that a statistically significant separation from placebo was observed with the use of Xelstrym® in Period 1.

Recommendation:

- Add Xelstrym™ (dextroamphetamine patch) with QTY LIMIT: 1 patch/day to non-preferred.
- Add Dyanavel® (amphetamine/dextroamphetamine SR) chewable tablet to non-preferred.
    - Clinical criteria:
        - Update Adzenys XR ODT, Adzenys ER suspension, Dynavel XR chewable tablet, Dyanavel XR suspension, Vyvanse Chew: patient must be unable to tolerate Adderall XR sprinkled onto applesauce or Vyvanse mixed with yogurt, water, or orange juice.
        - Add Xelstrym: patient has a documented medical necessity for a specialty non-oral dosage form.

Public Comment: No public comment.

Board Discussion: A board member questioned the efficacy of the methods used in the clinical trial for Xelstrym™.

Board Decision: The Board unanimously approved the above recommendations.

- Zonisade® (zonisamide)

Zonisamide, the active ingredient of Zonisade®, is chemically classified as a sulfonamide. The exact mechanism of action by which it exerts its anticonvulsant effects is unknown. Zonisamide may produce these effects through action at sodium and calcium channels. In vitro studies suggest that zonisamide blocks sodium channels and reduces voltage-dependent, transient inward currents, consequently stabilizing neuronal membranes. Other in vitro studies have demonstrated that zonisamide suppresses synaptically-driven electrical activity without affecting postsynaptic GABA or glutamate responses or neuronal or glial uptake of [3H]-GABA. Thus, zonisamide does not appear to potentiate the synaptic activity of GABA. It is indicated as an adjunctive therapy for the treatment of partial-onset seizures in adults and pediatric patients 16 years and older. The efficacy of Zonisade® is based upon a bioavailability study comparing Zonisade® oral suspension to zonisamide capsules in healthy subjects. The clinical studies information described in the Zonisade® prescribing information pertains to the

zonisamide capsule formulation. Zonisade® offers a different dosage formulation and is the only FDA-approved available ready-to-use liquid formulation of zonisamide.

Recommendation:

- Add Topiramate SR 24hr (compare to Trokendi®) capsules with QTY LIMIT: 200 mg = 2 caps/day, all other strengths = 1 cap/day to non-preferred.
- Add Zonisade™ (zonisamide) suspension to non-preferred.
    - Clinical criteria:
        - Update Eprontia, Zonisade: The patient has a medical necessity for a specialty dosage form.
        - Update Elepsia XR, Keppra XR, Lamictal XR, Lamotrigine ER, Oxtellar XR, Qudexy XR, Topiramate ER, Topiramate SR, Trokendi XR: patient has been unable to be compliant with or tolerate twice daily dosing of the immediate release product. Additionally, if brand Elepsia XR, Keppra XR or Lamictal XR is requested, the patient has a documented intolerance to the generic product. If topiramate ER sprinkle caps are requested, the patient must have a documented intolerance to Qudexy XR.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendations.

New Therapeutic Drug Classes

- None at this time.

Therapeutic Drug Classes- Periodic Review:

Antifungals, Oral

- No new drugs.
- No other significant clinical changes.

Recommendation:

- Add Posaconazole oral suspension (compare to Noxafil®) to non-preferred.
- Add Noxafil ® (posaconazole) DR Powder packets to non-preferred.
    - Clinical criteria:
        - Update Noxafil tablet, Posaconazole tablet, Noxafil powder packets: patient has a diagnosis of HIV/immunocompromised status (neutropenia secondary to chemotherapy, hematopoietic stem cell transplant recipients) AND medication is being used

for the prevention of invasive Aspergillosis/ Candida infections. OR patient is completing a course of therapy with the requested medication that was initiated in the hospital. Approval of powder packets will be limited to patients ≤ 12 years of age and < 40kg.

- Update Noxafil oral suspension, posaconazole oral suspension: Patient is completing a course of therapy with the requested medication that was initiated in the hospital OR Patient has a diagnosis of HIV/immunocompromised status (neutropenia secondary to chemotherapy, hematopoietic stem cell transplant recipients) AND medication is being used for the prevention of invasive Aspergillosis/ Candida infections OR Patient is being treated for oropharyngeal candidiasis and has a documented side-effect, allergy, or treatment failure to fluconazole and itraconazole.

Public Comments: None at this time.

Board Decision: The Board unanimously approved the above recommendations.

Antifungals, Topical

- No new drugs
- No other significant clinical changes.

Recommendation:

- Move Jublia® (efinaconazole 10% solution) with QTY LIMIT: 48 weeks treatment, Tavaborole solution with QTY LIMIT: 48 weeks treatment, Econazole 1% Cream, and Butenafine (compare to Mentax®) 1% Cream to preferred.
- Remove Ciclodan® (ciclopirox) Cream, Oxistat® (oxiconazole) cream from the PDL. They are no longer available.
    - Clinical criteria:
        - Update Kerydin: Patient has a documented side effect, allergy, or treatment failure to two preferred topical onychomycosis agents, one of which must be tavaborole.
        - Add Ciclodan: Patient has a documented intolerance to generic ciclopirox 8% solution.

Public Comments: None at this time.

Board Decision: The Board unanimously approved the above recommendations.

Bone Resorption Inhibitor & Related Agents

- No new drugs
- In November 2020, the FDA approved changes to the label for the parathyroid hormone (PTH) analogue teriparatide by removing the 2-year lifetime treatment limitation and the boxed warning about the potential risk of osteosarcoma.

Recommendation:

- Remove Boniva® (ibandronate) tablets and injection from the PDL. They are no longer available.
- Move Ibandronate with QTY LIMIT: 150 mg = 1 tablet/28 days to preferred
    - Clinical criteria:
        - Update Actonel, Atelvia, Risendronate: patient has had a documented side effect, allergy, or treatment failure (at least a six-month trial) to generic alendronate and ibandronate tablets AND if the request is for brand, the patient has also had a documented intolerance to generic equivalent.
        - Update Forteo, Teriperatide: patient has had a documented side effect, allergy, or treatment failure ** to a bisphosphonate. AND for approval for Forteo the patient has had a documented intolerance to generic Teriparatide.
        - Update Tymlos: patient has had a documented side effect, allergy, or treatment failure ** to a bisphosphonate and teriparatide AND prescriber has verified that the patient has been counseled about osteosarcoma risk.
        - Update Prolia Injection: Patient has had a documented side effect, allergy, or treatment failure ** to a preferred bisphosphonate OR medication is being used for osteopenia in women with breast cancer receiving adjuvant aromatase inhibitor therapy OR medication is being used for osteopenia in men receiving androgen deprivation therapy.

Public Comments: No public comment.

Board Decision: The Board unanimously approved the above recommendations.

Hypoglycemics, Incretin Mimetics/Enhancers & SGLT2-Inhibitors

- No new drugs
- No other significant clinical changes.

Recommendation:

Anti-Diabetics/DPP-4 Inhibitors and Combinations

- Remove clinical criteria for preferred agents.
- Add Alogliptan/metformin (compare to Kazano®) with QTY LIMIT: 1 tab/day and Alogliptin/pioglitazone (compare to Oseni®) with QTY LIMIT: 1 tab/day to non-preferred.
- Move Jentadueto® XR (linagliptan/metformin ER) and Onglyza® (saxagliptin) to preferred.
    - Clinical criteria:
        - Update Alogliptin, Nesina: patient has had a documented side effect, allergy, OR treatment failure with two preferred DPP-4 agents AND for approval of alogliptin,the patient has had a documented intolerance to the brand name equivalent.
        - Update Alogliptin/metformin, Kazano, Kombiglyze XR: patient has had a documented side effect, allergy OR treatment failure with at least one preferred DPP-4 combination agent AND for approval of Alogliptin/metformin, the patient has had a documented intolerance to the brand name equivalent.
        - Add Alogliptan/pioglitazone, Oseni: patient has had a documented side effect, allergy OR treatment failure with at least one preferred DPP-4 agent used in combination with pioglitazone AND for approval of Alogliptin/pioglitazone, the patient has had a documented intolerance to the brand name equivalent.

Anti-Diabetics/GLP-1 Receptor Agonists

- No changes

Anti-Diabetics/SGLT2 Inhibitors and Combinations

- Move Xigduo XR® (dapagliflozin & metformin ER) with QTY LIMIT: 5/1000 mg = 2/day, all other strengths = 1/day to non-preferred.
    - Clinical criteria:
        - Update Invokamet XR/Segluromet/ Synjardy XR, Xigduo XR: The patient has documentation of a failure of therapy with a preferred SGLT2 inhibitor used in combination with metformin/metformin XR.

Public Comments: None at this time.

Board Decision: The Board unanimously approved the above recommendations.

Hypoglycemics, Insulin

- The FDA approved for Rezvoglar (insulin glargine-aglr), a biosimilar for Lantus (insulin glargine) that was originally approved in December 2021, for

an interchangeability designation, allowing the product to be exchanged for the reference product at the pharmacy level without requiring physician permission.
- No other significant clinical changes.

Recommendation:
- Move Insulin Lispro (compare to Humalog®), Toujeo® Max (insulin glargine), and Insulin Aspart Protamine/aspart 70/30 (compare to Novolog Mix 70/30®) to preferred.
- Add Insulin Degludec (compare to Tresiba®), Insulin Glargine (compare to Lantus®), Insulin Glargine-yfgn (compare to Semglee®), and Rezvoglar™ (insulin glargine-aglr) to non-preferred.
    - Clinical criteria:
        - Update Admelog, Fiasp, Lyumjev: Preferred formulations of rapid-acting insulin must be on a long-term backorder and unavailable from the manufacturer.
        - Update Apidra, Humulin R (U-100), Novolin R: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, OR treatment failure to two preferred formulations of rapid-acting insulin.
        - Update Humulin 70/30, Novolin 70/30: patient has been started and stabilized on the requested medication. (Note: samples are not considered adequate justification for stabilization.) OR patient has had a documented side effect, allergy, or treatment failure to two preferred mixed insulin formulations.
        - Add Insulin Degludec: Tresiba must be on a long-term backorder and unavailable from the manufacturer.
        - Update Insulin Glargine, Insulin Glargine-Yfgn, Rezvoglar, Semglee: Lantus must be on a long-term backorder and unavailable from the manufacturer.
        - Add Basaglar: All formulations of insulin glargine must be on long-term backorder and unavailable from the manufacturer.

Public Comments: None at this time.

Board Decision: The Board unanimously approved the above recommendations.

Hypoglycemics, Other
- No new drugs
- No other significant clinical changes.

Recommendation:
- Move Miglitol to non-preferred.

- Remove Precose® (acarbose), Fortamet® (metformin ER Osmotic), and Glucotrol® (glipizide) from the PDL. They are no longer available.
- Move pioglitazone to preferred (clinical criteria no longer apply).
    - Clinical criteria:
        - Add Miglitol: Patient must have a documented side effect, allergy or treatment failure to acarbose.
        - Update Actos: the patient has a documented intolerance to the generic equivalent.

Public Comments: None at this time.

Board Decision: The Board unanimously approved the above recommendations.

Multiple Sclerosis Agents

- Ublituximab-xiiy, the active ingredient of Briumvi®, is a recombinant chimeric monoclonal IgG1 antibody with reduced fucose content directed against CD20-expressing B-cells. The precise mechanism of action for its approved indication is not known, but it is presumed to involve binding to CD20, a cell surface antigen present on pre-B and mature B lymphocytes. Following cell surface binding to B lymphocytes, ublituximab-xiiy results in cell lysis through mechanisms including antibody-dependent cellular cytolysis and complement-dependent cytolysis. It is indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. The efficacy of Briumvi® was demonstrated in two randomized, double-blind, double-dummy, parallel group, active comparator-controlled trials of identical design that included patients with RMS treated for 96 weeks. The safety and efficacy of Briumvi® were assessed in two randomized, double-blind, double-dummy, active comparator-controlled studies that included patients with RMS. Results suggested that Briumvi® significantly lowered the ARR (primary endpoint) compared to teriflunomide. Briumvi® also statistically significantly reduced the number of T1 Gd-enhancing lesions and the number of new or enlarging T2 lesions in both studies compared to teriflunomide; however, there was no statistically significant difference in disability progression confirmed at 12 weeks between treatments. There are two other products with a similar mechanism of action as Briumvi®, including Kesimpta and Ocrevus®. While Briumvi® is to be administered every 24 weeks as a 1-hour infusion, Kesimpta® can be self-administered but is dosed monthly and Ocrevus® is a twice yearly IV infusion but with a longer infusion time than Briumvi®.

Recommendation:

- Move Aubagio® (teriflunamide) tablet with QTY LIMIT: 1 tablet/day; Maximum 30-day supply per fill to non-preferred.

- Add Teriflunomide (compare to Aubagio®) tablet with QTY LIMIT: 1 tablet/day; Maximum 30-day supply per fill to preferred.
- Move Gilenya® (fingolimod) capsule with QTY LIMIT: 1 capsule/day; Maximum 30-day supply per fill to non-preferred.
- Add Fingolimod capsule (compare to Gilenya®) with QTY LIMIT: 1 capsule/day; Maximum 30-day supply per fill to preferred.
- Add Briumvi™ (ublituximab-xiiy) to non-preferred.
- Add Tascenso ODT® (fingolimod) to non-preferred.
    - Clinical criteria:
        - Update Ampyra, Aubagio, Gilenya, Tecfidera: patient must have a documented intolerance to the generic equivalent.
        - Update Briumvi, Kesimpta, Lemtrada, Ocrevus: Patient is ≥18 years AND has a diagnosis of relapsing multiple sclerosis AND has a documented side effect, allergy, treatment failure or contraindication to at least two preferred drugs, one of which must be Tysabri, unless contraindicated. OR Patient is ≥ 18 years AND has a diagnosis of primary progressive multiple sclerosis (Ocrevus only).
        - Add Tascenso ODT: patient has a medical necessity for a non-solid oral dosage form.

Public Comments: Evie Knisely from Novartis highlighted the attributes of Kesimpta®

Board Decision: The Board unanimously approved the above recommendations.

Review of Newly-Developed/Revised Criteria:

Continuous Glucose Monitoring

- A March 2nd policy update from the Centers for Medicare and Medicaid Services (CMS) removes key restrictions to CGM coverage for Medicare beneficiaries as of April 16, 2023. Individuals with type 2 diabetes will no longer need to meet the "three times daily insulin administration" requirement, opening up coverage for all who are "insulin treated." Coverage was also expanded to those with non-insulin treated diabetes who have "a history of problematic hypoglycemia."
- Feb 2023: The FDA approved coverage of the Dexcom G7. Manufacturer reports the following new features with Dexcom G7:
    - 60% smaller
    - 30-minute sensor warmup
    - 12-hour grace period to replace finished sensors for a more seamless transition between sessions
    - Improved alert settings for enhanced discretion
    - Indicated for wear on the back of the upper arm for ages 2 years and older.
- April 2023: The FDA approved Medtronic's MiniMed™ 780G insulin pump system with Guardian™ 4 sensor. The new system includes an algorithm that

can automatically deliver correction bolus doses if a user's blood sugar spikes above the preset range. The Guardian 4 sensor does not require fingersticks for calibration and is changed every 7 days.

Recommendation:

- Add Dexcom G7 to preferred with the following limits: Initial prescription: 1 receiver, 9 sensors; Refill Quantity Limits: 1 sensor every 10 days (maximum of 9 sensors every 90 days)
- Remove Freestyle Libre Pro 10-day sensors from the PDL. They have been discontinued.
- Add Medtronic 780G Guardian 4 to non-preferred with the following limits: Initial Prescription: 1 transmitter, 5 sensors; Refill Quantity Limits: 1 transmitter every year, 1 sensor every 7 days (maximum of 5 sensors every 35 days)
    - Clinical criteria:
        - Patient has a diagnosis of Diabetes Mellitus AND patient age is FDA approved for the requested product AND one of the following criteria are met:
            - The patient requires treatment with insulin OR
            - The patient has a history of problematic hypoglycemia AND medications that could contribute to hypoglycemia (e.g. sulfonureas, meglitinides) have been discontinued AND there is documentation of at least one of the following: Recurrent level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple attempts to adjust medication(s) and/or modify the diabetes treatment plan OR a history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third party assistance for treatment of hypoglycemia
            - Approval of non-preferred products will be limited to cases where the CGM is directly integrated with the patient's insulin pump. The make and model of pump must be documented on the prior authorization.
        - Add to Re-authorization: Initial Renewal Only: claims history shows a reduction in test strip utilization; for those using the same number of test strips or an increased amount of test strips after initiating a CGM, clinical justification needs to be provided for the continued use of a CGM.

Public Comments: None at this time.

Board Discussion: The board asked if it was possible to approve prior authorizations for CGMs automatically, with a lookback for insulin. Change Healthcare staff advised that they will look into this and that it may not be possible due to the quantity of NDCs (some preferred after clinical criteria and others non-preferred) that all fall within the same GPI.

Board Decision: The Board unanimously approved the above recommendations.

Opioid Use Disorder Treatment

- Update CLINICAL CONSIDERATIONS: These products are not FDA approved for alleviation of pain. For this indication, please refer to the Opioid Analgesics PDL category. Note: As of 1/1/23, a completed Buprenorphine Safety Checklist (page 2 of the buprenorphine Spoke (OBOT) prior authorization form) must be submitted with all PA requests.
- Update Buprenorphine/naloxone films, Zubsolv, Buprenorphine tablets: The patient has experienced a current or past intolerance to the preferred products that cannot be resolved or mitigated through alternative efforts AND the Buprenorphine Safety Checklist has been completed (see PA form for detailed requirements).
- Update Requests to exceed quantity limits or maximum daily dose: Documentation must be submitted explaining medical necessity for requested dosage regimen AND the Buprenorphine Safety Checklist has been completed (see PA form for detailed requirements).

Public Comments: None at this time.

Board Discussion: DVHA staff advised that these changes were based on H. 222 which was signed by the governor and went into effect May 25, 2023. The board voiced concerns that when the legislature overrides the DUR Board, it dilutes the power of the committee and that even if the intention of the legislature is good, these changes may not achieve the desired results.

Board Decision: None Needed

General Announcements:

- None at this time

Adjourn: Meeting adjourned at 8:25 p.m.