Department of Vermont Health Access
Pharmacy Benefit Management Program
DUR Board Meeting Minutes
February 19, 2019

Board Members:

Present:

Bill Breen, RPh	Jocelyn Van Opdorp, PharmD	Louise Rosales, NP
Zail Berry, MD	Clayton English, PharmD	Claudia Berger, MD
Patricia King, MD	Margot Kagan, PharmD	

Absent: Joseph Nasca, MD, Renee Mosier, PharmD

Staff:

Jason Pope, DVHA	Scott Strenio, MD, DVHA	Jacquelyn Hedlund, MD Change Healthcare
Laurie Brady, RPh, Change HealthCare	David Aboelezz, PharmD, Change Healthcare	Lisa Hurteau, PharmD, DVHA

Guests:

Linda Burns, Abbott	Daniel Shan, Shire	Keith Huff, BMS
Franco Casagrande, Abbvie	Tyson Thompson, Pfizer	Jessica Kritumen, Amgen
Tina McCann, Sarepta	Joe Miller, Novo Nordisk	Don Nopper, Dova
Marc Marquis, Novo	Bethany Zanrucha, Sarepta	Teri Howes, Greenwich Biosciences
Bhavisha Descei, Dova	Nick Cassotis	Ivan Tosques

1. Executive Session:

- An executive session was held from 6:00 p.m. until 6:35 p.m.

2. Introductions and Approval of DUR Board Minutes:

- Introductions were made around the table.
- The December meeting minutes were accepted as printed.

3. DVHA Pharmacy Administration Updates: Lisa Hurteau, PharmD, DVHA

- S43 introduced – Proposed to prohibit PA for Medication Assisted Treatment (MAT). Medicaid was excluded from this.
- Proposals to lower the age of patients that pharmacists will be able to immunize.

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4. Medical Director Update: Scott Strenio, MD, DVHA

- DVHA is working on determining best practices for urine drug testing. The first step is to get an understanding of why so many are being done. It appears that multiple provider's are often requesting the same test.
- Dr. Stephen Genereaux, a family physician out of Wells River, addressed the board. Dr. Genereaux started an MAT program approximately 2-3 years ago and is currently managing about 50 patients. Hepatitis C is not uncommon in

this patient population, and there is a need for both screening and treatment. He states that the current PA form is very clear and is appreciated. However, he requested that the section on the form that requires "A prescriber is or has consulted with a gastroenterologist, hepatologist, ID specialist or other Hepatitis specialist. Consult must be within the past year with documentation of recommended regimen" be changed or removed. Below are three reasons why.

One: Primary care work force needs to be trusted to use their judgement.

Two: Patients are seen regularly for buprenorphine prescriptions, counseling, etc. so adherence and lab monitoring can be managed as part of the comprehensive care they are already receiving.

Third: More cost effective and geographically more flexible.

Laurie Brady from Change Healthcare updated the board that the Hepatis C class review is currently on the agenda for May.

5. Follow-up Items from Previous Meetings: Laurie Brady, RPh, Change Healthcare

- **Additional data on Vivitrol RetroDUR**

The update was to look at use in patients that had uninterrupted eligibility during the entire timeframe of the analysis. The member count was significantly lower, but the percentage of patients with Alcohol use, Opiate use, or both diagnoses were similar. It was also noted that, similar to the previous analysis, the majority of patients fill the medication only 1 or 2 times.

Public Comments: No public comment.

Board Decision: None needed.

6. RetroDUR/DUR: Laurie Brady, RPh, Change Healthcare, Jacquelyn Hedlund, Change Healthcare

- **Introduce: Evaluation of Opioid Prescribing for Chronic Pain**

Chronic opioid use has become endemic and the societal problems of substance abuse and deaths related to opioids are devastating in the United States. Patients can become addicted to opioids very quickly, even at low doses. Although overdose may occur at any opioid dose, higher doses are associated with higher risk of overdose and death. Opioid doses ≥ 100 morphine milligram equivalents (MME) per day increase overdose risk by nine times compared with dosages between 0 and 20 MME. It has been well identified that for many types of pain, opioids are not necessary or, in some cases, particularly effective. National efforts to stem the prescriptions of opioids are underway, including better patient and physician education around pain management, prescription drug monitoring programs and quantity limits on narcotics.

Problems of diversion, misuse, selling and stockpiling narcotics are well known issues that plague the use of these medications today.

Change Healthcare will use paid, non-reversed Medicaid pharmacy claims from calendar year 2017 and compare them with those of calendar year 2018, excluding members with Part D, VMAP and Healthy Vermonters coverage. Change Healthcare will identify members on any opioid medication (short or long acting) for greater than 90 days and stratify into those on a combined daily dose of ≥ 100MME, ≥200MME and ≥ 300MME, excluding members with diagnoses of cancer or patients on MAT. They will look at prescriber patterns to see if more than one prescriber is writing for the narcotics and whether the prescriber is a pain management specialist. They will also look at the prescribing patterns geographically and the diagnoses for which the narcotics might be prescribed.

Recommendation: None at this time.

Public Comment: No public comment.

Board Decision: None needed.

- **Data presentation: Co-prescribing of Opiates and Benzodiazepines**

Chronic pain is among the most common reasons for visits to primary care and opioid use/misuse is an epidemic in the US population. Anxiety disorders are also common, and many patients are prescribed benzodiazepines to mitigate symptoms. Both opioids and benzodiazepines have addiction potential, are highly desirable street drugs and are commonly diverted to those in whom use is not intended. Use of the combination frequently results in respiratory depression, over-sedation, accidental injuries and death. A study of 1220 patients with noncancer pain on long-term opioids who also used benzodiazepines were found to have greater pain severity, prescription of higher doses of opioids, substance abuse and greater mental health comorbidities. Even short-term use of either class of medication can lead to addiction and substance abuse.

Change Healthcare used paid, non-reversed Medicaid pharmacy and medical claims date from calendar year 2017 and 2018, excluding members with Part D, VMAP and Healthy Vermonters coverage. They identified members, excluding those with a cancer diagnosis, who were prescribed an opioid for at least 90 days within a 180-day span, and examined how many were given an overlapping prescription for a benzodiazepine along with continued use of the opioid.

Total members on 90 or more days of opioids	2805
Total members on 90 or more days of opioids with overlapping benzo	1115 (40%)
Total members on 90 or more days of opioids and no benzo	1690 (60%)

Total ED or Inpatient admissions	1204
Total Members with ED or Inpatient Admission	444

Number of prescriptions where prescriber was the same	23034
Number of prescriptions where prescriber was different	11279

Different prescriber	627 members
Same prescriber	667 members

Of the 1115 members with an overlapping benzodiazepine, 804 members had > 30 days of overlap (72%), and 311 members had an overlap of 30 days or less (28%). Below is the breakdown of the benzos filled. Please note that the same member may have filled more than one medication/strength and would therefore be counted twice.

Recommendation: A substantial number of members on chronic opioids were also prescribed benzodiazepines chronically, despite the risks. As well, the prescribers were discordant in a large number of members, raising the question of whether the prescriber of the benzodiazepine was aware of the chronic opioid use. Of the 2805 members on chronic opioids, 16% (444) had an ED or hospital admission, raising concerns about the effects of the medications. No specific diagnoses of falls or accidents were noted, however. Generalized education to the provider community of the prevalence of co-prescribing and reminders of the dangers of combined therapy may be warranted.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation. They asked for follow up looking at the average daily dose to see if low doses of either the benzo or opiates are being prescribed. They also wanted to look further into the diagnoses of the ED visits to see if drug interactions are listed.

7. Clinical Update: Drug Reviews: Jacquelyn Hedlund, MD and Laurie Brady RPh, Change Healthcare

Abbreviated New Drug Reviews:

- None at this time.

Full New Drug Reviews:

a) Doptelet® (avatrombopag)

Defer until the Platelet Stimulating Agents Therapeutic Drug Class review.

Recommendation:

- Defer until the Platelet Stimulating Agents Therapeutic Drug Class review.

Public Comment: None at this time.

Board Decision: None at this time.

b) Jivi® (recombinat)

Defer until the Hemophilia Factor Deficiency Therapeutic Drug Class review.

Recommendation:

- Defer until the Hemophilia Factor Deficiency Therapeutic Drug Class review.

Public Comments: None at this time.

Board Decision: None at this time.

c) Lokelma® (sodium zirconinum cyclosilcate)

Sodium zirconium cyclosilicate, the active ingredient of Lokelma®, is a potassium binder. It is a non-absorbed binder that preferentially captures potassium in exchange for hydrogen and sodium. In vitro, Lokelma® has a high affinity for potassium ions, even in the presence of other cations such as calcium and magnesium. It increases fecal potassium excretion through binding of potassium in the lumen of the GI tract. It is indicated for the treatment of hyperkalemia in adults. It should not be used as an emergency treatment for life-threatening hyperkalemia because of its delayed onset of action. In clinical trials, Lokelma® was effective for lowering potassium in both the acute and maintenance phases. In a 2017 systematic review and meta-analysis by Meaney et al[2], the authors concluded that both treatments resulted in statistically and clinically significant reductions in potassium; however, sodium zirconium cyclosilicate had fewer adverse events (less frequent GI effects) and a faster onset of action. The authors also indicate that while "...the clinical niche for these drugs remain to be

seen, patiromer appears likely to play more of a role in the chronic management of hyperkalemia, whereas SZ-9 may be better suited for acute therapy."

Recommendation:

- Add new PDL category Hyperkalemia Agents and remove previously posted agents out of the miscellaneous category.
- Add Lokelma™ (sodium zirconium cyclosilicate) to non-preferred.
    - Clinical criteria
        - Add Lokelma to the Veltassa clinical criteria.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

d) Mulpleta® (lusutrombopag)

Defer until the Platelet Stimulating Agents Therapeutic Drug Class review.

Recommendation:

- Defer until the Platelet Stimulating Agents Therapeutic Drug Class review.

Public Comment: No public comment.

Board Decision: None at this time.

e) Orilissa® (elagolix)

Elagolix, the active ingredient of Orilissa®, is a gonadotropin-releasing hormone (GnRH) receptor antagonist that inhibits endogenous GnRH signaling by binding competitively to GnRH receptors in the pituitary gland. Administration of Orilissa® results in dose-dependent suppression of luteinizing hormone (LH) and follicle-stimulating hormone (FSH), leading to decreased blood concentrations of the ovarian sex hormones, estradiol and progesterone. It is indicated for the management of moderate to severe pain associated with endometriosis. In clinical trials compared with placebo, Orilissa® (low and high dose) was found to have a significantly larger number of responders to treatment for dysmenorrhea and non-menstrual pelvic pain. Suicidal ideation and behavior, including one completed suicide, occurred in subjects treated with Orilissa® in the endometriosis clinical trials. Orilissa® subjects had a higher incidence of depression and mood changes compared to placebo, and Orilissa® subjects with a history of suicidality or depression had a higher incidence of depression compared to subjects without such a history. Promptly assess patients with depressive symptoms to determine if the

risks of continued therapy outweigh the benefits. Orilissa® causes a dose dependent decrease in Bone Mineral Density (BMD), therefore, it is important to limit the duration of use to reduce the extent of bone loss.

Recommendation:

- Add new PDL category Endometriosis Agents.
- Add Lupaneta Pack™ (leuprolide acetate for depot suspension and norethindrone acetate tablets) with QL = 3.75 mg kit/month or 11.25 mg kit/3 months, Lupron Depot® (leuprolide acetate for depot suspension) with QL = 3.75 mg kit/month or 11.25 mg kit/3 months, Synarel® (nafarelin acetate) nasal solution and Zoladex® (goserelin acetate) implant with QL = 3.6mg/month to preferred.
- Add Orilissa® (elagolix) tablets to non-preferred.
    - Clinical criteria
        - **Orilissa:** Patient has a diagnosis of moderate-severe endometriosis pain and has a documented side effect, allergy, or treatment failure to at least TWO medications from at least 2 different classes (oral contraceptives, NSAIDs, progestins, and GnRH agonists). **Note:** Approval for 200mg dose will be limited to 2 tablets/day for a maximum of 6 months. Approval for 150mg dose will be limited to 1 tablet/day. Initial approval will be granted for 6 months. For re-approval, the patient must have documentation of clinical improvement and lipid and bone mineral density (BMD) monitoring. Maximum length of therapy 2 years.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

f) Perseris® (risperidone)

Risperidone, the active ingredient of Perseris®, is an atypical antipsychotic. While its exact mechanism of action is not clear, it is thought that the drugs activity could be mediated through a combination of dopamine type 2 (D2) and serotonin type 2 (5HT2) receptor antagonism. Antagonism at receptors other than D2 and 5HT2 may explain some of the other effects of risperidone. The clinical effects from risperidone results from the combined concentrations of risperidone and its major metabolite, 9-hydroxyrisperidone (paliperidone). It is indicated for the treatment of schizophrenia in adults. Perseris is to be given as an abdominal SC injection only, and each injection must be administered by a healthcare professional. The safety and

efficacy of Perseris® were assessed in a double-blind, randomized, placebo-controlled study that included adults aged 18-55 years experiencing acute exacerbations of schizophrenia. Both Perseris® 90mg and 120mg demonstrated statistically significant improvements as compared with placebo for the primary endpoint. Perseris® provides a more convenient once-monthly formulation of risperidone injection (which, as Risperdal® Consta, is given every two weeks). There is no evidence at this time, however, to support that Perseris® is safer or more effective than the currently available, more cost-effective medications.

Recommendation:

- Add Perseris® (risperidone) with FDA maximum recommended dose = 120mg/month and Quantity Limit = 1 syringe/28 days to non-preferred.
  - Clinical criteria:
    - Perseris: Medical necessity for a specialty dosage form has been provided (non-compliance with oral medications) AND tolerability has been established previously with oral risperidone AND the patient is unable to tolerate Risperdal Consta.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

g) Takhzyro® (lanadelumab-flyo)

Defer until the Hereditary Angioedema Therapeutic Drug Class review.

Recommendation:

- Defer until the Hereditary Angioedema Therapeutic Drug Class review.

Public Comment: No public comment.

Board Decision: None at this time.

8. New Therapeutic Drug Classes:

a) Platelet Stimulating Agents

- New drug Doptelet® (avatrombopag)

  Avatrombopag, the active ingredient of Doptelet®, is a thrombopoietin (TPO) receptor agonist that stimulates proliferation and differentiation of megakaryocytes from bone marrow progenitor cells, resulting in an increased production of platelets. Avatrombopag does not compete with

TPO for binding to the TPO receptor and has an additive effect with TPO on platelet production. It is indicated for the treatment of thrombocytopenia in adults with chronic liver disease who are scheduled to undergo a procedure. The safety and efficacy of Doptelet® for the treatment of thrombocytopenia were assessed in 2 identically-designed multicenter, randomized, double-blind, placebo-controlled trials (ADAPT-1 and ADAPT-2) that included patients with chronic liver disease who were scheduled to undergo a procedure. In clinical trials, there was a significantly greater number in the Doptelet® group who met the primary endpoint of the proportion not requiring a platelet transfusion or any rescue procedure for bleeding after randomization and up to 7 days after an elective procedure by baseline platelet count and treatment group.

- New drug Mulpleta® (lusutrombopag)

  Lusutrombopag, the active ingredient of Mulpleta®, is a thrombopoietin (TPO) receptor agonist that interacts with the transmembrane domain of human TPO receptors expressed on megakaryocytes to induce the proliferation and differentiation of megakaryocytic progenitor cells from hematopoietic stem cells and megakaryocyte maturation. It is indicated for the treatment of thrombocytopenia in adults with chronic liver disease who are scheduled to undergo a procedure. The safety and efficacy of Mulpleta® for the treatment of thrombocytopenia were assessed in 2 randomized, double-blind, placebo-controlled studies that included adults with chronic liver disease who were scheduled to undergo a procedure. In clinical trials, there was a significantly greater number who met the primary endpoints and a significantly larger number of responders with Mulpleta® as compared with placebo, with responders defined as patients who had a platelet count of ≥50 X 109/L with an increase of ≥20 X 109/L from baseline.

Recommendation:

- Add Doptelet® (avatrombopag) with a Maximum 5 days' supply per procedure and Mulpleta® (lusutrombopag) with a Maximum 7 days' supply per procedure to non-preferred.
  - Clinical criteria:
    - Doptelet, Mulpleta: The patient is at least 18 years of age AND the diagnosis is thrombocytopenia in a patient with chronic liver disease scheduled to undergo an elective surgical or dental procedure AND the patient's platelet count is less than 50,000/µL (< 50 x 10^9/L)

- NPlate: The diagnosis or indication is chronic immune (idiopathic) thrombocytopenic purpura (ITP) AND The patient's platelet count is less than 30,000/µL (< 30 x 10^9/L) or the patient is actively bleeding AND The patient has an insufficient response or documented intolerance to corticosteroids, immunoglobulins, or splenectomy AND Promacta.
- Promacta:
  - Indication for use is chronic immune thrombocytopenia (ITP): The patient's platelet count is less than 30,000/µL (< 30 x 10^9/L) or the patient is actively bleeding AND the patient has had an insufficient response or documented intolerance to corticosteroids, immunoglobulins, or splenectomy.
  - Indication for use if chronic Hepatitis C-associated thrombocytopenia: The patient is at least 18 years of age AND medication is used to initiate or maintain interferon-based therapy.
  - Indication for use is Severe Aplastic Anemia: patient has had an inadequate response to standard immunosuppressive therapy (e.g. cyclosporine).

Public Comment: Bhavisha Desai from Dova: Highlighted the attribute of Avatrombopag.

Board Decision: The Board unanimously approved the above recommendation.

9. Therapeutic Drug Classes- Periodic Review: Jeffrey Barkin, MD and Laurie Brady, RPh, Change Healthcare

a) Atopic Dermatitis

- No new drugs
- No new significant clinical changes

Recommendation:

- Add Pimecrolimus cream (compare to Elidel®) to non-preferred.
  - Clinical criteria
    - Elidel, Protopic, Pimecrolimus,Tacrolimus additional criteria: The quantity requested does not exceed 30 grams/fill and 90 grams/6 months. AND If

the request is for generic pimecrolimus or tacrolimus ointment, the patient has a documented intolerance to the brand name equivalent.

Public Comment: Tyson Thompson from Pfizer: Highlighted the attribute of Eucrisa.

Board Decision: The Board unanimously approved the above recommendation.

b) Gaucher Disease

- No new drugs
- No new significant clinical changes
- Eliglustat (Cerdelga®) is contraindicated in the following based on CYP2D6 metabolizer status due to the risk of cardiac arrhythmias from prolongation of the PR, QTc, and/or QRS cardiac intervals: EMs or IMs taking a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor, EMs: Moderate or severe hepatic impairment; Mild hepatic impairment and taking a strong or moderate CYP2D6 inhibitor, IMs and PMs: Taking a strong CYP3A inhibitor; Any degree of hepatic impairment

Recommendation:

- Add Miglustat (compare to Zavesca®) with QL = 3 caps/daily) to non-preferred.
  - Clinical criteria
    - Add Miglustat to Cerdelga and Zavesca age limits.
    - Add Miglustat to the additional criteria for Zavesca.
    - Revise Cerdelga additional criteria: Testing to verify if CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), poor metabolizer (PM), or if CYP2D6 genotype cannot be determined, Dose max: 84mg twice/day if EM or IM, Dose max: 84mg/day if PM, Case by case determination if CYP2D6 cannot be determined.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

c) Hereditary Angioedema

- New drug Takhzyro® (lanadelumab-flyo)

Lanadelumab-flyo, the active ingredient of Takhzyro®, is a recombinant, human monoclonal antibody (IgG1/k-light chain) produced in Chinese Hamster Ovary (CHO) cells. It binds plasma kallikrein and inhibits its proteolytic activity. Plasma kallikrein is a protease that cleaves high-molecular-weight-kininogen (HMWK) to generate cleaved HMWK (cHMWK) and bradykinin, a potent vasodilator that increases vascular permeability resulting in swelling and pain associated with hereditary angioedema (HAE). In patients with HAE due to C1-inhibitor deficiency or dysfunction, normal regulation of plasma kallikrein activity is not present, which leads to

uncontrolled increases in plasma kallikrein activity and results in angioedema attacks. Lanadelumab-flyo decreases plasma kallikrein activity to control excess bradykinin generation in patients with HAE. It is indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in patients 12 years and older. The safety and efficacy of Takhzyro® for the prevention of angioedema in patients 12 years of age and older with Type I or II HAE were assessed in a multicenter, randomized, double-blind, placebo-controlled study. Results suggested that all Takhzyro® treatment arms produced clinically meaningful and statistically significant reductions in the mean HAE attack rate as compared to placebo for all primary and secondary endpoints assessed. There is no evidence at this time to support that Takhzyro® more effectively reduces attacks of HAE than the C1 esterase inhibitors approved for prophylaxis (Cinryze® and Haegarda®), which are somewhat more cost-effective. In addition, there is a lack of long-term safety data for Takhzyro®.

Recommendation:

- Move Berinert® (human C1 inhibitor) and Haegarda® (human C1 inhibitor) to preferred after clinical criteria are met.
- Add Takhzyro™ (lanadelumab-flyo) with QL = 2 vials/28 days to non-preferred.
    - Clinical criteria:
        - Revise Berinert: The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack. (Approval may be granted so that 2 doses may be kept on hand).
        - Combine Firazyr, Kalbitor, Ruconest: The diagnosis or indication is treatment of an acute Hereditary Angioedema (HAE) attack AND the patient has a documented side effect, allergy, treatment failure or a contraindication to Berinert. (Approval may be granted so that 2 doses may be kept on hand for Kalbitor or Ruconest and 3 doses for Firazyr).
        - Move Cinryze to combine with Takhzyro criteria.
        - Cinryze, Takhzyro: The diagnosis or indication is prophylaxis of Hereditary Angioedema (HAE) attacks AND the patient has a documented side effect, allergy, treatment failure or a contraindication to Haegarda OR the request is for Cinryze in a patient between the ages of 6-11.

Public Comment: Daniel Shan from Shire: Highlighted the attribute of Takhzyro.

Board Decision: The Board unanimously approved the above recommendation.

d) Hemophilia Factor Deficiency

- **New drug Jivi® (recombinat)**

Antihemophilic factor (recombinant), PEGylated-aucl (Jivi®) temporarily replaces the missing coagulation Factor VIII. The site-specific PEGylation in the A3 domain reduces binding to the physiologic Factor VIII clearance receptors resulting in an extended half-life and increased area under the curve (AUC). The administration of Jivi® increases plasma levels of Factor VIII and can

temporarily correct the coagulation defect in hemophilia A patients. It is indicated for A recombinant DNA-derived, Factor VIII concentrate indicated for use in previously treated adults and adolescents 12 years of age and older with hemophilia A (congenital Factor VIII deficiency) for: On demand treatment and control of bleeding episodes, Perioperative management of bleeding, Routine prophylaxis to reduce the frequency of bleeding episodes. Jivi® is not indicated for use in children <12 years of age due to greater risk for hypersensitivity reactions and is not indicated for use in previously untreated patients. In addition, Jivi® is not indicated for treatment of von Willebrand disease. The safety and efficacy of Jivi® for on-demand treatment, perioperative management of bleeding and routine prophylaxis in male subjects with severe hemophilia A were assessed in one study that included immunocompetent subjects ≥12 years of age with no history of Factor VIII inhibitors. There is no evidence at this time to support that Jivi® is safer or more effective than the currently available, more cost-effective medications.

Recommendation:

- Under the AHF-Factor VII category move NOVOSEVEN® RT to non-preferred.
- Under the AHF-Factor VIII category move NUWIQ® and XYNTHA® to preferred. Move HEMLIBRA® to non-preferred. Add Jivi® to non-preferred.
- Add Anti-Inhibitor Coagulation Complex to the AHF category.
- Under AHF – Anti-Inhibitor Coagulation Complex add Feiba® to non-preferred.
    - Clinical criteria
        - Revise Hemlibra: Patient has Hemophilia A with factor VIII inhibitors OR patient has Hemophilia A without factor VIII inhibitors and the prescriber provides a clinically compelling reason for use including reasons why any of the preferred products would not be suitable alternatives. Note: Hemlibra will not be approved for breakthrough bleeding.
        - Feiba: medication is being used for the treatment of acute bleeding episodes or routine prophylaxis in a patient with Hemophilia A or B with inhibitors.
        - Novoseven RT: medication is being used for the treatment f acute bleeding episodes in a patient with Hemophilia A or B with inhibitors OR patient has congenital Factor VII deficiency.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

e) Muscular Dystrophy

- No new drugs.
- No new significant clinical changes
- A 2018 systematic review and meta-analysis by Shimizu-Motohashi et al19 included 5 double-blind, randomized controlled trials (N-322) to assess the

efficacy of exon skipping drugs in treating DMD. One study assessed eteplirsen and 4 studies assessed drisapersen. Note that drisapersen is not FDA approved in the US as the company that made drisapersen discontinued the development of the product. The primary outcomes were changes in 6-minute walk test (6MWT) distance. Safety was also assessed. There were 4 studies (N=291) with data on the 6MWT after 24 weeks of treatment. Significant differences in the change in distance covered by the 6MWT from baseline to week 24 of treatment were not seen between the exon-skipping and placebo groups (mean difference [MD] -9.16). The North Star Ambulatory Assessment (NSAA) scores were assessed, and there were no significant differences in changes in the NSAA scores after 24 weeks of treatment in the exon-skipping group compared with placebo (MD 1.20). Data on adverse events were found in all 5 studies. Overall, there was no significant difference in injection site reactions between the exon skipping and placebo groups. Compared with placebo, administration of an exon skipping drug was associated with a higher incidence of renal toxicity (RR 1.72); however, with subgroup analysis, this was only demonstrated in the drisapersen studies and not in the eteplirsen trial. The authors concluded that the available data do not demonstrate evidence that exon-skipping drugs are effective in DMD. The small number of studies with relatively small number of subjects indicate the difficulty in conducting sufficiently powered studies of DMD.

Recommendation:

- No changes.

Public Comment: Bethany Zanrucha from Sarepta: Highlighted the attribute of Exondys 51.

Board Decision: None needed.

f) Pancreatic Enzymes

- No new drugs.
- No new significant clinical changes

Recommendation:

- No changes.

Public Comment: No public comment.

Board Decision: None needed.

g) Prenatal Vitamins

- No new drugs.
- No new significant clinical changes

Recommendation:

- Remove Inatal Ultra, PNV, Virt Vite GT and Virt Advance they are no longer available.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

h) Psoriasis Nonbiologic Oral and Topical

- No new drugs.
- No new significant clinical changes

Recommendation:

Psoriasis, Non-Biologics

- Move Methoxsalen (compare to Oxsoralen Ultra®) and Calcipotriene cream (compare to Dovonex®) to non-preferred.
- Move DOVONEX® (calipotriene) cream to preferred.
  - Clinical criteria
    - Calcipotriene cream: The patient has a documented intolerance to Brand Dovonex cream.
    - Update Vectical Ointment, Calcitriol Ointment: The patient ≥ 18 years of age AND The patient has a diagnosis of mild-to-moderate plaque psoriasis AND The patient has demonstrated inadequate response, adverse reaction or contraindication to calcipotriene.
    - Methoxsalen, Oxsoralen Ultra: The patient has a documented diagnosis of moderate to severe psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 topical agents and at least 1 oral systemic agent, unless otherwise contraindicated.

PDE-4 Inhibitors

- Update quantity limit on Otezla to 55 tablets/28 days
  - Clinical criteria:

- Otezla: The patient is 18 years of age or older AND The patient has a diagnosis of psoriatic arthritis AND The patient has had inadequate response to, intolerance to, or contraindication to methotrexate OR The patient has a diagnosis of moderate to severe plaque psoriasis affecting > 10% of the body surface area (BSA) and/or has involvement of the palms, soles, head and neck, or genitalia and has had a documented side effect, allergy, inadequate treatment response, or treatment failure to at least 2 topical agents and at least 1 oral systemic agent, unless otherwise contraindicated.

Public Comment: No public comment.

Board Decision: The Board unanimously approved the above recommendation.

10. Newly Developed/Revised Criteria:

- None at this time.

Public Comment: No public comment.

Board Decision: None at this time**.**

11. General Announcements:
Selected FDA Safety Alerts

FDA warns about rare but serious risks of stroke and blood vessel wall tears with multiple sclerosis drug Lemtrada (alemtuzumab)
https://www.fda.gov/downloads/Drugs/DrugSafety/UCM626584.pdf

Public Comment: No public comment.

Board Decision: No action is needed.

12. Adjourn: Meeting adjourned at 8:15 p.m.