



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

May 14, 2024: 6:00 – 8:30 p.m.

**Board Members Present:**

Andy Miller, RPH	Lucy Miller, MD	Douglas Franzoni, PharmD
Katharina Cahill, PharmD	Bram Starr, MD	Louise Rosales, APRN
Rima Carlson, MD	Margot Kagan, PharmD	

**Board Members Absent:**

Anne Daly, PharmD	Mark Pasanen, MD	
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**DVHA Staff Present:**

Carrie Germaine	Lisa Hurteau, PharmD	Sandi Hoffman
Taylor Robichaud, PharmD	Michael Rapaport, MD	

**Change Healthcare Staff Present:**

Jacquelyn Hedlund, MD	Mike Ouellette, RPh	

**Guests/Members of the Public:**

Michelle Zellner, Phong Pham, Jon Ciruso, Tina McCann, Kristen Chopas, Anita Gulmiri, Nikhil Kacker, Annie Vong, Ryan Miller, Joseph Ward, Tina Hartmann, Omer Aziz, Mark Golick, Jai Persico, Nick Boyer, Adam Denman, Kevin Gaffrey, Jessica Katzman, Tim McSherry, Nicole Pinkerton

- **Executive Session**
- **Introductions and Approval of DUR Board Minutes**
- **DVHA Pharmacy Administration Updates**
- **DVHA Chief Medical Officer Update**
- **Follow-up Items from Previous Meetings**
  - None at this time.
- **RetroDUR/Pro DUR**
  - None at this time.
- **Clinical Update: Drug Reviews**

**Biosimilar Drug Reviews**

- None at this time.

**Full New Drug Reviews**

- **Airsupra® (albuterol/budesonide)**  
Recommendation: Add Airsupra® (albuterol/budesonide) QTY LIMIT: 3 inhalers (32.1 gm)/30 days to non-preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred

- Furoscix® (furosemide injection)

Recommendation:

- Add new subcategory LOOP DIURETICS
- Add Furoscix® (furosemide) injection *QTY LIMIT: 4 injections/30 days* (Maximum 30-day supply), Ethacrynic Acid (compare to Edecrin®), Edecrin® (ethacrynic acid) tablet, and Lasix® (furosemide) tablet to non-preferred.
- Add Bumetanide (compare to Bumex®) tablet, Furosemide (compare to Lasix®) tablet, oral solution, and Torsemide (compare to Demadex®) tablet to preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred

- Lyuzeh™ (latanoprost)

Recommendation: Add Lyuzeh™ (latanoprost) to non-preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred

- Likmez™ (metronidazole)

Recommendation:

- Add new subcategory Nitroimidazole antimicrobial.
- Add Likmez™ (metronidazole oral suspension) to non-preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved

Deferred

- Miebo<sup>®</sup> (perfluorohexyloctane)

Recommendation: Add Miebo<sup>®</sup> (perfluorohexyloctane) to non-preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred

- Rykindo<sup>®</sup> (risperidone injection, extended release)

Recommendation: Add Rykindo<sup>®</sup> (risperidone injection, extended release) to non-preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred

- Sohonos<sup>®</sup> (palovarotene)

Recommendation: Add Sohonos<sup>®</sup> (palovarotene) to non-preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred

- Xdemvy<sup>®</sup> (lotilaner)

Recommendation: Add Xdemvy<sup>®</sup> (lotilaner) QTY limit 20 ml per approval (6 weeks of treatment) to non-preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred

- **New Managed Therapeutic Drug Classes**

- None at this time

- **Therapeutic Drug Classes – Periodic Review**

- Alpha-1 Proteinase Inhibitors  
Recommendation: No change

- Anti-parasitics, Topical  
Recommendation: Add Crotan 10% lotion to non-preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred
- None needed

- Atopic Dermatitis  
Recommendation: No change

- Bladder Relaxants  
Recommendation:

- Move Fesoterodine ER (compare to Toviaz®) to preferred.
    - Add bethanechol to preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred
- None needed

- BPH Agents

Recommendation: Remove Avodart® from the PDL.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred

- Hematopoietics

Recommendation:

Colony Stimulating Agents

- Move Nivestym™ (figrastim-aafi) Vial, Syringe to preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred

Erythropoiesis Stimulating Agents

- No change

- Idiopathic Pulmonary Fibrosis

Recommendation: Move Pirfenidone (compare to Esbriet®) QTY LIMIT:267 mg tablets/capsules = 270 Tabs/Caps per month, 801 mg tablets = 90 Tabs per month to preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred

- Immunosuppressants, Oral

Recommendation:

- Move AZATHIOPRINE 50MG tablet to preferred,
- Move AZATHIOPRINE 75MG and 100MG tablet to non-preferred.

Board Decision:

- Approved
- Approved with modifications
- Not approved
- Deferred
- None needed

- Movement Disorder Agents

Recommendation:

- No change

- Select Contraceptive Products

Recommendation:

Monophasic Agents

Recommendation:



- Remove Beyaz® (drospirenone/ethinyl estradiol/levomefol) and Sayfral® (drospirenone/ethinyl estradiol/levomefol) from non-preferred.
- Move Yaz® (drospirenone/ ethinyl estradiol) and Yasmin® 28 (drospirenone/ ethinyl estradiol) to preferred.

#### Biphasic Agents

Recommendation: Move Lo Loestrin FE (norethindrone/ ethinyl estradiol/FE) to preferred.

#### Triphasic Agents

Recommendation:  
▪ No change.

#### Extended Cycle

Recommendation:  
▪ No change.

#### Progestin Only Contraceptives

Recommendation:  
▪ No change.

#### Injectable Contraceptives

Recommendation:  
▪ No change.

#### Vaginal Ring

Recommendation:  
▪ Add Enilloring® (Etonogestrel/ethinyl estradiol vaginal ring) and Haloette® (Etonogestrel/ethinyl estradiol vaginal ring) to non-preferred.

#### Long Acting Reversible Contraceptives (LARCs)

Recommendation:  
▪ No change.

#### Topical Contraceptives

Recommendation:  
▪ No change.

#### Vaginal Contraceptives

Recommendation:  
▪ No change.

#### Emergency Contraceptives

Recommendation:  
▪ No change.

#### Board Decision:

Approved

- Approved with modifications
- Not approved
- Deferred
- None needed

- **Review of Newly-Developed/Revised Criteria**

- None at this time

- **General Announcements**

- Amylyx Pharmaceuticals Announces Formal Intention to Remove RELYVRIO®/ALBRIOZA™ from the Market

- **Adjourn**

**8:15 pm**

DRAFT