Oklahoma Health Care Authority

Drug Utilization Review Board

Wednesday,
September 14, 2016
4 p.m.

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

The University of Oklahoma

Health Sciences Center

COLLEGE OF PHARMACY

PHARMACY MANAGEMENT CONSULTANTS

MEMORANDUM

TO: Drug Utilization Review (DUR) Board Members

FROM: Bethany Holderread, Pharm.D.

SUBJECT: Packet Contents for DUR Board Meeting – September 14, 2016

DATE: August 31, 2016

Note: The DUR Board will meet at 4:00 p.m. The meeting will be held at 4345 N Lincoln Blvd.

Enclosed are the following items related to the September meeting.
Material is arranged in order of the agenda.

Call to Order

Public Comment Forum

Action Item – Approval of DUR Board Meeting Minutes – Appendix A

Action Item – Update on Medication Coverage Authorization Unit/Concomitant Benzodiazepine and Opioid Utilization – Appendix B

Action Item – Vote to Prior Authorize Dexilant™ SoluTab (Dexlansoprazole Delayed-Release Orally Disintegrating Tablets) – Appendix C

Action Item – Vote to Prior Authorize AK-Tracin® (Bacitracin) and Bleph-10® (Sulfacetamide Sodium) Ophthalmic Ointment – Appendix D

Action Item – Vote to Prior Authorize Betoptic® (Betaxolol Ophthalmic Solution), Timoptic-XE® (Timolol Maleate Ophthalmic Gel-Forming Solution), & Betimol® (Timolol Ophthalmic Solution) – Appendix E

Action Item – Vote to Prior Authorize Nasarel® (Flunisolide Nasal Spray) – Appendix F

Action Item – Vote to Prior Authorize Ocaliva™ (Obeticholic Acid) – Appendix G

Action Item – Vote to Prior Authorize Belbuca™ (Buprenorphine Buccal Film), Dolophine® (Methadone), MorphaBond™ (Morphine Extended-Release), Xtampza™ ER (Oxycodone Extended-Release), & Probuphine® (Buprenorphine Implant) – Appendix H

Action Item – Vote to Prior Authorize Vivlodex™ (Meloxicam Capsules) – Appendix I

Annual Review of Prednisolone Special Formulations and 30-Day Notice to Prior Authorize Millipred™ (Prednisolone Sodium Phosphate Oral Solution 10mg/5mL) – Appendix J

Annual Review of Synagis® (Palivizumab) – Appendix K

Action Item – Annual Review of Antihyperlipidemics – Appendix L

Action Item – Annual Review of Anticoagulants and Platelet Aggregation Inhibitors – Appendix M

Annual Review of Dry Eye Disease Products and 30-Day Notice to Prior Authorize Xiidra™ (Lifitegrast 5% Ophthalmic Solution) – Appendix N

Annual Review of Butalbital Products and 30-Day Notice to Prior Authorize Allzital® (Butalbital/Acetaminophen 25mg/325mg) & Esgic® Capsules (Butalbital/Acetaminophen/Caffeine 50mg/325mg/40mg) – Appendix O

FDA and DEA Updates – Appendix P

Future Business (Upcoming Product and Class Reviews)

Adjournment

Oklahoma Health Care Authority

Drug Utilization Review Board
(DUR Board)
Meeting – September 14, 2016 @ 4:00 p.m.

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma 73105

AGENDA

Discussion and Action on the Following Items:

Items to be presented by Dr. Muchmore, Chairman:

1. Call to Order

A. Roll Call – Dr. Keast

Items to be presented by Dr. Muchmore, Chairman:

2. Public Comment Forum

A. Acknowledgment of Speakers and Agenda Items

Items to be presented by Dr. Muchmore, Chairman:

3. Action Item – Approval of DUR Board Meeting Minutes – See Appendix A

A. July 13, 2016 DUR Minutes – Vote
B. July 13, 2016 DUR Recommendations Memorandum
C. August 10, 2016 DUR Recommendations Memorandum

Items to be presented by Dr. Holderread, Dr. Muchmore, Chairman:

4. Action Item – Update on Medication Coverage Authorization Unit/Concomitant Benzodiazepine and Opioid Utilization – See Appendix B

A. Medication Coverage Activity for August 2016
B. Pharmacy Help Desk Activity for August 2016
C. Concomitant Benzodiazepine and Opioid Utilization

Items to be presented by Dr. Nawaz, Dr. Muchmore, Chairman:

5. Action Item – Vote to Prior Authorize Dexilant™ SoluTab (Dexlansoprazole Delayed-Release Orally Disintegrating Tablets) – See Appendix C

A. Indication(s) and Dosing
B. College of Pharmacy Recommendations

Items to be presented by Dr. Nawaz, Dr. Muchmore, Chairman:

6. Action Item – Vote to Prior Authorize AK-Tracin® (Bacitracin) and Bleph-10® (Sulfacetamide Sodium) Ophthalmic Ointment – See Appendix D

A. Indication(s)
B. College of Pharmacy Recommendations

Items to be presented by Dr. Adams, Dr. Muchmore, Chairman:

7. Action Item – Vote to Prior Authorize Betoptic® (Betaxolol Ophthalmic Solution), Timoptic-XE® (Timolol Maleate Ophthalmic Gel-Forming Solution), & Betimol® (Timolol Ophthalmic Solution) – See Appendix E

A. Introduction
B. College of Pharmacy Recommendations

Items to be presented by Dr. Chandler, Dr. Muchmore, Chairman:

8. Action Item – Vote to Prior Authorize Nasarel® (Flunisolide Nasal Spray) – See Appendix F

A. Introduction
B. College of Pharmacy Recommendations

Items to be presented by Dr. Chandler, Dr. Muchmore, Chairman:

9. Action Item – Vote to Prior Authorize Ocaliva™ (Obeticholic Acid) – See Appendix G

A. Introduction
B. College of Pharmacy Recommendations

Items to be presented by Dr. Holderread, Dr. Muchmore, Chairman:

10. Action Item – Vote to Prior Authorize Belbuca™ (Buprenorphine Buccal Film), Dolophine® (Methadone), MorphaBond™ (Morphine Extended-Release), Xtampza™ ER (Oxycodone Extended-Release), & Probuphine® (Buprenorphine Implant) – See Appendix H

A. Introduction
B. College of Pharmacy Recommendations

Items to be presented by Dr. Holderread, Dr. Muchmore, Chairman:

11. Action Item – Vote to Prior Authorize Vivlodex™ (Meloxicam Capsules) – See Appendix I

A. Introduction
B. College of Pharmacy Recommendations

Items to be presented by Dr. Holderread, Dr. Muchmore, Chairman:

12. Annual Review of Prednisolone Special Formulations and 30-Day Notice to Prior Authorize Millipred™ (Prednisolone Sodium Phosphate Oral Solution 10mg/5mL) – See Appendix J

A. Introduction
B. Current Prior Authorization Criteria
C. Utilization of Prednisolone Special Formulations
D. Prior Authorization of Prednisolone Special Formulations
E. Prednisolone Special Formulations Claims Analysis
F. Millipred™ (Prednisolone Sodium Phosphate Oral Solution 10mg/5mL) Product Summary
G. College of Pharmacy Recommendations
H. Utilization Details of Prednisolone Special Formulations

Items to be presented by Dr. Holderread, Dr. Muchmore, Chairman:

13. Annual Review of Synagis® (Palivizumab) – See Appendix K

A. Current Prior Authorization Criteria
B. Utilization of Palivizumab
C. Prior Authorization of Palivizumab
D. Season Comparison
E. Market News and Updates
F. College of Pharmacy Recommendations

Items to be presented by Dr. Adams, Dr. Muchmore, Chairman:

14. Action Item – Annual Review of Antihyperlipidemics – See Appendix L

A. Current Prior Authorization Criteria
B. Utilization of Antihyperlipidemics
C. Prior Authorization of Antihyperlipidemics
D. Market News and Updates
E. College of Pharmacy Recommendations
F. Utilization Details of Statin Medications and Zetia® (Ezetimibe)
G. Utilization Details of Omega-3 Fatty Acids
H. Utilization Details of Juxtapid® (Lomitapide) and Kynamro® (Mipomersen)
I. Utilization Details of PCSK9 Inhibitors

Items to be presented by Dr. Nawaz, Dr. Muchmore, Chairman:

15. Action Item – Annual Review of Anticoagulants and Platelet Aggregation Inhibitors – See Appendix M

A. Current Prior Authorization Criteria
B. Utilization of Anticoagulants and Platelet Aggregation Inhibitors
C. Prior Authorization of Anticoagulants and Platelet Aggregation Inhibitors
D. Market News and Updates
E. College of Pharmacy Recommendations

F. Utilization Details of Anticoagulants
G. Utilization Details of Platelet Aggregation Inhibitors

Items to be presented by Dr. Chandler, Dr. Muchmore, Chairman:

16. Annual Review of Dry Eye Disease Products and 30-Day Notice to Prior Authorize Xiidra™ (Lifitegrast 5% Ophthalmic Solution) – See Appendix N

A. Utilization of Dry Eye Disease Products
B. Dry Eye Disease
C. Xiidra™ (Lifitegrast Ophthalmic Solution) Product Summary
D. College of Pharmacy Recommendations

Items to be presented by Dr. Chandler, Dr. Muchmore, Chairman:

17. Annual Review of Butalbital Products and 30-Day Notice to Prior Authorize Allzital® (Butalbital/Acetaminophen 25mg/325mg) & Esgic® Capsules (Butalbital/Acetaminophen/Caffeine 50mg/325mg/40mg) – See Appendix O

A. Current Prior Authorization Criteria
B. Utilization of Butalbital Products
C. Prior Authorization of Butalbital Products
D. Pricing Trend(s)
E. Allzital® (Butalbital/Acetaminophen 25mg/325mg) Product Summary
F. College of Pharmacy Recommendations
G. Utilization Details of Butalbital Products

Items to be presented by Dr. Keast, Dr. Muchmore, Chairman:

18. FDA and DEA Updates – See Appendix P

Items to be presented by Dr. Holderread, Dr. Muchmore, Chairman:

19. Future Business* (Upcoming Product and Class Reviews)

A. Heart Failure Medications
B. Targeted Immunomodulator Agents
C. Breast Cancer Medications
D. Skin Cancer Medications
E. Constipation and Diarrhea Medications
F. Topical Corticosteroids
G. Bladder Control Medications
H. Topical Lidocaine Medications
I. Growth Hormone

**Future business subject to change.*

20. Adjournment

Appendix A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW BOARD MEETING
MINUTES OF MEETING OF JULY 13, 2016

BOARD MEMBERS:	PRESENT	ABSENT
Theresa Garton, M.D.	x	
Carla Hardzog-Britt, M.D.		x
Anetta Harrell, Pharm.D.	x	
Ashley Huddleston, Pharm.D., BCOP	x	
John Muchmore, M.D., Ph.D.; Chairman	x	
James Osborne, Pharm.D.		x
Paul Louis Preslar, D.O., MBA; Vice Chairman	x	
James Rhymer, D.Ph.	x	
Bruna Varalli-Claypool, MHS, PA-C	x	
Eric Winegardner, D.Ph.	x	

COLLEGE OF PHARMACY STAFF:	PRESENT	ABSENT
Terry Cothran, D.Ph.; Pharmacy Director	x	
Melissa Abbott, Pharm.D.; Clinical Pharmacist		x
Michyla Adams, Pharm.D.; Clinical Pharmacist	x	
Wendi Chandler, Pharm.D.; Clinical Pharmacist	x	
Karen Egesdal, D.Ph.; SMAC-ProDUR Coordinator/OHCA Liaison	x	
Erin Ford, Pharm.D.; Clinical Pharmacist		x
Bethany Holderread, Pharm.D.; Clinical Coordinator	x	
Shellie Keast, Ph.D.; Assistant Professor		x
Tammy Lambert, Ph.D.; Postdoctoral Research Fellow		x
Carol Moore, Pharm.D.; Clinical Pharmacist		x
Brandy Nawaz, Pharm.D.; Clinical Pharmacist	x	
Leslie Robinson, D.Ph.; PA Coordinator		x
Ashley Teel, Pharm.D.; Clinical Pharmacist		x
Jacquelyn Travers, Pharm.D.; Practice Facilitating Pharmacist	x	
Graduate Students: Christina Bulkley, Pharm.D.	x	
David George, Pharm.D.		x
Timothy Pham, Pharm.D.	x	
Visiting Pharmacy Student(s): Not applicable		

OKLAHOMA HEALTH CARE AUTHORITY STAFF:	PRESENT	ABSENT
Marlene Asmussen, R.N.; Population Care Management Director	x	
Burl Beasley, D.Ph.; M.P.H.; M.S. Pharm	x	
Kelli Brodersen, Marketing Coordinator	x	
Nico Gomez, Chief Executive Officer		x
Ed Long, Chief Communications Officer		x
Nancy Nesser, Pharm.D.; J.D.; Pharmacy Director	x	
Rebecca Pasternik-Ikard, J.D.; M.S.; R.N.; State Medicaid Director		x
Jill Ratterman, D.Ph.; Clinical Pharmacist		x
Garth Splinter, M.D.; M.B.A.; Deputy Chief Executive Officer		x
Joseph Young, Deputy General Counsel IV	x	
Kerri Wade, Pharmacy Operations Manager	x	

OTHERS PRESENT:		
Edie Dodson, Genzyme	Gay Thomas, BMS	Corinne Copeland, Eisai Inc.
Bob Gustafson, Lundbeck	Jimmy Martin, Allergan	Erica Brumleve, GSK
Jon Maguire, GSK	Sean Seago, Merck	Elizabeth Ariano, Indivior
Marc Parker, Sunovion	Dan Doyle, Trividia	James McAdams, Insulet
Rose Mullen, Alkermes	Hope Berry, Upsher	Mark Boyd, Astellas
Tyler, Craddock, MDCO	Toby Thompson, Pfizer	Gwendolyn Caldwell, PhRMA
Kristin Pareja, Otsuka	Brian Maves, Pfizer	Richard Ponder, J & J
Terry McCurren, Otsuka		

PRESENT FOR PUBLIC COMMENT:	
Nick Casale	Indivior

AGENDA ITEM NO. 1: **CALL TO ORDER**

1A: ROLL CALL

Dr. Muchmore called the meeting to order. Roll call by Dr. Cothran established the presence of a quorum.

ACTION: NONE REQUIRED

AGENDA ITEM NO. 2: **PUBLIC COMMENT FORUM**

2A: AGENDA NO. 14 NICK CASALE

ACTION: NONE REQUIRED

AGENDA ITEM NO. 3: **APPROVAL OF DUR BOARD MINUTES**

3A: JUNE 8, 2016 DUR MINUTES – VOTE

3B: JUNE 8, 2016 DUR RECOMMENDATIONS MEMORANDUM

Materials included in agenda packet; presented by Dr. Muchmore

Dr. Preslar moved to approve; seconded by Dr. Rhymer

ACTION: MOTION CARRIED

AGENDA ITEM NO. 4: **UPDATE ON MEDICATION COVERAGE AUTHORIZATION UNIT/OPIOID PRESCRIPTIONS IN PREGNANT WOMEN**

4A: MEDICATION COVERAGE ACTIVITY FOR JUNE 2016

4B: PHARMACY HELP DESK ACTIVITY FOR JUNE 2016

4C: OPIOID PRESCRIPTIONS IN PREGNANT WOMEN – VOTE

Materials included in agenda packet; presented by Dr. Holderread

Dr. Preslar moved to approve; seconded by Dr. Rhymer

ACTION: MOTION CARRIED

AGENDA ITEM NO. 5: **VOTE TO PRIOR AUTHORIZE ZYTIGA® (ABIRATERONE), JEVTANA® (CABAZITAXEL), XTANDI® (ENZALUTAMIDE), XOFIGO® (RADIUM-223 DICHLORIDE), AND PROVENGE® (SIPULEUCEL-T)**

5A: INTRODUCTION

5B: RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Schmidt, Dr. Borders, Dr. Medina

Ms. Varalli-Claypool moved to approve; seconded by Dr. Huddleston

ACTION: MOTION CARRIED

AGENDA ITEM NO. 6: **VOTE TO PRIOR AUTHORIZE DYANAVEL™ XR (AMPHETAMINE EXTENDED-RELEASE), QUILLICHEW ER™ (METHYLPHENIDATE EXTENDED-RELEASE), AND ADZENYS XR-ODT™ (AMPHETAMINE EXTENDED-RELEASE)**

6A: INTRODUCTION

6B: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented Dr. Adams

Dr. Harrell moved to approve; seconded by Ms. Varalli-Claypool

ACTION: MOTION CARRIED

AGENDA ITEM NO. 7: VOTE TO PRIOR AUTHORIZE REXULTI® (BREXPIPRAZOLE), VRAYLAR™ (CARIPRAZINE), AND ARISTADA™ (ARIPIPRAZOLE LAUROXIL)

7A: INDICATION(S)

7B: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Nawaz
Dr. Harrell moved to approve; seconded by Ms. Varalli-Claypool
ACTION: MOTION CARRIED

AGENDA ITEM NO. 8: VOTE TO PRIOR AUTHORIZE ALBENZA® (ALBENDAZOLE) AND EMVERM™ (MEBENDAZOLE)

8A: INTRODUCTION

8B: REGIMEN COMPARISON

8C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Nawaz
Ms. Varalli-Claypool moved to approve; seconded by Dr. Harrell
ACTION: MOTION CARRIED

AGENDA ITEM NO. 9: VOTE TO PRIOR AUTHORIZE OSMOPREP® (SODIUM PHOSPHATE MONOBASIC/SODIUM PHOSPHATE DIBASIC), PREPOPIK® (SODIUM PICOSULFATE/MAGNESIUM OXIDE/CITRIC ACID), SUCLEAR® (SODIUM SULFATE/POTASSIUM SULFATE/MAGNESIUM SULFATE/PEG-3350/SODIUM CHLORIDE/SODIUM BICARBONATE/POTASSIUM CHLORIDE), AND SUPREP® (SODIUM SULFATE/POTASSIUM SULFATE/MAGNESIUM SULFATE)

9A: COST SAVINGS

9B: BOWEL PREPARATION MEDICATIONS SUMMARY

9C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Holderread
Dr. Harrell moved to approve; seconded by Dr. Huddleston
ACTION: MOTION CARRIED

AGENDA ITEM NO. 10: VOTE TO PRIOR AUTHORIZE NUVESSA™ (METRONIDAZOLE VAGINAL GEL 1.3%), ZYCLARA® (IMIQUIMOD CREAM), AND KRISTALOSE® (LACTULOSE PACKETS)

10A: INTRODUCTION

10B: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Holderread
Ms. Varalli-Claypool moved to approve; seconded by Dr. Harrell
ACTION: MOTION CARRIED

AGENDA ITEM NO. 11: VOTE TO PRIOR AUTHORIZE H.P. ACTHAR® GEL (CORTICOTROPIN INJECTION)

11A: INTRODUCTION

11B: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Holderread
Dr. Rhymer moved to approve; seconded by Dr. Garton
ACTION: MOTION CARRIED

AGENDA ITEM NO. 12: VOTE TO PRIOR AUTHORIZE ECONAZOLE NITRATE 1% CREAM AND CLOTRIMAZOLE 1% SOLUTION

12A: INTRODUCTION

12B: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Chandler
Dr. Garton moved to approve; seconded by Dr. Huddleston
ACTION: MOTION CARRIED

AGENDA ITEM NO. 13: **30-DAY NOTICE TO PRIOR AUTHORIZE OCALIVA™ (OBETICHOLIC ACID)**

13A: PRIMARY BILIARY CHOLANGITIS (PBC) BACKGROUND INFORMATION
13B: OCALIVA™ (OBETICHOLIC ACID) PRODUCT SUMMARY
13C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Chandler

ACTION: NONE REQUIRED

AGENDA ITEM NO. 14: **ANNUAL REVIEW OF OPIOID ANALGESICS AND BUPRENORPHINE PRODUCTS & 30-DAY NOTICE TO PRIOR AUTHORIZE BELBUCA™ (BUPRENORPHINE BUCCAL FILM), DOLOPHINE® (METHADONE), MORPHABOND™ (MORPHINE EXTENDED-RELEASE), XTAMPZA™ ER (OXYCODONE EXTENDED-RELEASE), & PROBUPHINE® (BUPRENORPHINE IMPLANT)**

14A: CURRENT PRIOR AUTHORIZATION CRITERIA
14B: UTILIZATION OF OPIOID ANALGESICS AND BUPRENORPHINE PRODUCTS
14C: PRIOR AUTHORIZATION OF OPIOID ANALGESICS & BUPRENORPHINE PRODUCTS
14D: OPIOID ANALGESIC UTILIZATION TRENDS
14E: MARKET NEWS AND UPDATES
14F: BELBUCA™ (BUPRENORPHINE BUCCAL FILM) PRODUCT SUMMARY
14G: MORPHABOND™ (MORPHINE EXTENDED-RELEASE) PRODUCT SUMMARY
14H: XTAMPZA™ ER (OXYCODONE EXTENDED-RELEASE) PRODUCT SUMMARY
14I: PROBUPHINE® (BUPRENORPHINE IMPLANT) PRODUCT SUMMARY
14J: COLLEGE OF PHARMACY RECOMMENDATIONS
14K: UTILIZATION DETAILS OF OPIOID ANALGESICS
14L: UTILIZATION DETAILS OF BUPRENORPHINE PRODUCTS

Materials included in agenda packet; presented by Dr. Holderread

ACTION: NONE REQUIRED

AGENDA ITEM NO. 15: **ANNUAL REVIEW OF ANTI-ULCER MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE DEXILANT™ SOLUTAB (DEXLANSOPRAZOLE DELAYED-RELEASE ORALLY DISINTEGRATING TABLETS)**

15A: CURRENT PRIOR AUTHORIZATION CRITERIA
15B: UTILIZATION OF ANTI-ULCER MEDICATIONS
15C: PRIOR AUTHORIZATION OF ANTI-ULCER MEDICATIONS
15D: MARKET NEWS AND UPDATES
15E: DEXILANT™ SOLUTAB (DEXLANSOPRAZOLE) PRODUCT SUMMARY
15F: COLLEGE OF PHARMACY RECOMMENDATIONS
15G: UTILIZATION DETAILS OF ANTI-ULCER MEDICATIONS

Materials included in agenda packet; presented by Dr. Nawaz

ACTION: NONE REQUIRED

AGENDA ITEM NO. 16: **ANNUAL REVIEW OF ANTIDEPRESSANTS**

16A: CURRENT PRIOR AUTHORIZATION CRITERIA
16B: UTILIZATION OF ANTIDEPRESSANTS
16C: PRIOR AUTHORIZATION OF ANTIDEPRESSANTS
16D: MARKET NEWS AND UPDATES
16E: COLLEGE OF PHARMACY RECOMMENDATIONS
16F: UTILIZATION DETAILS OF ANTIDEPRESSANTS

Materials included in agenda packet; presented by Dr. Adams

ACTION: NONE REQUIRED

AGENDA ITEM NO. 17: **ANNUAL REVIEW OF MYALEPT® (METRELEPTIN)**

17A: INTRODUCTION
17B: CURRENT PRIOR AUTHORIZATION CRITERIA
17C: UTILIZATION OF MYALEPT® (METRELEPTIN)
17D: PRIOR AUTHORIZATION OF MYALEPT® (METRELEPTIN)

17E: COLLEGE OF PHARMACY RECOMMENDATIONS
Materials included in agenda packet; presented by Dr. Adams (Non-presentation; questions only)
ACTION: NONE REQUIRED

AGENDA ITEM NO. 18: FDA AND DEA UPDATES
Materials included in agenda packet; presented by Dr. Cothran
ACTION: NONE REQUIRED

AGENDA ITEM NO. 19: FUTURE BUSINESS* (UPCOMING PRODUCT AND CLASS REVIEWS)
August 2016 not scheduled as a live meeting (packet only)
19A: OCULAR ANTI-INFECTIVES
19B: GLAUCOMA MEDICATIONS
19C: PREDNISOLONE SPECIAL FORMULATIONS
19D: ALZHEIMER'S MEDICATIONS
19E: NASAL ALLERGY MEDICATIONS
19F: NONSTEROIDAL ANTI-INFLAMMATORY MEDICATIONS
FUTURE BUSINESS SUBJECT TO CHANGE.
Materials included in agenda packet; presented by Dr. Holderread
ACTION: NONE REQUIRED

AGENDA ITEM NO. 20: ADJOURNMENT
The meeting was adjourned at 4:57 pm

The University of Oklahoma
Health Sciences Center
COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS

Memorandum

Date: July 14, 2016

To: Nancy Nesser, Pharm.D.; J.D.
Pharmacy Director
Oklahoma Health Care Authority

From: Bethany Holderread, Pharm.D.
Clinical Coordinator
Pharmacy Management Consultants

Subject: DUR Board Recommendations From Meeting of July 13, 2016

Recommendation 1: Opioid Prescriptions in Pregnant Women

MOTION CARRIED by unanimous approval.

In light of the recent studies suggesting the teratogenic potential of opioid medications, and the known risks of neonatal withdrawal after in utero exposure, opioid use in pregnant women is a significant public health concern. Delays and inaccuracies in the SoonerCare claims database in obtaining pregnancy data limit options for implementation of edits that would stop payment for opioid claims in pregnant women alone. Additionally women who experience miscarriage or pre-term delivery may still be classified as pregnant in the claims database and hard-stop edits could limit appropriate treatment with opioid medications. Alternative methodologies for reducing rates of opioid use in pregnant women recommended by the College of Pharmacy in collaboration with the Oklahoma Health Care Authority include the following:

- Provider education targeted to obstetricians and gynecologists regarding the risk of opioid use during pregnancy and the SoonerCare rates of opioid use in pregnant women.
- A clinical edit at the pharmacy level for members with a pregnancy indicator in the SoonerCare claims database. The edit would recommend members be switched to buprenorphine when running a claim for an opioid medication but could be overridden without prior authorization submission if deemed appropriate.

- Removal of prior authorization for buprenorphine/naloxone for all female beneficiaries. Preferred products, quantity limits, and claim denials for concomitant opioid medications would still apply.

Recommendation 2: Vote to Prior Authorize Zytiga® (Abiraterone), Jevtana® (Cabazitaxel), Xtandi® (Enzalutamide), Xofigo® (Radium-223 Dichloride), and Provenge® (Sipuleucel-T)

MOTION CARRIED by unanimous approval.

Zytiga® (Abiraterone) Approval Criteria:

1. A diagnosis of metastatic, castration-resistant prostate cancer; and
2. Abiraterone must be used in combination with a corticosteroid; and
3. Approvals will be for the duration of three months at which time additional authorization may be granted if the prescriber documents that the member has not shown evidence of progressive disease while on abiraterone therapy.

Jevtana® (Cabazitaxel) Approval Criteria:

1. A diagnosis of metastatic, castration-resistant prostate cancer; and
2. Member must have been previously treated with a docetaxel-containing regimen; and
3. Cabazitaxel should be used in combination with prednisone; and
4. Approvals will be for the duration of three months at which time additional authorization may be granted if the prescriber documents that the member has not shown evidence of progressive disease while on cabazitaxel therapy.

Xtandi® (Enzalutamide) Approval Criteria:

1. A diagnosis of metastatic, castration-resistant prostate cancer; and
2. Approvals will be for the duration of three months at which time additional authorization may be granted if the prescriber documents that the member has not shown evidence of progressive disease while on enzalutamide therapy.

Xofigo® (Radium-223 Dichloride) Approval Criteria:

1. A diagnosis of metastatic, castration-resistant prostate cancer; and
2. Member must have symptomatic bone metastases; and
3. Member must not have known visceral metastatic disease; and
4. Prescriber must verify radium-223 dichloride is not to be used in combination with chemotherapy; and
5. Member must have an absolute neutrophil count ≥ 1.5 x 10^9/L, platelet count ≥ 100 x 10^9/L, and hemoglobin ≥10 g/dL; and
6. Approvals will be for the duration of three months at which time additional authorization may be granted if the prescriber documents the following:
    a. The member has not shown evidence of progressive disease while on radium-223 dichloride therapy; and
    b. Member must have an absolute neutrophil count ≥ 1 x 10^9/L, platelet count ≥ 100 x 10^9/L (radium-223 dichloride should be delayed 6 to 8 weeks otherwise).

Provenge® (Sipuleucel-T) Approval Criteria:

1. A diagnosis of metastatic, castration-resistant prostate cancer; and
2. Member must be asymptomatic or minimally symptomatic; and
3. Member must not have hepatic metastases; and
4. Member must have a life expectancy of greater than six months; and
5. Good performance status (ECOG 0 to 1); and
6. Approvals will be for the duration of three months at which time additional authorization may be granted if the prescriber documents that the member has not shown evidence of progressive disease while on sipuleucel-T therapy.

Recommendation 3: Vote to Prior Authorize Dyanavel™ XR (Amphetamine Extended-Release), QuilliChew ER™ (Methylphenidate Extended-Release), and Adzenys XR-ODT™ (Amphetamine Extended-Release)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the ADHD & Narcolepsy Medications Product Based Prior Authorization (PBPA) category:

1. Place Dyanavel™ XR (amphetamine ER) into the Special Prior Authorization (PA) category based on estimated acquisition cost (EAC).
    a. The existing criteria for special formulation products in the Special PA category will apply.
    b. A quantity limit of 240mL per 30 days will apply, based on the maximum dose of 20mg (or 8mL) per day.
    c. An age restriction of ten years and younger will apply. Members older than ten years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.
2. Place QuilliChew ER™ (methylphenidate ER) into the Special PA category based on EAC.
    a. The existing criteria for special formulation products in the Special PA category will apply.
    b. A quantity limit of 30 chewable tablets per 30 days will apply on all strengths except for the 30mg strength, and a quantity limit of 60 chewable tablets per 30 days will apply on the 30mg strength, based on the maximum dose of 60mg per day.
        i. Members needing to titrate the dose of QuilliChew ER™ up or down should be instructed to break in half the functionally scored chewable tablets to achieve the required dose, and the appropriate quantity of chewable tablets will be approved for dose titration purposes.
    c. An age restriction of ten years and younger will apply. Members older than ten years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.
3. Place Adzenys XR-ODT™ (amphetamine ER) into the Special PA category based on EAC.
    a. The existing criteria for special formulation products in the Special PA category will apply.
    b. A quantity limit of 30 orally disintegrating tablets (ODTs) per 30 days will apply.

c. An age restriction of ten years and younger will apply. Members older than ten years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.

4. Update the wording of the Tier-2, Tier-3, Kapvay®, and Xyrem® Approval Criteria to emphasize the requirement of previously failed trial(s) that resulted in an inadequate response, as requested by the Drug Utilization Review (DUR) Board at the previous DUR meeting in June 2016.

ADHD & Narcolepsy Medications Tier-2 Approval Criteria:

1. A covered diagnosis; and
2. A previously failed trial with at least one long-acting Tier-1 stimulant that resulted in an inadequate response:
    a. Trials should have been within the last 180 days; and
    b. Trials should have been dosed up to maximum recommended dose or documented adverse effects at higher doses should be included; and
    c. If trials are not in member's claim history, the pharmacy profile should be submitted or detailed information regarding dates and doses should be included along with the signature from the physician.

ADHD & Narcolepsy Medications Tier-3 Approval Criteria:

1. A covered diagnosis; and
2. A previously failed trial with at least one long-acting Tier-1 stimulant that resulted in an inadequate response; and
3. A previously failed trial with at least one long-acting Tier-2 stimulant that resulted in an inadequate response:
    a. Trials should have been within the last 365 days; and
    b. Trials should have been dosed up to maximum recommended dose or documented adverse effects at higher doses should be included; and
    c. If trials are not in member's claim history, the pharmacy profile should be submitted or detailed information regarding dates and doses should be included along with the signature from the physician.
4. A clinical exception may apply for special formulation products when there is a patient-specific, clinically significant reason why the member cannot use the available long-acting capsule formulation.
5. Use of Kapvay® (clonidine extended-release tablets) requires:
    a. An FDA approved diagnosis; and
    b. Previously failed trials (within the last 180 days) with a long-acting Tier-1 stimulant, a long-acting Tier-2 stimulant, Intuniv®, and Strattera®, unless contraindicated, that did not yield adequate results; and
    c. A patient-specific, clinically significant reason why the member cannot use clonidine immediate-release tablets.

ADHD & Narcolepsy Medications Special Prior Authorization Approval Criteria:

1. Desoxyn®, Dexedrine®, Dexedrine Spansules®, Evekeo™, ProCentra® Solution, and Zenzedi® Criteria:
    a. A covered diagnosis; and

b. A patient-specific, clinically significant reason why the member cannot use all other available stimulant medications.

2. Adzenys XR-ODT™, Daytrana®, Dyanavel™ XR, QuilliChew ER™, Quillivant XR®, and Methylin® Chewable Tablets and Solution Criteria:
   a. An FDA approved diagnosis; and
   b. A patient-specific, clinically significant reason why the member cannot use all other available formulations of long-acting stimulant medications that can be used for members who cannot swallow capsules or tablets; and
   c. An age restriction of ten years and younger will apply. Members older than ten years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.
3. Provigil®, Nuvigil®, and Xyrem® Criteria:
   a. An FDA approved diagnosis; and
   b. Use of Provigil® or Nuvigil® requires a patient-specific, clinically significant reason why the member cannot use stimulant medications to improve wakefulness during the daytime.
   c. Use of Xyrem® requires previously failed trials (within the last 180 days) with Tier-1 and Tier-2 stimulants from different chemical categories, Provigil®, and Nuvigil®, unless contraindicated, that did not yield adequate results.
   d. The diagnosis of obstructive sleep apnea requires concurrent treatment for the obstructive sleep apnea.
   e. The diagnosis of shift work sleep disorder requires the member's work schedule to be included with the prior authorization request.

ADHD & Narcolepsy Medications Additional Criteria:

1. Doses exceeding 1.5 times the FDA maximum are not covered.
2. Prior Authorization is required for all tiers for members greater than 20 years of age and for members 0 to 4 years of age. All prior authorization requests for members younger than the age of 5 years must be reviewed by an OHCA-contracted psychiatrist.
3. Vyvanse® (Lisdexamfetamine) Approval Criteria: Binge Eating Disorder (BED)
   a. An FDA approved diagnosis of moderate-to-severe binge eating disorder; and
   b. Member must be 18 years or older; and
   c. Vyvanse® for the diagnosis of BED must be prescribed by a psychiatrist; and
   d. Authorizations will not be granted for the purpose of weight loss without the diagnosis of BED or for the diagnosis of obesity alone. The safety and effectiveness of Vyvanse® for the treatment of obesity have not been established; and
   e. A quantity limit of 30 capsules per 30 days will apply; and
   f. Initial approvals will be for the duration of three months. Continued authorization will require prescriber documentation of improved response/effectiveness of Vyvanse®.

ADHD & Narcolepsy Medications			
Tier-1*	**Tier-2***	**Tier-3***	**Special PA**
Amphetamine			**Adzenys XR-ODT™ (amphetamine ER ODT)**
Short-Acting			
Adderall® (amphetamine/ dextroamphetamine)		ProCentra™ (dextroamphetamine)	Daytrana™ (methylphenidate ER)
Long-Acting			Desoxyn® (methamphetamine)
Vyvanse® (lisdexamfetamine)+	Adderall XR® brand name only (amphetamine/ dextroamphetamine ER)	amphetamine/ dextroamphetamine ER (generic Adderall XR®)	Dexedrine® (dextroamphetamine)
Methylphenidate			Dexedrine Spansules® (dextroamphetamine ER)
Short-Acting			**Dyanavel™ XR (amphetamine ER susp)**
Focalin® (dexmethylphenidate) Methylin® (methylphenidate) Ritalin® (methylphenidate)			Evekeo™ (amphetamine)
Long-Acting			Methylin® (methylphenidate soln & chew tabs)
Metadate CD® brand name only (methylphenidate ER) Metadate ER® (methylphenidate ER) Methylin ER® (methylphenidate ER) Ritalin SR® (methylphenidate ER)	Focalin XR® (dexmethylphenidate ER) Ritalin LA® brand name only (methylphenidate ER)	Aptensio XR™ (methylphenidate ER) Concerta® (methylphenidate ER) methylphenidate ER (generic Metadate CD®) methylphenidate ER (generic Ritalin LA®)	Nuvigil® (armodafinil) Provigil® (modafinil) **QuilliChew ER™ (methylphenidate ER chew tabs)** Quillivant XR® (methylphenidate ER) Xyrem® (sodium oxybate) Zenzedi® (dextroamphetamine)
Non-Stimulants			
Intuniv® (guanfacine ER) Strattera® (atomoxetine)		Kapvay® (clonidine ER)	

*Tier structure based on State Maximum Allowable Cost (SMAC) and/or supplemental rebate participation.
+Unique criteria applies for the diagnosis of binge eating disorder (BED).
ER = Extended-Release, SR = Sustained-Release, ODT = Orally Disintegrating Tablet, Chew Tabs = Chewable Tablets, Soln = Solution, Susp = Suspension

Recommendation 4: Vote to Prior Authorize Rexulti® (Brexpiprazole), Vraylar™ (Cariprazine), and Aristada™ (Aripiprazole Lauroxil)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following:

1. The addition of Rexulti® (brexpiprazole) to the current approval criteria for atypical antipsychotics as adjunctive treatment for major depressive disorder.
2. The placement of Rexulti® (brexpiprazole), Vraylar™ (cariprazine), and Aristada® (aripiprazole lauroxil) into Tier-3 of the Atypical Antipsychotic Product Based Prior Authorization (PBPA) category. Current Tier-3 criteria for this category will apply.
    a. Aristada® (aripiprazole lauroxil) is currently rebated to Tier-2 but will be placed in Tier-3 if the manufacturer chooses not to participate in supplemental rebates.

Atypical Antipsychotics*		
Tier-1	**Tier-2**	**Tier-3**
clozapine (Clozaril®)¥	aripiprazole (Abilify®)	**brexpiprazole (Rexulti®)**
olanzapine (Zyprexa®)	aripiprazole (Abilify Maintena®)	**cariprazine (Vraylar™)**
quetiapine (Seroquel®)	**aripiprazole lauroxil (Aristada®)**	clozapine (Fazaclo®)
risperidone (Risperdal®)	asenapine (Saphris®)	clozapine oral suspension (Versacoz™)
risperidone (Risperdal Consta®)	lurasidone (Latuda®)	iloperidone (Fanapt™)
ziprasidone (Geodon®)	paliperidone (Invega® Sustenna®)	olanzapine/fluoxetine (Symbyax®)
	paliperidone (Invega® Trinza™)∞	paliperidone (Invega®)
	quetiapine ER (Seroquel XR®)	

ER = extended-release

*Tier structure based on supplemental rebate participation and/or state maximum allowable cost (SMAC). Mandatory generic plan applies.

¥ Does not count towards a Tier-1 trial

∞ In addition to tier trials, use of Invega Trinza™ requires adequate treatment with the 1-month paliperidone extended-release injection (Invega® Sustenna®) for at least four months.

Tier-1 products are available without prior authorization for members age five years and older. Prior authorization requests for members younger than five years of age are reviewed by an OHCA-contracted child psychiatrist.

Atypical Antipsychotic Tier-2 Approval Criteria:

1. Trials of two Tier-1 medications at least 14 days in duration each, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects.
    a. *Pending aripiprazole move to Tier-1:* One of the Tier-1 trials must include a trial with aripiprazole unless the member has a patient-specific, clinically significant reason why aripiprazole is not appropriate or an FDA approved diagnosis not covered by aripiprazole.
    b. Clozapine does not count towards a Tier-1 trial.

Atypical Antipsychotic Tier-3 Approval Criteria:

1. Trials of two Tier-1 medications at least 14 days in duration each, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects; and
    a. *Pending aripiprazole move to Tier-1:* One of the Tier-1 trials must include a trial with aripiprazole unless the member has a patient-specific, clinically significant reason why aripiprazole is not appropriate or an FDA approved diagnosis not covered by aripiprazole.
    b. Clozapine does not count towards a Tier-1 trial.
2. Trials of two Tier-2 medications, at least 14 days in duration each, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects.
3. A manual prior authorization may be submitted for consideration of a Tier-3 medication when the member has had at least four trials of Tier-1 and Tier-2 medications (two trials must be from Tier-1) that did not yield an adequate response or resulted in intolerable adverse effects.
4. Use of Versacloz™ (clozapine oral suspension) and Fazaclo® (clozapine orally disintegrating tablet) requires a patient-specific, clinically significant reason why the member cannot use the oral tablet formulation.

Approval Criteria for Atypical Antipsychotics as Adjunctive Treatment for Major Depressive Disorder:

1. Authorization of Abilify® (aripiprazole), Seroquel XR® (quetiapine extended-release), Symbyax® (olanzapine/fluoxetine), or **Rexulti® (brexpiprazole)** for a diagnosis of major depressive disorder requires current use of an antidepressant, and previous trials with at least two other antidepressants from both categories (an SSRI and duloxetine) and a trial of aripiprazole tablets (*pending aripiprazole move to Tier-1*) that did not yield adequate response. Tier structure applies.

Recommendation 5: Vote to Prior Authorize Albenza® (Albendazole) and Emverm™ (Mebendazole)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Albenza® (albendazole) and Emverm™ (mebendazole) with the following criteria:

Albenza® (Albendazole) Approval Criteria:

1. A quantity of six tablets per 180 days will process without prior authorization. For infections requiring additional doses, a prior authorization will need to be submitted and the following criteria will apply:
    a. An FDA approved diagnosis of one of the following:
        i. Treatment of parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm, *Taenia solium*.
        ii. Treatment of cystic hydatid disease of the liver, lung, and peritoneum, caused by the larval form of the dog tapeworm, *Echinococcus granulosus*.

Emverm™ (Mebendazole) Approval Criteria:

1. An FDA approved diagnosis of any of the following:
    a. Treatment of *Enterobius vermicularis* (pinworm); or
    b. Treatment of *Trichuris trichiura* (whipworm); or
    c. Treatment of *Ascaris lumbricoides* (common roundworm); or
    d. Treatment of *Ancylostoma duodenale* (common hookworm); or
    e. Treatment of *Necator americanus* (American hookworm); and
2. For the treatment of *Enterobius vermicularis* (pinworms), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), or *Necator americanus* (American hookworm), a patient-specific, clinically significant reason why a more cost-effective anthelmintic therapy, such as albendazole or pyrantel pamoate, cannot be used must be provided.
3. The following quantity limits will apply:
    a. *Enterobius vermicularis (*pinworms): 2 tablets per 30 days
    b. *Trichuris trichiura* (whipworm): 6 tablets per 30 days
    c. *Ascaris lumbricoides* (common roundworm): 6 tablets per 30 days
    d. *Ancylostoma duodenale* (common hookworm): 6 tablets per 30 days
    e. *Necator americanus* (American hookworm): 6 tablets per 30 days

Recommendation 6: Vote to Prior Authorize OsmoPrep® (Sodium Phosphate Monobasic/Sodium Phosphate Dibasic), Prepopik® (Sodium Picosulfate/ Magnesium Oxide/Citric Acid), Suclear® (Sodium Sulfate/Potassium Sulfate/ Magnesium Sulfate/PEG-3350/Sodium Chloride/Sodium Bicarbonate/Potassium Chloride), and SUPREP® (Sodium Sulfate/Potassium Sulfate/Magnesium Sulfate)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of OsmoPrep®, Prepopik®, Suclear®, and SUPREP® with the following criteria:

OsmoPrep®, Prepopik®, Suclear®, and SUPREP® Approval Criteria:

1. An FDA approved indication for use in cleansing of the colon as a preparation for colonoscopy; and
2. A patient-specific, clinically significant reason other than convenience the member cannot use other bowel preparation medications available without prior authorization.
3. If the member requires a low volume polyethylene glycol electrolyte lavage solution, Moviprep® is available without prior authorization. Other medications currently available without a prior authorization include: Colyte®, Gavilyte®, Golytely®, and Trilyte®.

Based on the low net cost of MoviPrep® the College of Pharmacy does not recommend the prior authorization of MoviPrep® at this time.

Recommendation 7: Vote to Prior Authorize Nuvessa™ (Metronidazole Vaginal Gel 1.3%), Zyclara® (Imiquimod Cream), & Kristalose® (Lactulose Packets)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Nuvessa™ (metronidazole vaginal gel 1.3%), Zyclara® (imiquimod), and Kristalose® (lactulose packets for oral solution) with the following criteria:

1. **Nuvessa™ (Metronidazole Vaginal Gel 1.3%) Approval Criteria:**
   a. An FDA approved diagnosis of bacterial vaginosis in non-pregnant women; and
   b. A patient-specific, clinically significant reason why the member cannot use MetroGel-Vaginal® 0.75% (metronidazole vaginal gel 0.75%) or the generic metronidazole oral tablet.
2. **Zyclara® (Imiquimod) 2.5% and 3.75% Cream Approval Criteria:**
   a. An FDA approved diagnosis of actinic keratosis (AK) of the full face or balding scalp in immunocompetent adults or topical treatment of external genital and perianal warts/condyloma acuminata (EGW) in patients 12 years and older; and
   b. Member must be 12 years or older; and
   c. Requests for a diagnosis of molluscum contagiosum in children 2 to 12 years of age will generally not be approved; and
   d. A patient-specific, clinically significant reason why the member cannot use generic imiquimod 5% cream in place of Zyclara® (imiquimod) 2.5% and 3.75%.
3. **Kristalose® (Lactulose Packets for Oral Solution) Approval Criteria:**
   a. A patient-specific, clinically significant reason why the member cannot use the liquid lactulose formulation.

Recommendation 8: Vote to Prior Authorize H.P. Acthar® Gel (Corticotropin Injection)

MOTION CARRIED by unanimous approval.

H.P. Acthar® Gel (Corticotropin Injection) Approval Criteria:

1. An FDA approved diagnosis of infantile spasms; and
   a. Member must be two years of age or younger; and
   b. Must be prescribed by, or in consultation with, a neurologist or an advanced care practitioner with a supervising prescriber that is a neurologist; or
2. An FDA approved diagnosis of multiple sclerosis (MS); and
   a. Member is experiencing an acute exacerbation; and
   b. Must be prescribed by, or in consultation with, a neurologist or an advanced care practitioner with a supervising prescriber that is a neurologist or a physician that specializes in MS; and
   c. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy (e.g. IV methylprednisolone).
   d. Therapy will be limited to five weeks per approval (three weeks of treatment, followed by taper). Additional approval, beyond the initial five weeks, will require

prescriber documentation of response to initial treatment and need for continued treatment; or

3. An FDA approved diagnosis of nephrotic syndrome without uremia of the idiopathic type or that is due to lupus erythematosus to induce a diuresis or a remission; and
    a. Must be prescribed by, or in consultation with, a nephrologist or an advanced care practitioner with a supervising prescriber that is a nephrologist; and
    b. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy (e.g., prednisone); or
4. An FDA approved diagnosis of the following disorders and diseases: rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous states; and
    a. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy.

Recommendation 9: Vote to Prior Authorize Econazole Nitrate 1% Cream and Clotrimazole 1% Solution

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the Topical Antifungal Product Based Prior Authoriation (PBPA) category:

1. Move econazole nitrate 1% cream and clotrimazole 1% solution from Tier-1 to Tier-2 based on increases in SMAC. The existing criteria for this category will apply.
2. Move ciclopirox suspension and clotrimazole/betamethasone cream from Tier-2 to Tier-1 based on decreases in SMAC.
3. Initiate pharmacy/prescriber education regarding these tier changes, which includes the option of using clotrimazole 1% cream as an alternative for econazole nitrate 1% cream and clotrimazole 1% cream or ketoconazole cream as an alternative for clotrimazole 1% solution.

Topical Antifungal Tier-2 Approval Criteria:

1. Documented, recent trials with at least two Tier-1 topical antifungal products for at least 90 days each; and
2. When the same medication is available in Tier-1, a patient-specific, clinically significant reason must be provided for using a special dosage formulation of that medication in Tier-2 (foams, shampoos, sprays, kits, etc.).
3. Authorization of combination products nystatin/triamcinolone cream, nystatin/triamcinolone ointment, ~~or clotrimazole/betamethasone~~ or clotrimazole/betamethasone lotion requires a patient-specific, clinically significant reason why the member cannot use the individual components separately, or in the case of clotrimazole/betamethasone lotion why Tier-1 cream cannot be used.
4. For treatment of onychomycosis, a trial of oral antifungals (6 weeks for fingernails and 12 weeks for toenails) will be required for consideration of approval of Penlac® (ciclopirox solution).

Topical Antifungal Medications		
Tier-1	**Tier-2**	**Special PA**
ciclopirox cream, **suspension**	butenafine (Mentax®)	efinaconazole (Jublia®)
clotrimazole (Rx) cream	ciclopirox solution, shampoo, gel (Penlac® and Loprox®)	tavaborole (Kerydin™)
clotrimazole (OTC)* cream	**clotrimazole solution**	
clotrimazole/betamethasone cream	clotrimazole/betamethasone lotion	
ketoconazole cream, shampoo	**econazole cream**	
nystatin cream, ointment, powder	ketoconazole foam (Extina®)	
terbinafine (OTC)* cream	ketoconazole gel (Xolegel™)	
tolnaftate (OTC)*cream	luliconazole cream (Luzu™)	
	miconazole/zinc oxide/white petrolatum (Vusion®)	
	naftifine (Naftin®)	
	nystatin/triamcinolone cream, ointment	
	oxiconazole (Oxistat®)	
	salicylic acid (Bensal HP®)	
	sertaconazole nitrate (Ertaczo®)	
	sulconazole (Exelderm®)	

*Over-the-counter (OTC) antifungal products are covered for pediatric members 0-20 years of age without prior authorization.

Recommendation 10: 30-Day Notice to Prior Authorize Ocaliva™ (Obeticholic Acid)

NO ACTION REQUIRED.

Recommendation 11: Annual Review of Opioid Analgesics and Buprenorphine Products & 30-Day Notice to Prior Authorize Belbuca™ (Buprenorphine Buccal Film), Dolophine® (Methadone), MorphaBond™ (Morphine Extended-Release), Xtampza™ ER (Oxycodone Extended-Release), & Probuphine® (Buprenorphine Implant)

NO ACTION REQUIRED.

Recommendation 12: Annual Review of Anti-Ulcer Medications and 30-Day Notice to Prior Authorize Dexilant™ SoluTab (Dexlansoprazole Delayed-Release Orally Disintegrating Tablets)

NO ACTION REQUIRED.

Recommendation 13: Annual Review of Antidepressants

NO ACTION REQUIRED.

Recommendation 14: Annual Review of Myalept® (Metreleptin)

NO ACTION REQUIRED.

The University of Oklahoma
Health Sciences Center
COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS

Memorandum

Date: August 11, 2016

To: Nancy Nesser, Pharm.D.; J.D.
Pharmacy Director
Oklahoma Health Care Authority

From: Bethany Holderread, Pharm.D.
Clinical Coordinator
Pharmacy Management Consultants

Subject: DUR Board Recommendations From Packet of August 10, 2016

Recommendation 1: FDA Safety Alerts

NO ACTION REQUIRED.

Recommendation 2: Annual Review of Ocular Antibiotic Products and 30-Day Notice to Prior Authorize AK-Tracin® (Bacitracin) and Bleph-10® (Sulfacetamide Sodium) Ophthalmic Ointment

NO ACTION REQUIRED.

Recommendation 3: Annual Review of Glaucoma Medications and 30-Day Notice to Prior Authorize Betimol® (Timolol Ophthalmic Solution), Betoptic® (Betaxolol Ophthalmic Solution), and Timoptic-XE® (Timolol Maleate Ophthalmic Gel-Forming Solution)

NO ACTION REQUIRED.

Recommendation 4: Annual Review of Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) and 30-Day Notice to Prior Authorize Vivlodex™ (Meloxicam Capsules)

NO ACTION REQUIRED.

Recommendation 5: Annual Review of Alzheimer's Medications

NO ACTION REQUIRED.

Recommendation 6: Annual Review of Daraprim® (Pyrimethamine)

NO ACTION REQUIRED.

Recommendation 7: Annual Review of Oral Antifungal Medications

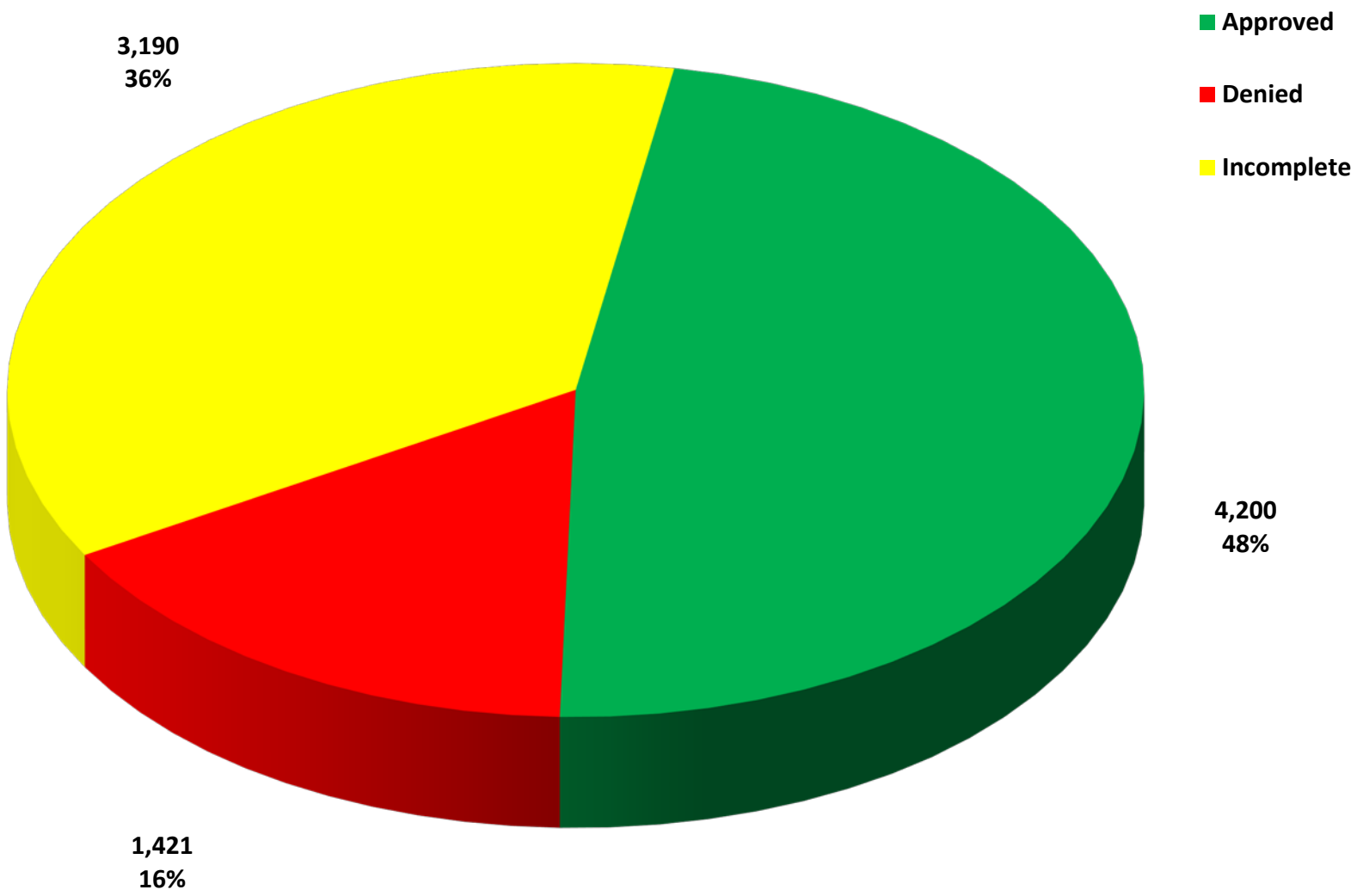
NO ACTION REQUIRED.

Recommendation 8: Annual Review of Nasal Allergy Medications and 30-Day Notice to Prior Authorize Nasarel® (Flunisolide)

NO ACTION REQUIRED.

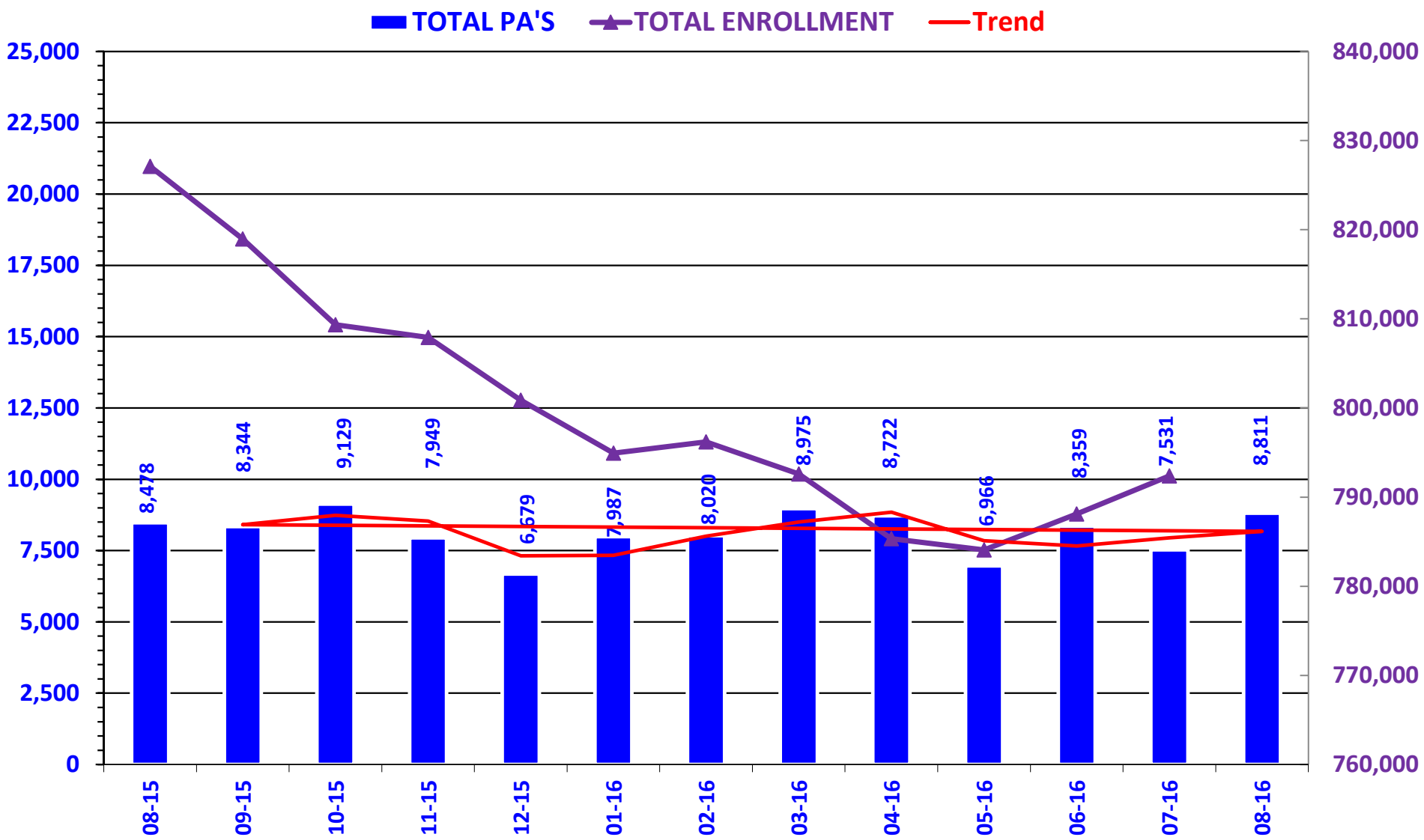
Appendix B

PRIOR AUTHORIZATION ACTIVITY REPORT: AUGUST 2016



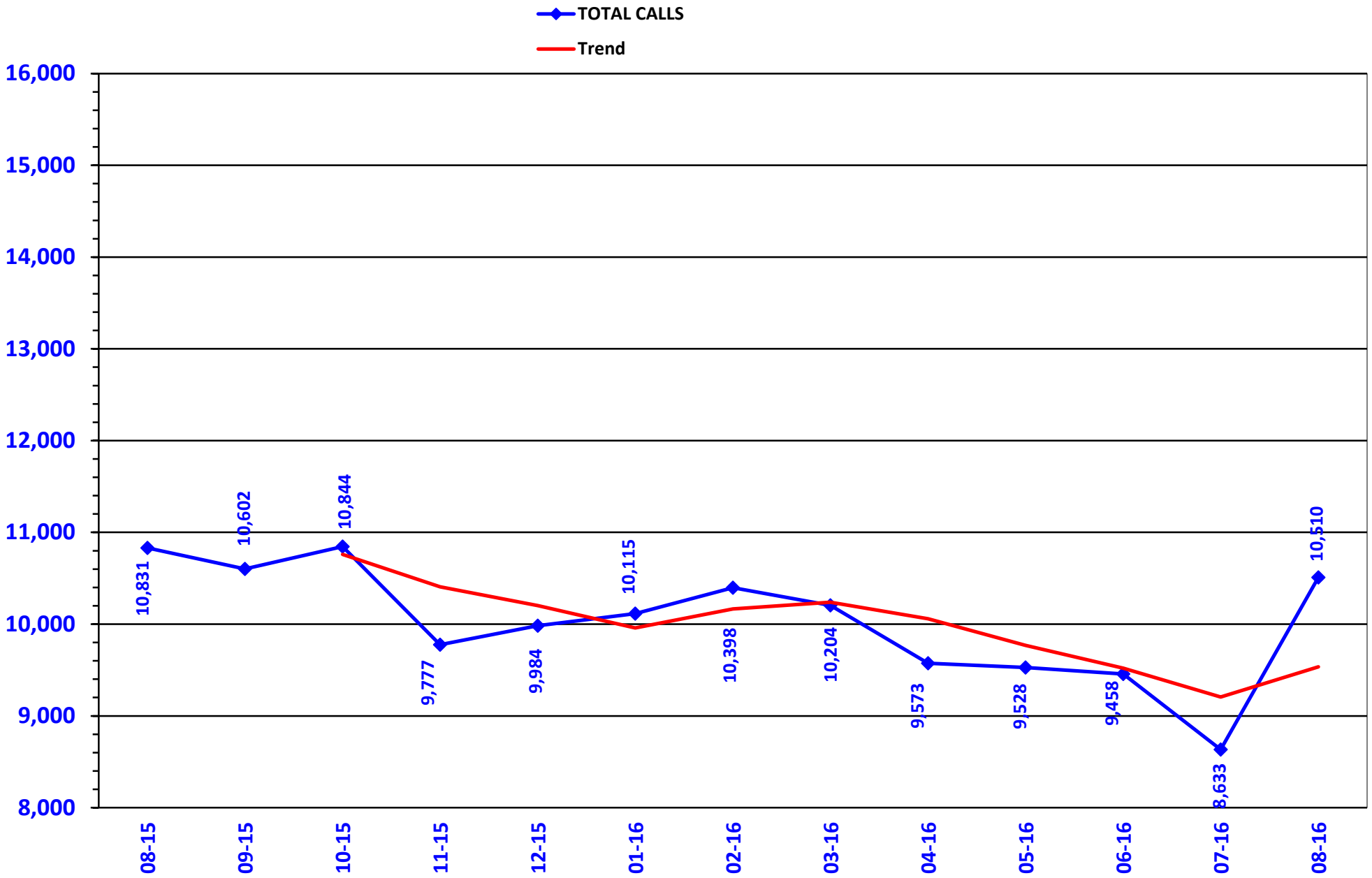
PA totals include approved/denied/incomplete/overrides

PRIOR AUTHORIZATION REPORT: AUGUST 2015 – AUGUST 2016



PA totals include approved/denied/incomplete/overrides

CALL VOLUME MONTHLY REPORT:
AUGUST 2015 – AUGUST 2016



Prior Authorization Activity
8/1/2016 Through 8/31/2016

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort/Dulera	356	128	62	166	348
Analgesic - NonNarcotic	21	0	4	17	0
Analgesic - Narcotic	494	292	37	165	161
Angiotensin Receptor Antagonist	22	1	11	10	358
Antiasthma	79	27	13	39	305
Antibiotic	24	10	1	13	228
Anticonvulsant	133	55	25	53	323
Antidepressant	104	20	28	56	290
Antidiabetic	218	90	31	97	353
Antifungal	10	2	4	4	21
Antigout	13	7	1	5	357
Antihistamine	151	115	8	28	352
Antimigraine	46	13	9	24	252
Antineoplastic	19	9	3	7	159
Antiulcers	173	43	53	77	178
Antiviral	41	12	17	12	17
Anxiolytic	74	46	6	22	248
Atypical Antipsychotics	409	198	50	161	326
Biologics	99	56	14	29	304
Bladder Control	53	17	18	18	328
Blood Thinners	236	145	12	79	320
Botox	38	28	7	3	355
Buprenorphine Medications	305	233	14	58	77
Cardiovascular	93	41	10	42	304
Chronic Obstructive Pulmonary Disease	77	12	18	47	327
Constipation/Diarrhea Medications	165	20	74	71	166
Contraceptive	27	20	1	6	339
Dermatological	119	21	64	34	104
Diabetic Supplies	569	331	22	216	197
Endocrine & Metabolic Drugs	79	61	4	14	132
Erythropoietin Stimulating Agents	26	20	2	4	78
Fibromyalgia	185	36	84	65	343
Fish Oils	27	3	11	13	308
Gastrointestinal Agents	167	24	64	79	118
Genitourinary Agents	12	3	7	2	162
Glaucoma	12	1	2	9	359
Growth Hormones	74	51	7	16	146
Hematopoietic Agents	41	14	6	21	81
Hepatitis C	123	65	34	24	8
HFA Rescue Inhalers	68	18	9	41	299
Insomnia	34	6	6	22	151
Insulin	76	23	21	32	357
Miscellaneous Antibiotics	33	6	5	22	29
Multiple Sclerosis	84	40	15	29	200
Muscle Relaxant	68	16	25	27	63
Nasal Allergy	78	13	20	45	226
Neurological Agents	61	43	9	9	340
NSAIDs	210	34	67	109	277
Ocular Allergy	55	7	16	32	162
Osteoporosis	15	7	2	6	358
Other*	311	95	81	135	238

* Includes any therapeutic category with less than 10 prior authorizations for the month.

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Otic Antibiotic	27	1	7	19	5
Pediculicide	47	13	9	25	9
Stimulant	909	454	92	363	335
Testosterone	58	14	16	28	356
Topical Antibiotic	11	2	0	9	50
Topical Antifungal	37	0	10	27	0
Topical Corticosteroids	153	1	57	95	359
Vitamin	84	23	42	19	303
Pharmacotherapy	86	74	0	12	311
Emergency PAs	0	0	0	0	
Total	**7,474**	**3,173**	**1,356**	**2,945**	
Overrides					
Brand	60	39	10	11	304
Diabetic Supplies	5	1	1	3	9
Dosage Change	320	289	0	31	10
High Dose	4	2	0	2	359
Ingredient Duplication	36	31	0	5	10
Lost/Broken Rx	116	110	3	3	12
NDC vs Age	20	18	0	2	249
Nursing Home Issue	53	51	0	2	9
Opioid Quantity	16	16	0	0	161
Other*	27	27	0	0	11
Quantity vs. Days Supply	639	414	46	179	263
STBS/STBSM	11	11	0	0	123
Stolen	17	16	0	1	11
Temporary Unlock	5	3	0	2	11
Third Brand Request	29	16	6	7	41
Overrides Total	**1,337**	**1,027**	**65**	**245**	
Total Regular PAs + Overrides	**8,811**	**4,200**	**1,421**	**3,190**	

Denial Reasons	
Unable to verify required trials.	2,610
Does not meet established criteria.	1,445
Lack required information to process request.	544

Other PA Activity	
Duplicate Requests	604
Letters	8,208
No Process	54
Changes to existing PAs	686
Helpdesk Initiated Prior Authorizations	745
PAs Missing Information	35

* Includes any therapeutic category with less than 10 prior authorizations for the month.

Concomitant Benzodiazepine and Opioid Utilization

Oklahoma Health Care Authority
September 2016

Introduction[1,2,3,4,5,6]

In March of 2016 the Centers for Disease Control and Prevention (CDC) released guidelines for prescribing opioids for primary care clinicians in outpatient settings who are prescribing opioids for chronic pain (i.e., pain lasting >3 months) outside of active cancer treatment, palliative care, and end-of-life care. The guidelines outlined 12 recommendations including the following: *Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible*. Additionally, in August of 2016 the U.S. Food and Drug Administration (FDA) announced class-wide changes to drug labeling and patient information, including the addition of boxed warnings regarding the risks associated with using these medications concurrently.

The guidelines highlighted that both benzodiazepines and opioids cause central nervous system depression leading to decreased respiratory drive and greater risk for fatal overdoses. The experts agreed that although there are circumstances when it might be appropriate to prescribe opioids to a patient receiving benzodiazepines, clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible. Several studies were cited and are summarized below.

- Park and colleagues conducted a case-cohort study of veterans who received opioid analgesics from 2004 to 2009. Results of the study found 27% of participants received both opioid analgesics and benzodiazepines. Study results also found that risk of death from drug overdose increased with both a history of benzodiazepine prescriptions and current benzodiazepine prescriptions compared to no prescription [adjusted hazard ratios: 2.33 (95% CI: 2.05, 2.64) for former prescriptions versus no prescription and 3.86 (95% CI: 3.49, 4.26) for current prescriptions versus no prescription].[3]
- Gomes and colleagues conducted a population-based, nested, case-control study evaluating 593 deaths in patients who had received an opioid for nonmalignant pain from August 1997 to December 2006. Of these cases, the coroner's toxicologic screening detected benzodiazepines in 60.4%.[4]
- Dasgupta and colleagues conducted a prospective observational cohort study evaluating 629 overdose deaths in a North Carolina population over a period of one year (2010). Data was compiled using a controlled substances prescription monitoring program with mortality data. Results revealed that 80% of opioid analgesic patients also received benzodiazepines; rates of overdose deaths were ten times higher for those receiving both opioids and benzodiazepines than opioids alone [7.0 per 10,000 person years (95% CI: 6.3, 7.8) versus 0.7 per 10,000 person years (95% CI: 0.6, 0.9)].[5]
- Jones and colleagues conducted a retrospective review of data from the National Vital Statistics System from 2004 to 2011. The authors found that benzodiazepine association in opioid overdose deaths increased yearly from 18% of deaths in 2004 to 31% in 2011 (p-trend <0.0001).[6]

The guidelines also advise prescribers to check the prescription drug monitoring program (PDMP) for concomitant controlled medications prescribed by other clinicians, and to taper or discontinue concurrent opioids and benzodiazepines whenever possible. Benzodiazepines are associated with a greater risk of withdrawal compared to opioids, and prescribers are advised to consider tapering opioids first. Prescribers tapering benzodiazepines should taper gradually and the tapering schedule recommended is a reduction of the benzodiazepine dose by 25% every 1 to 2 weeks. Prescribers should also consider evidence-based psychotherapies such as cognitive behavior therapy (CBT) or antidepressants when benzodiazepines prescribed for anxiety are tapered or discontinued. Collaboration with mental health professionals is recommended.

Concomitant Benzodiazepine & Opioid SoonerCare Claims Analysis

Members were reviewed for paid pharmacy claims for at least one benzodiazepine and at least one opioid medication in the 12 months prior to the report date. Concomitant use was determined by paid claims for a benzodiazepine and an opioid medication concurrently for 90 consecutive days or greater.

Concomitant Benzodiazepine and Opioid Utilization: Overall Results

Concomitant Therapy Length	Number of Members
90 days or more	7,859
180 days or more	6,484
300 days or more	5,169

Members are not unduplicated.

Concomitant Utilization Details

The following table includes the most common benzodiazepines used concomitantly with at least one opioid medication.

Most Common Benzodiazepines Used Concomitantly	
Drug Name	**% of All Benzodiazepine Members with an Opioid Medication**
Alprazolam	46.49%
Clonazepam	24.01%
Diazepam	19.07%
Lorazepam	9.72%

The following table includes the most common opioid medications used concomitantly with at least one benzodiazepine.

Most Common Opioid Medications Used Concomitantly	
Drug Name	**% of All Opioid Medication Members with a Benzodiazepine**
Hydrocodone/Acetaminophen	41.38%
Oxycodone/Acetaminophen	12.99%
Tramadol	12.46%
Oxycodone	10.35%
Codeine/Acetaminophen	7.39%

Discussion[1,7,8,9,10,11]

In Oklahoma, opioids are the most common class of drugs involved in overdose deaths with 427 opioid-involved deaths in 2014. The most common prescription drugs involved in overdose deaths were hydrocodone, oxycodone, and alprazolam. As mentioned in the introduction section of this report, concomitant benzodiazepine and opioid therapy can lead to additive CNS depression causing increased risk of overdose. Three of the studies specifically highlighted in the CDC guidelines found evidence of concurrent benzodiazepine and opioid use in 31% to 61% of fatal overdoses. Reduction of concurrent use of benzodiazepines and opioid medications will likely lead to a reduction in prescription drug overdose deaths.

Different methods could be employed to reduce concomitant use of benzodiazepines and opioids including targeted prescriber education and prior authorization edits for concomitant therapy. While both methods are valid, there is concern that implementation of a hard-stop edit would change the route of reimbursement rather than prescribing and dispensing behaviors. Members would still be able to pay cash for medications denied by SoonerCare, particularly low-cost benzodiazepines. If cash claims remain frequent, little impact is made on overdose risk and SoonerCare utilization data on those using concomitant therapy is lost, limiting educational and monitoring efforts. Changing the reimbursement method is unlikely to decrease overdose death rates. Instead, the goal of an effective intervention would be to encourage a change in prescribing and dispensing habits. Additionally, a hard-stop edit would impact the small population of members where concomitant therapy is appropriate.

A targeted prescriber educational initiative may be the most effective method for changing prescribing habits and reducing opioid overdose deaths. Several physician groups have recommended additional prescriber education and use of the PDMP to reduce inappropriate opioid prescribing; some studies have shown efficacy in different methods of prescriber education. Examples of both are cited below.

- In May 2016, the president of the American Medical Association, Stephen Stack, MD, called on prescribers to re-examine prescribing practices to reverse the opioid overdose epidemic including: not initiating opioids for new patients with chronic noncancer pain unless the benefits are anticipated to outweigh the risks; limiting the amount of opioids prescribed for postoperative care and acutely injured patients; and registering for and using the PDMP.[9]
- Dr. Ali Mchaourab conducted a telemedicine program through the Cleveland Veterans Affairs Medical Center and 13 outpatient clinics. The program concentrated on training primary care prescribers on appropriate opioid prescribing. Clinics who participated in the program after one year had significant declines in the number of opioid prescriptions ($p<0.05$) as well as a shift from higher to lower doses.[10]
- Dr. Ming-Chih Kao evaluated data from 3.1 billion primary care visits between 2002 and 2009 represented by the National Ambulatory Medical Center Survey (NAMCS) and found patient visits involving opioid prescriptions were 4.2 times more likely to also have concurrent prescriptions of a benzodiazepine. The study also found joint prescriptions of both benzodiazepines and opioids increased by 12% a year. Dr. Kao called for better provider education as well as coordination between prescribers of opioid medications and prescribers of benzodiazepines as the medications may have been started at different episodes of care.[10,11]

Recommendations

The College of Pharmacy recommends the following:

- Working with the Oklahoma Health Care Authority and the Prescription Drug Fatality Task Force on targeting education to prescribers in specific counties with high rates of overdose death rates or concomitant benzodiazepine and opioid prescribing. Educational interventions may include practice facilitator education to prescribers, targeted educational letters to prescribers (particularly those who have members who are using the same prescriber for both prescriptions), and newsletter articles.
- If targeted educational interventions are ineffective at changing prescriber behaviors, consider implementation of an edit that would require prior authorization for reimbursement of concomitant benzodiazepine and opioid therapy for longer than 90 days. The edit would need to be phased in over a period of time to allow for adequate tapering. The edit would not go into effect until all patient and prescriber groups had been notified. Additionally, medication groups would be selected and implemented over time to ensure a smoother transition.

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[1] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recomm Rep* 2016; 65 (No. RR-1):1–49. Available online at: http://dx.doi.org/10.15585/mmwr.rr6501e1. Issued 03/18/2016. Last accessed 08/18/2016.

[2] U.S. Food and Drug Administration (FDA). FDA requires strong warnings for opioid analgesics, prescription opioid cough products, and benzodiazepine labeling related to serious risks and death from combined use. Available online at: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm518697.htm. Issued 08/31/2016. Last accessed 08/31/2016.

[3] Park TW, Saitz R, Ganoczy D, Ilgen MA, Bohnert AS. Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study. *BMJ* 2015; 350:h2698.

[4] Gomes T, Mamdani MM, Dhalla IA, Paterson JM, Juurlink DN. Opioid dose and drug-related mortality in patients with nonmalignant pain. *Arch Intern Med* 2011; 171:686–91.

[5] Dasgupta N, Funk MJ, Proescholdbell S, Hirsch A, Ribisl KM, Marshall S. Cohort study of the impact of high-dose opioid analgesics on overdose mortality. *Pain Med* 2015. Epub ahead of print. Available online at: https://uncch.pure.elsevier.com/en/publications/cohort-study-of-the-impact-of-high-dose-opioid-analgesics-on-over.

[6] Jones CM, McAninch JK. Emergency Department Visits and Overdose Deaths From Combined Use of Opioids and Benzodiazepines. *Am J Prev Med* 2015; 49(4):493-501.

[7] Oklahoma Department of Mental Health and Substance Abuse Services. A State Plan: Reducing Prescription Drug Abuse in Oklahoma. Available online at: http://www.ok.gov/odmhsas/documents/Rx%20Abuse%20Prevention%20Plan.pdf. Last revised 11/2013. Last accessed 08/19/2016.

[8] Oklahoma State Department of Health Injury Prevention Service. Unintentional Poisonings Database (abstracted from the Medical Examiner reports).

[9] AMA President Calls on Physicians to Stop Opioid Epidemic. *Managed Care Magazine*. Available online at: http://www.managedcaremag.com/news/ama-president-calls-physicians-stop-opioid-epidemic. Issued 05/12/2016. Last accessed 08/19/2016.

[10] Melville, Nancy A. Benzodiazepine, Opioid Prescribing Rises in Primary Care. *Medscape*. Available online at: http://www.medscape.com/viewarticle/821836. Issued 03/2014. Last accessed 08/19/2016.

[11] American Academy of Pain Medicine. Prescriptions for Benzodiazepines Rising and Risky When Combined with Opioids, Stanford Researchers Warn. Available online at: http://www.painmed.org/2014press/files/prescriptions-for-benzodiazepines-rising-and-risky-when-combined-with-opioids.pdf. Issued 03/2014. Last accessed 08/19/2016.

Appendix C

Vote to Prior Authorize Dexilant™ SoluTab (Dexlansoprazole Delayed-Release Orally Disintegrating Tablets)

Oklahoma Health Care Authority
September 2016

Indication(s) and Dosing[1]

- **Dexilant™ SoluTab (dexlansoprazole)** delayed-release orally disintegrating tablet is a proton pump inhibitor (PPI) indicated in patients 12 years of age and older for the following:
  - Maintaining healing of erosive esophagitis (EE); and
  - Treating heartburn associated with gastroesophageal reflux disease (GERD).
- Dexilant™ SoluTab is available as a delayed-release orally disintegrating 30mg tablet.
- Two 30mg Dexilant™ SoluTabs are not interchangeable with one 60mg Dexilant™ capsule.
- The FDA approved dosing for maintenance healing of EE is 30mg once daily for up to six months in adults and 16 weeks in patients 12 to 17 years of age.
- The FDA approved dosing for treatment of symptomatic non-erosive GERD is 30mg once daily for four weeks.
- Dexilant™ SoluTab should be taken at least 30 minutes before a meal and should not be cut or broken.
- Dexilant™ SoluTab should be placed on the tongue, allowed to disintegrate, and swallowed without water. Patients should not chew the microgranules. Dexilant™ SoluTab may also be swallowed whole with water.
- Alcohol use should be avoided when taking Dexilant™ SoluTab.
- Information regarding the anticipated cost and launch date of Dexilant™ SoluTab is unknown at this time.

Recommendations

The College of Pharmacy recommends the placement of Dexilant™ SoluTab into Tier-3 of the Anti-Ulcer Product Based Prior Authorization (PBPA) category. Current Tier-3 criteria for this category would apply.

Anti-Ulcer Medications*		
Tier-1	**Tier-2**	**Tier-3**
omeprazole (Prilosec®)	dexlansoprazole (Dexilant®)	**dexlansoprazole (Dexilant™ SoluTab)**
pantoprazole (Protonix®)	lansoprazole (Prevacid® and ODT)	esomeprazole magnesium (Nexium®)
	rabeprazole (Aciphex®)	esomeprazole strontium
		omeprazole suspension (Prilosec®)
		pantoprazole (Protonix® suspension)
		rabeprazole (Aciphex® sprinkles)

*Tier structure based on supplemental rebate participation and/or state maximum allowable cost (SMAC).
ODT = orally disintegrating tablet

Anti-Ulcer Medications Tier-2 Approval Criteria:

1. A recent 14-day trial of all available Tier-1 medications titrated up to the recommended dose that has resulted in inadequate relief of symptoms or intolerable adverse effects; or
2. A contraindication to all available Tier-1 medications; or
3. An indication not covered by lower tiered medications.

Anti-Ulcer Medications Tier-3 Approval Criteria:

1. A recent 14-day trial of all available Tier-1 and Tier-2 medications that has resulted in inadequate relief of symptoms or intolerable adverse effects; or
2. A contraindication to all available Tier-1 and Tier-2 medications; or
3. An indication not covered by lower tiered medications.
4. Special formulations including orally disintegrating tablets (ODTs), sprinkle capsules, granules, suspensions, and solutions for intravenous (IV) use require patient-specific, clinically significant reasoning why the member cannot use standard dosage formulations.

[1] Dexilant™ SoluTab Prescribing Information. Takeda Pharmaceuticals America, Inc. Available online at: http://general.takedapharm.com/content/file.aspx?filetypecode=DEXILANTPI&cacheRandomizer=39e9925b-a093-45fa-adb9-15b97aa98060. Last revised 07/2016. Last accessed 08/2016.

Appendix D

Vote to Prior Authorize AK-Tracin® (Bacitracin) and Bleph-10® (Sulfacetamide Sodium) Ophthalmic Ointment

Oklahoma Health Care Authority
September 2016

Indication(s)[1,2]

- **AK-Tracin® (bacitracin)** ophthalmic ointment is indicated for the treatment of superficial ocular infections involving the conjunctiva and/or cornea caused by bacitracin susceptible organisms.
- **Bleph-10® (sulfacetamide sodium)** ophthalmic ointment is indicated for the treatment of conjunctivitis and other superficial ocular infections due to susceptible microorganisms: *Escherichia coli, Staphylococcus aureus, Staphylococcus pneumonia, Streptococcus* (viridans group), *Haemophilus influenzae, Klebsiella* species, and *Enterobacter* species. Topically applied sulfonamides do not provide adequate coverage against *Neisseria* species, *Serratiamarcescens* and *Pseudomonas aeroginosa*. A significant percentage of staphylococcal isolates are completely resistant to sulfa drugs.

Recommendations

The College of Pharmacy recommends the following changes to the ophthalmic antibiotics category:

1. Move AK-Tracin® (bacitracin) ophthalmic ointment and Bleph-10® (sulfacetamide sodium) ophthalmic ointment from Tier-1 to Tier-2 of the Ophthalmic Antibiotic Ointments Tier Chart based on increases in state maximum allowable costs (SMAC). Current Tier-2 criteria for this category will apply.
2. Move Maxitrol® suspension and ointment (neomycin/polymyxin B/dexamethasone) from Tier-2 to Tier-1 of the Ophthalmic Antibiotics/Steroid Combination Products Tier Chart based on low net costs.

Ophthalmic Antibiotic Tier-2 Approval Criteria:

1. An approved indication/suspected infection by an organism not known to be covered by Tier-1 products, or failure of a Tier-1 product; or
2. Known contraindication to all indicated Tier-1 medications; or
3. Prescription written by optometrists/ophthalmologists; or
4. When requested medication is being used for pre/post-operative prophylaxis.

Ophthalmic Antibiotic Tier-3 Approval Criteria:

1. An approved indication/suspected infection by an organism not known to be covered by Tier-2 products, or failure of a Tier-2 product; or
2. Known contraindication to all indicated Tier-2 medications; or
3. Prescription written by optometrists/ophthalmologists; or
4. When requested medication is being used for pre/post-operative prophylaxis.

Ophthalmic Antibiotic/Steroid Combination Tier-2 Approval Criteria:

1. Prescription written by optometrists/ophthalmologists; or
2. When requested medication is being used for pre/post-operative prophylaxis.

Ophthalmic Antibiotics: Liquids		
Tier-1	**Tier-2**	**Tier-3**
ciprofloxacin (Ciloxan®)	levofloxacin (Quixin®)	azithromycin (Azasite®)
gentamicin (Gentak®)		besifloxacin (Besivance®)
neomycin/polymyxin B/gramicidin (Neosporin®)		gatifloxacin (Zymaxid®)
ofloxacin (Ocuflox®)		moxifloxacin (Vigamox®, Moxeza®)
polymyxin B/trimethoprim (Polytrim®)		
sulfacetamide sodium (Bleph-10®)		
tobramycin (Tobrex®)		

Ophthalmic Antibiotics: Ointments	
Tier-1	**Tier-2**
bacitracin/polymyxin B (AK-Poly-Bac®)	**bacitracin (AK-Tracin®)**
erythromycin (Ilotycin™, Roymcin®)	ciprofloxacin (Ciloxan®)
gentamicin (Gentak®)	**sulfacetamide sodium (Bleph-10®, Sodium Sulamyd®)**
neomycin/polymyxin B/bacitracin (Neosporin®)	
tobramycin (Tobrex®)	

Ophthalmic Antibiotics/Steroid Combination Products	
Tier-1	**Tier-2**
neomycin/polymyxin B/dexamethasone (Maxitrol®) susp & oint	bacitracin/polymyxin B/neomycin/HC oint
sulfacetamide/prednisolone 10%-0.23% solution	gentamicin/prednisolone (Pred-G®) susp & oint
	neomycin/polymyxin B/HC (Cortisporin®) susp
	sulfacetamide/prednisolone 10%-0.2% (Blephamide®) susp & oint
	tobramycin/dexamethasone (Tobradex®) susp & oint
	tobramycin/loteprednol (Zylet®) susp

oint = ointment; susp = suspension; HC = hydrocortisone
Tier structures based on rebated prices and/or state maximum allowable cost (SMAC).

[1] Bacitracin Prescribing Information. Dailymed: Bacitracin ophthalmic ointment. Available online at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=6ed2f2bd-9d2f-46af-a44c-95a02ca034de. Last revised 12/2013. Last accessed 08/2016.

[2] Sulfacetamide Sodium Prescribing Information. Dailymed: Sulfacetamide sodium ophthalmic ointment. Available online at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=558280c6-893e-4645-9018-40c69be936d3. Last revised 08/2014. Last accessed 08/2016.

Appendix E

Vote to Prior Authorize Betoptic® (Betaxolol Ophthalmic Solution), Timoptic-XE® (Timolol Maleate Ophthalmic Gel-Forming Solution), & Betimol® (Timolol Ophthalmic Solution)

Oklahoma Health Care Authority
September 2016

Introduction[1,2,3,4]

- **Betoptic® (betaxolol ophthalmic solution)** is a beta-blocker indicated for the treatment of elevated intraocular pressure (IOP) in patients with ocular hypertension or open-angle glaucoma. Betaxolol ophthalmic solution is available as a generic product, and its current state maximum allowable cost (SMAC) is $9.60 per milliliter. The average cost of other available Tier-1 beta-blocker glaucoma medications is $1.48 per milliliter.
- **Timoptic-XE® (timolol maleate ophthalmic gel-forming solution)** is a beta-blocker indicated for the treatment of elevated IOP in patients with ocular hypertension or open-angle glaucoma. Timolol maleate ophthalmic gel-forming solution is available as a generic product, and its current SMAC is $21.05 per milliliter. The average cost of other available Tier-1 beta-blocker glaucoma medications is $1.48 per milliliter.
- **Betimol® (timolol ophthalmic solution)** is a beta-blocker indicated for the treatment of elevated IOP in patients with ocular hypertension or open-angle glaucoma. Generic timolol maleate ophthalmic solution is available as a Tier-1 product; however, there is not a therapeutic equivalent to Betimol® currently available. Betimol® is not a supplementally rebated product, and its current estimated acquisition cost (EAC) is $14.23 per milliliter. The average cost of other available Tier-1 beta-blocker glaucoma medications is $1.48 per milliliter.
- **Discontinued Medications:** Using the U.S. Food and Drug Administration (FDA) website for FDA approved drug products, the following medications were determined to be discontinued: **Propine® (dipivefrin), Rescula® (unoprostone), and Izba® (travoprost 0.003%)**.

Recommendations

The College of Pharmacy recommends the following changes to the Glaucoma Medications Product Based Prior Authorization (PBPA) category:

1. Move betaxolol ophthalmic solution (Betoptic®) and timolol maleate ophthalmic gel-forming solution (Timoptic-XE®) to Tier-2 based on an increased state maximum allowable cost (SMAC). The existing Tier-2 criteria for this category will apply.
2. Move Betimol® (timolol ophthalmic solution) to Tier-2 based on increased net cost. The existing Tier-2 criteria for this category will apply.
3. Update the Glaucoma Medications tier chart to remove the discontinued medications: Propine® (dipivefrin), Rescula® (unoprostone), and Izba® (travoprost 0.003%).

Glaucoma Medications*	
Tier-1	**Tier-2**
Beta-Blockers	
carteolol (Ocupress® 1%)	betaxolol (**Betoptic®,** Betoptic-S®)
dorzolamide/timolol (Cosopt®)	brimonidine/timolol (Combigan®)
levobunolol (Betagan®)	dorzolamide/timolol (Cosopt® PF)
metipranolol (OptiPranolol®)	**timolol (Betimol®)**
timolol maleate (Istalol®, Timoptic®)	timolol maleate (**Timoptic-XE®,** Timoptic Ocudose®)
Prostaglandin Analogs	
latanoprost (Xalatan®)	bimatoprost (Lumigan®)
travoprost 0.004% (Travatan-Z®)	tafluprost (Zioptan™)
	travoprost 0.004% (Travatan®)
	~~**unoprostone (Rescula®)**~~
	~~**travoprost 0.003% (Izba®)**~~
Adrenergic Agonists	
~~**dipivefrin (Propine®)**~~	
Alpha-2 Adrenergic Agonists	
brimonidine 0.2%	apraclonidine (Iopidine®)
brinzolamide/brimonidine (Simbrinza™)	brimonidine (Alphagan-P® 0.1%, 0.15%)
	brimonidine/timolol (Combigan®)
Carbonic Anhydrase Inhibitors	
acetazolamide (Diamox®)[+]	dorzolamide/timolol (Cosopt® PF)
dorzolamide/timolol (Cosopt®)	
dorzolamide (Trusopt®)	
brinzolamide (Azopt®)	
brinzolamide/brimonidine (Simbrinza™)	
methazolamide (Neptazane®)[+]	
([+]Indicates Available Oral Products)	
Cholinergic Agonists/Cholinesterase Inhibitors	
pilocarpine (Isopto® Carpine, Pilopine HS®)	carbachol (Miostat® 0.01%)
	echothiophate iodide (Phospholine Iodide®)

*Tier structure based on State Maximum Allowable Cost (SMAC) and/or supplemental rebate participation. Please note, combination products are included in both applicable pharmaceutical classes; therefore, are each listed twice in the tier chart.

[1] Betimol® Package Insert. Medlibrary.org. Available online at: http://medlibrary.org/lib/rx/meds/betimol/. Last revised 03/18/2010. Last accessed 08/26/2016.
[2] Betoptic® Package Insert. Medlibrary.org. Available online at: http://medlibrary.org/lib/rx/meds/betoptic/. Last revised 10/30/2006. Last accessed 08/26/2016.
[3] Timoptic-XE® Package Insert. Medlibrary.org. Available online at: http://medlibrary.org/lib/rx/meds/timoptic-xe/. Last revised 10/27/2011. Last accessed 08/26/2016.
[4] Drugs@FDA: FDA Approved Drug Products. Available online at: http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm. Last revised 07/26/2016. Last accessed 08/29/2016.

Appendix F

Vote to Prior Authorize Nasarel® (Flunisolide Nasal Spray)

Oklahoma Health Care Authority
September 2016

Introduction[1]

The medications in the Nasal Allergy Product Based Prior Authorization (PBPA) category have experienced a number of changes since October 2013, beginning with the U.S. Food and Drug Administration (FDA) approval of over-the-counter (OTC) Nasacort® (triamcinolone acetonide). This approval ultimately led to the removal of Nasacort® from the Nasal Allergy PBPA. Since 2014, a total of four nasal allergy products were granted generic product approval by the FDA. In July 2014, Flonase® (fluticasone), and in March 2015, Rhinocort® Allergy (budesonide), were granted OTC approval.

Generic price increases have impacted the category as well. The state maximum allowable cost (SMAC) for flunisolide nasal spray is $1.88 per milliliter or $47.00 for a 25mL bottle. In striking contrast, the other Tier-1 nasal allergy product, fluticasone has a SMAC of $0.36 per gram or $5.76 for a 16g bottle.

Recommendations

The College of Pharmacy recommends the following changes to the Nasal Allergy Product Based Prior Authorization (PBPA) category:

1. Move Astelin® (azelastine) and Qnasl® 80mcg (beclomethasone) from Tier-3 to Tier-2 based on SMAC and net costs after rebates. The existing criteria for this category will apply.
2. Move flunisolide (Nasalide®, Nasarel®) from Tier-1 to Tier-3 based on increases in SMAC. The existing criteria for this category will apply.
3. Move beclomethasone (Beconase® AQ) from Tier-2 to Tier-1 based on net costs after rebates.
4. Initiate a prescriber/pharmacy mailing or fax to inform providers of Nasal Allergy PBPA category changes.

Nasal Allergy Medications*		
Tier-1	**Tier-2**	**Tier-3**
beclomethasone (Beconase® AQ)	**azelastine (Astelin®)**	azelastine (Astepro®)
fluticasone (Flonase®)	**beclomethasone (Qnasl® 80mcg)**	azelastine/fluticasone (Dymista®)
		beclomethasone (Qnasl® 40mcg)
		budesonide (Rhinocort AQ®)
		ciclesonide (Omnaris®, Zetonna®)
		flunisolide (Nasalide®, Nasarel®)
		fluticasone (Veramyst®)
		mometasone (Nasonex®)
		olopatadine (Patanase®)

*Tier structure based on rebate participation and/or state maximum allowable cost (SMAC).

Nasal Allergy Medications Tier-2 Approval Criteria:

1. Failure with all Tier-1 medications defined as no beneficial response after at least three weeks use at the maximum recommended dose; or
2. Documented adverse effect or contraindication to all Tier-1 medications.
3. No grandfathering of Tier-2 or Tier-3 medications will be allowed for this category.
4. For 2 to 4 year old members, the age-appropriate, lower-tiered generic medications must be tried prior to the approval of higher tiered medications.
5. Approvals will be for the duration of three months, except for members with chronic diseases such as asthma or chronic obstructive pulmonary disease (COPD), in which case authorizations will be for the duration of one year.

Nasal Allergy Medications Tier-3 Approval Criteria:

1. All Tier-2 criteria must be met; and
2. Failure with all available Tier-2 medications defined as no beneficial response after at least three weeks use at the maximum recommended dose; or
3. Documented adverse effect or contraindication to all Tier-2 medications.
4. No grandfathering of Tier-2 or Tier-3 medications will be allowed for this category.
5. For 2 to 4 year old members, the age-appropriate, lower-tiered generic medications must be tried prior to the approval of higher tiered medications.
6. Approvals will be for the duration of three months, except for members with chronic diseases such as asthma or COPD, in which case authorizations will be for the duration of one year.

[1] Drugs@FDA: FDA Approved Drug Products. Available online at: http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction=Reports.MonthlyApprovalsAll. Last updated 08/26/2016. Last accessed 08/26/2016.

Appendix G

Vote to Prior Authorize Ocaliva™ (Obeticholic Acid)

Oklahoma Health Care Authority
September 2016

Introduction[1]

Ocaliva™ (obeticholic acid) is indicated for the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA, or as monotherapy in adults unable to tolerate UDCA. Obeticholic acid is a farnesoid X receptor (FXR) agonist. FXR is a key regulator of bile acid, inflammatory, fibrotic, and metabolic pathways. FXR activation decreases the intracellular hepatocyte concentrations of bile acids by suppressing new synthesis from cholesterol as well as by increased transport of bile acids out of the hepatocytes. These mechanisms limit the overall size of the circulating bile acid pool while promoting secretion of bile by the liver, thus reducing hepatic exposure to bile acids. The recommended starting dose is 5mg once daily. Dosing should be titrated to the maximum recommended dose of 10mg daily if adequate reduction in alkaline phosphatase and/or total bilirubin has not been achieved after three months.

Recommendations

The College of Pharmacy recommends the prior authorization of Ocaliva™ (obeticholic acid) with the following criteria:

Ocaliva™ (Obeticholic Acid) Approval Criteria:

1. An FDA approved diagnosis of primary biliary cholangitis (PBC); and
2. Member must have taken ursodeoxycholic acid (UDCA) at an appropriate dose for at least one year and prescriber must confirm a lack of improvement in liver function tests, lack of superimposed liver disease, proper timing of bile acid sequestrants if co-administered with UDCA (four hours before or four hours after), and patient compliance with UDCA; and
3. Ocaliva™ must be taken in combination with UDCA. For Ocaliva™ monotherapy consideration, the prescriber must document a patient-specific, clinically significant reason why the member is unable to take UDCA; and
4. A quantity limit of one tablet daily will apply.

[1] Ocaliva™ Prescribing Information. Intercept Pharmaceuticals, Inc. Available online at: https://ocaliva.com/ocaliva_pi.pdf. Last revised 05/2016. Last accessed 08/26/2016.

Appendix H

Vote to Prior Authorize Belbuca™ (Buprenorphine Buccal Film), Dolophine® (Methadone), MorphaBond™ (Morphine Extended-Release), Xtampza™ ER (Oxycodone Extended-Release), & Probuphine® (Buprenorphine Implant)

Oklahoma Health Care Authority
September 2016

Introduction[1,2,3,4,5,6]

- **Center for Medicaid and Chip Services (CMCS) Bulletin:** The Centers for Medicare and Medicaid Services (CMS) issued a CMCS informational bulletin regarding Medicaid strategies for preventing opioid-related harms. The bulletin specifically highlighted methods states could use to target prescribing of methadone for pain relief due to the disproportionate share of opioid-related overdose deaths associated with methadone when used for pain. States are encouraged to consider additional steps to reduce the use of methadone prescribed for pain relief in order to reduce prescription opioid-related harms including reassessing preferred drug list placement, introducing clinical criteria, prior authorization, step therapy, and quantity limits.
- **Belbuca™ (buprenorphine buccal film)** is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Belbuca™ is available as a buccal film supplied in cartons of 60 individual child-resistant foil packages in the following strengths: 75mcg, 150mcg, 300mcg, 450mcg, 600mcg, 750mcg, and 900mcg. Belbuca™ should be applied to the buccal mucosa every 12 hours.
- **MorphaBond™ (morphine extended-release)** is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. MorphaBond™ is available as oral extended-release tablets in the following strengths: 15mg, 30mg, 60mg, and 100mg. MorphaBond™ is administered orally every 12 hours.
- **Xtampza™ ER (oxycodone extended-release)** is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Xtampza™ ER is available as oral extended-release capsules in the following strengths (strengths are in oxycodone base): 9mg, 13.5mg, 18mg, 27mg, and 36mg. Xtampza™ ER is administered by mouth every 12 hours with food.
- **Probuphine® (buprenorphine implant)** is a partial opioid agonist indicated for the maintenance treatment of opioid dependence in patients who have achieved and sustained prolonged clinical stability on low-to-moderate doses of a transmucosal buprenorphine containing products (i.e., doses of no more than 8mg per day of Subutex® or Suboxone® sublingual tablet or equivalent). Probuphine® is not appropriate for new entrants to treatment. Probuphine® is available as a kit containing four implants and one applicator. Each dose consists of four Probuphine® implants inserted subdermally under

aseptic conditions in the inner side of the upper arm. Probuphine® subdermal implants are intended to be in place for six months of treatment and removed by the end of the sixth month.

- In July 2015 the U.S. Food and Drug Administration (FDA) announced that Pfizer has discontinued **Avinza® (morphine extended-release capsules)**. The company decided to remove Avinza® from the market since it does not have abuse-deterrent properties; Pfizer also makes Embeda® (morphine extended-release/naltrexone), an abuse-deterrent formulation of morphine extended-release.

Recommendations

The College of Pharmacy recommends the following:

1. The placement of Belbuca™ (buprenorphine buccal film), MorphaBond™ (morphine extended-release), and Xtampza™ ER (oxycodone extended-release) into Tier-3 of the Opioid Analgesics Product Based Prior Authorization (PBPA) category. Current Tier-3 criteria for this category will apply.
2. Moving methadone from Tier-1 to Tier-3 of the Opioid Analgesics PBPA category based on CMS recommendations and the disproportionate share of opioid-related overdose deaths associated with methadone when used for pain. Current Tier-3 criteria for this category will apply.
3. The prior authorization of Probuphine® (buprenorphine implant) with the criteria listed in red.

Probuphine® (Buprenorphine Implant) Approval Criteria:

1. An FDA approved diagnosis of maintenance treatment of opioid dependence; and
2. Members must be currently on a maintenance dose of 8mg per day or less of a Subutex® or Suboxone® sublingual tablet or its transmucosal buprenorphine product equivalent; and
3. Member must have been stable on current transmucosal buprenorphine dose (of 8mg per day or less) for three months or longer without any need for supplemental dosing or adjustments; and
4. Members must have had no positive urine toxicology results or paid claims for opioids for the last three months. Concomitant treatment with opioids (including tramadol) will be denied; and
5. Probuphine® must be prescribed by a licensed physician who qualifies for a waiver under the Drug Addiction Treatment Act (DATA) and has notified the Center for Substance Abuse Treatment of the intention to treat addiction patients and has been assigned a DEA (X) number; and
6. Prescribers must verify they have considered the following factors in determining clinical stability and suitability for Probuphine®:
    a. Period free from illicit opioid drug use
    b. Stability of living environment
    c. Participation in a structured activity/job
    d. Consistency in participation in recommended behavioral therapy/peer support program
    e. Consistency in compliance with clinic visit requirements

f. Minimal to no desire or need to use illicit opioids
g. Period without episodes of hospitalizations (addiction or mental health issues), emergency room visits, or crisis interventions
h. Social support system

7. The prescriber must verify enrollment in the Probuphine® Risk Evaluation and Mitigation Strategy (REMS) program; and
8. Approvals will be for one kit (four implants) per six months. Reauthorizations for an additional six months may be granted if the member does not have ongoing use of supplemental dosing with transmucosal buprenorphine or opioid analgesics while utilizing Probuphine®.

Opioid Analgesics*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
Long-Acting: oxycodone ER 10mg, 15mg, 20mg only (Oxycontin®)◊ **Short-Acting:** ASA/butalbital/caffeine/codeine (Fiorinal with Codeine®) codeine codeine/APAP hydrocodone/APAP (Norco®) hydrocodone/IBU (Vicoprofen®, Ibudone®, Reprexain™) hydromorphone (Dilaudid®) morphine IR (MSIR®) oxycodone IR (Oxy IR®) oxycodone/APAP (Percocet®) oxycodone/ASA (Percodan®) oxycodone/ibuprofen (Combunox™) tramadol/APAP (Ultracet®) tramadol (Ultram®)	**Long-Acting:** buprenorphine (Butrans®) fentanyl patches (Duragesic®) hydrocodone bitartrate ER (Hysingla™ ER) morphine ER tablets (MS Contin®) oxycodone ER (Oxycontin®)◊ **Short-Acting:** oxymorphone IR (Opana®) tapentadol IR (Nucynta®)	**Long-Acting:** **buprenorphine ER buccal film (Belbuca™)** hydrocodone bitartrate ER (Zohydro™ ER) hydromorphone ER (Exalgo®) **methadone (Dolophine®)** ~~**morphine sulfate ER (Avinza®)**~~ morphine sulfate ER (Kadian®) **morphine sulfate ER (MorphaBond™)** morphine/naltrexone (Embeda®) **oxycodone ER (Xtampza™ ER)** oxymorphone (Opana® ER)+ tapentadol ER (Nucynta® ER) tramadol ER (Ultram ER®, Ryzolt®) **Short-Acting:** hydrocodone/APAP (Xodol®, Zamicet®, Liquicet®) hydrocodone/APAP/caffeine (Trezix™) oxycodone/APAP (Primlev™, Xolox®) oxycodone (Oxecta®)	**Long-Acting:** oxycodone/APAP ER (Xartemis™ XR) **Oncology Only:** fentanyl transmucosal lozenge (Actiq®) fentanyl buccal tablet (Fentora®) fentanyl buccal film (Onsolis®) fentanyl sublingual tablet (Abstral®) fentanyl nasal spray (Lazanda®) fentanyl sublingual spray (Subsys™)

APAP = Acetaminophen, ASA = Aspirin, IBU = Ibuprofen, IR = Immediate-Release, ER = Extended-Release
*Tier Structure based on supplemental rebate participation and/or state maximum allowable cost. Tier-2 medications subject to move to Tier-3.
◊ Brand name preferred.
+Brand name Opana® ER preferred. Generic oxymorphone extended-release tablets require special authorization. The generic formulation is not abuse-deterrent.

- Tier-1 products are covered with no prior authorization necessary.
- Members with an oncology-related diagnosis are exempt from the prior authorization process, and do not require pain contracts.
- Only one long-acting and one-short acting agent can be used concurrently.

- Short-acting, solid dosage formulation products are limited to a quantity of four units per day or a quantity of 120 units per 30 days.
- An age restriction applies on oral liquid narcotic analgesic products for all members older than 12 years of age and oral solid dosage forms for all members younger than 10 years of age.

Opioid Analgesics Tier-2 Approval Criteria:

1. A documented 30-day trial/titration period with at least one Tier-1 medication(s) within the last 90 days is required for a Tier-2 long-acting medication; or
2. A documented 30-day trial with at least two Tier-1 short-acting medications within the last 90 days is required for a Tier-2 short-acting medication; or
3. A chronic pain diagnosis requiring time-released medication (for long-acting medication requests).

Opioid Analgesics Tier-3 Approval Criteria:

1. A documented 30-day trial with at least two Tier-2 long-acting medications within the last 90 days is required for approval of a long-acting Tier-3 medication; or
2. A documented 30-day trial with at least two Tier-2 short-acting medications within the last 90 days is required for approval of a Tier-3 short-acting medication; or
3. A documented allergy or contraindication to all available Tier-2 medications.

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[1] Wachino Vikki. Centers for Medicare and Medicaid Services. CMCS Informational Bulletin: Best Practices for Addressing Opioid Overdoses, Misuse and Addiction. Available online at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-02-02-16.pdf. Issued 01/28/2016. Last accessed 08/22/2016.

[2] Belbuca™ Prescribing Information. Endo Pharmaceuticals, Inc. Available online at: http://www.endo.com/File%20Library/Products/Prescribing%20Information/BELBUCA_prescribing_information.html. Last revised 12/2015. Last accessed 08/22/2016.

[3] MorphaBond™ Prescribing Information. Inspirion Delivery Technologies. Available online at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2015/206544lbl.pdf. Last revised 10/2015. Last accessed 08/22/2016.

[4] Xtampza™ ER Prescribing Information. Patheon Pharmaceuticals. Available online at: http://www.collegiumpharma.com/uploads/downloads/Xtampza-ER-Full-Prescribing-Information.pdf. Last revised 04/2016. Last accessed 08/22/2016.

[5] Probuphine® Prescribing Information. Braeburn Pharmaceuticals, Inc. Available online at: https://braeburnpharmaceuticals.com/wp-content/uploads/2016/05/Probuphine-Full-Prescribing-Information.pdf. Last revised 05/2016. Last accessed 08/22/2016.

[6] MPR. FDA: Narcotic Painkiller No Longer Available. Available online at: http://www.empr.com/news/avinza-discontinued/article/426124/. Issued 07/13/2015. Last accessed 08/22/2016.

Appendix I

Vote to Prior Authorize Vivlodex™ (Meloxicam Capsules)

Oklahoma Health Care Authority
September 2016

Introduction[1]

- Vivlodex™ (meloxicam capsules) is a nonsteroidal anti-inflammatory drug (NSAID) indicated for management of osteoarthritis (OA) pain. Like other NSAIDs, Vivlodex™ has a boxed warning for increased risk of cardiovascular thrombotic events and gastrointestinal bleeding, ulceration, and perforation. Vivlodex™ is available as oral capsules in the following strengths: 5mg and 10mg. The recommended dose for the management of osteoarthritis pain is 5mg by mouth once daily. The dose may be increased to 10mg daily in patients who require additional analgesia. The maximum recommended dose is 10mg daily. Patients should use the lowest effective dose for the shortest duration consistent with individual patient treatment goals.

Recommendations

The College of Pharmacy recommends the following:

1. The placement of Vivlodex™ (meloxicam capsules) into the Special Prior Authorization (PA) Tier of the NSAID Product Based Prior Authorization (PBPA) category. Current Special PA criteria for this category will apply.
2. The addition of an age restriction on meloxicam suspension. Members older than 7 years of age would require a reason why they need the liquid formulation and cannot use the oral tablet formulation.
3. Move indomethacin 25mg and 50mg immediate-release capsules from the Special PA Tier to Tier-1. A quantity limit of eight tablets per day would apply. The suspension and extended-release formulation would remain in the Special PA Tier.
    a. Indomethacin capsules were previously included in the Special PA Tier due to a poor adverse effect profile compared to other NSAIDs. Due to the low net cost of indomethacin and similar adverse effect profile to other non-selective NSAIDs the College of Pharmacy recommends moving indomethacin to Tier-1.
4. Move piroxicam capsules from the Special PA Tier to Tier-2 based on decreases in state maximum allowable cost (SMAC). The current Tier-2 criteria for this category will apply.

Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)		
Tier-1	**Tier-2**	**Special PA**
diclofenac ER (Voltaren® XR)	celecoxib (Celebrex®)	diclofenac (Zorvolex®)
diclofenac potassium (Cataflam®)	diclofenac sodium/ misoprostol (Arthrotec®)	diclofenac epolamine (Flector® patch)
diclofenac sodium (Voltaren®) 50mg and 75mg tablets	diclofenac sodium (Voltaren®) 25mg tablets	diclofenac potassium (Cambia® powder pack)
etodolac (Lodine®) 400mg and 500mg tablets	etodolac (Lodine®) 200mg and 300mg capsules	diclofenac potassium (Zipsor® capsule)
flurbiprofen (Ansaid®)	etodolac ER (Lodine® XL)	diclofenac sodium (Dyloject™)
ibuprofen (Motrin®)	fenoprofen (Nalfon®)	diclofenac sodium (Pennsaid® topical drops)
indomethacin immediate-release capsules (Indocin®)	meclofenamate (Meclomen®)	diclofenac sodium (Voltaren Gel®)
ketoprofen (Orudis®)	naproxen sodium (Anaprox®) 275mg and 550mg tablets	ibuprofen/famotidine (Duexis®)
meloxicam (Mobic®)	oxaprozin (Daypro®)	**indomethacin suspension and extended-release capsules (Indocin®)**
nabumetone (Relafen®)	**piroxicam (Feldene®)**	indomethacin (Tivorbex™)
naproxen (Naprosyn®)	tolmetin (Tolectin®)	ketoprofen ER (Oruvail®)
naproxen EC (Naprosyn®)		mefenamic acid (Ponstel®)
sulindac (Clinoril®)		**meloxicam capsules (Vivlodex™)**
		naproxen sodium ER (Naprelan®)
		naproxen/esomeprazole (Vimovo®)

ER = Extended-Release, EC = Enteric Coated
Tier structure based on supplemental rebate participation and/or state maximum allowable cost.

NSAIDs Tier-2 Approval Criteria:

1. Previous use of at least two Tier-1 NSAID products (from different product lines) plus a proton pump inhibitor (PPI) within the last 120 days; or
2. For those with a prior gastrointestinal (GI) bleed who must have an NSAID, a Tier-2 product may be approved (celecoxib should be taken with a PPI).

NSAIDs Special Prior Authorization (PA) Approval Criteria:

1. A unique indication for which a Tier-1 or Tier-2 medication is not appropriate; or
2. Previous use of at least two Tier-1 NSAID products (from different product lines); and
3. A patient-specific, clinically significant reason why a special formulation is needed over a Tier-1 product.
4. Additionally, use of Tivorbex™ will require a patient-specific, clinically significant reason why the member cannot use all other available generic indomethacin products.

[1] Vivlodex™ Prescribing Information. Iroko Pharmaceuticals, Inc. Available online at: https://www.iroko.com/wp-content/uploads/2015/10/vivlodex-prescribing-information.pdf. Last revised 10/2015. Last accessed 08/29/2016.

Appendix J

Annual Review of Prednisolone Special Formulations and 30-Day Notice to Prior Authorize Millipred™ (Prednisolone Sodium Phosphate Oral Solution 10mg/5mL)

Oklahoma Health Care Authority
September 2016

Introduction[1,2,3]

The Drug Utilization Review (DUR) board voted to prior authorize Veripred™ 20 (prednisolone sodium phosphate oral solution 20mg/5mL) and Orapred ODT® (prednisolone sodium phosphate orally disintegrating tablet) in March 2013. The prior authorization of Orapred ODT® was implemented in 2013, however the prior authorization of Veripred™ 20 was not implemented until October 2015. In March 2013, the estimated acquisition cost (EAC) of Veripred™ 20 was $0.89 per mL and although higher in cost, it did not significantly differ from other prednisolone oral solutions. Since that time the price per milliliter of Veripred™ 20 has increased by 500% resulting in a cost of $5.34 per milliliter. Similarly, the EAC of Millipred™ (prednisolone sodium phosphate oral solution 10mg/5mL) increased from $0.35 per milliliter to $3.75 per milliliter, an increase of 971%.

Millipred™ and Veripred 20™ have an average cost of $321.00 for a 10 day course of treatment. Alternative generic products are readily available and have an average cost of $56.83 for a 10 day course of treatment.* The generic preparations available have been noted to have an extremely bitter taste leading to poor patient compliance, particularly when given to pediatric patients. Additionally, some generic formulations contain alcohol; both Veripred™ 20 and Millipred™ are alcohol-free formulations.

Several additives have been shown to improve palatability and potentially compliance when combined with prednisolone including: chocolate syrup, simple syrup, orange juice, and lemon-lime carbonated beverages. Changes in administration techniques may also improve the palatability of prednisolone including the following:

- Using a popsicle/ice to temporarily numb the mouth prior to administration
- Using an oral syringe to administer dose to far back and side of mouth

Prescribers may also consult local pharmacies regarding several alcohol-free, generic formulations which are available for pediatric patients without prior authorization. Immediate-release, oral tablet formulation glucocorticoids are also available without prior authorization for members who can swallow tablets. Additionally, one study found children age 5 to 12 years show a demonstrated taste preference for liquid dexamethasone over liquid prednisolone.

*Costs based on a regimen of 20mg prednisolone per day for 10 days for both brand and generic estimates.

Current Prior Authorization Criteria

Veripred™ 20 (Prednisolone Sodium Phosphate Oral Solution 20mg/5mL) Approval Criteria:

1. Authorization of Veripred™ 20 requires a patient-specific, clinically significant reason why the member cannot use a tablet or an alternative strength liquid formulation.

Orapred ODT® (Prednisolone Sodium Phosphate Orally Disintegrating Tablet)
Approval Criteria:

1. Approval requires a patient-specific, clinically significant reason why the member cannot use prednisone tablets.
2. A quantity limit of 10 tabs per 30 days will be available without prior authorization for members 10 years or younger.

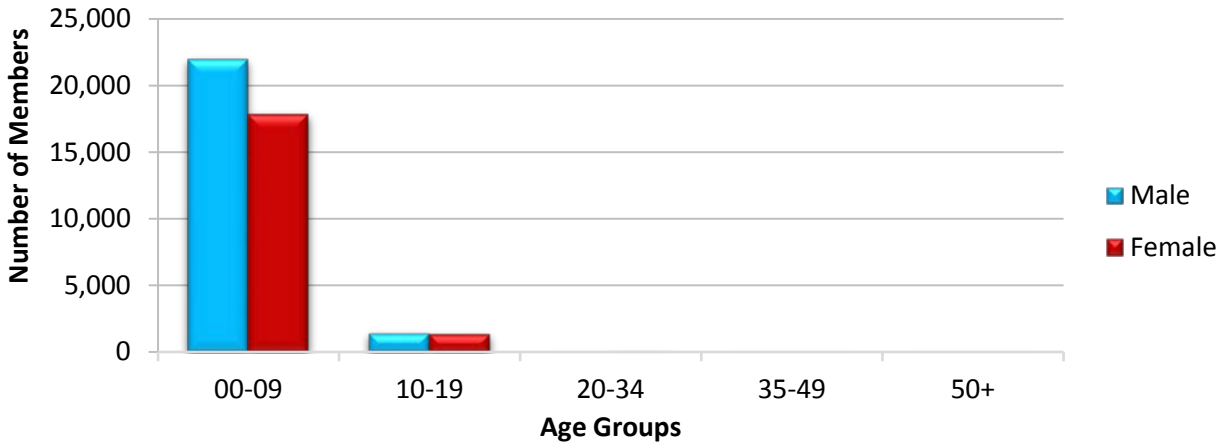
Utilization of Prednisolone Special Formulations: October 1, 2015 through March 31, 2016

Comparison of Seasons: October 1st through March 31st

Season	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
Oct 2014-Mar 2015	39,625	50,631	$1,634,355.56	$32.28	$5.84	2,054,983	279,782
Oct 2015-Mar 2016	42,670	54,604	$602,166.93	$11.03	$2.00	2,107,367	301,621
% Change	7.68%	7.85%	-63.16%	-65.83%	-65.75%	2.55%	7.81%
Change	3,045	3,973	-$1,032,188.63	-$21.25	-$3.84	52,384	21,839

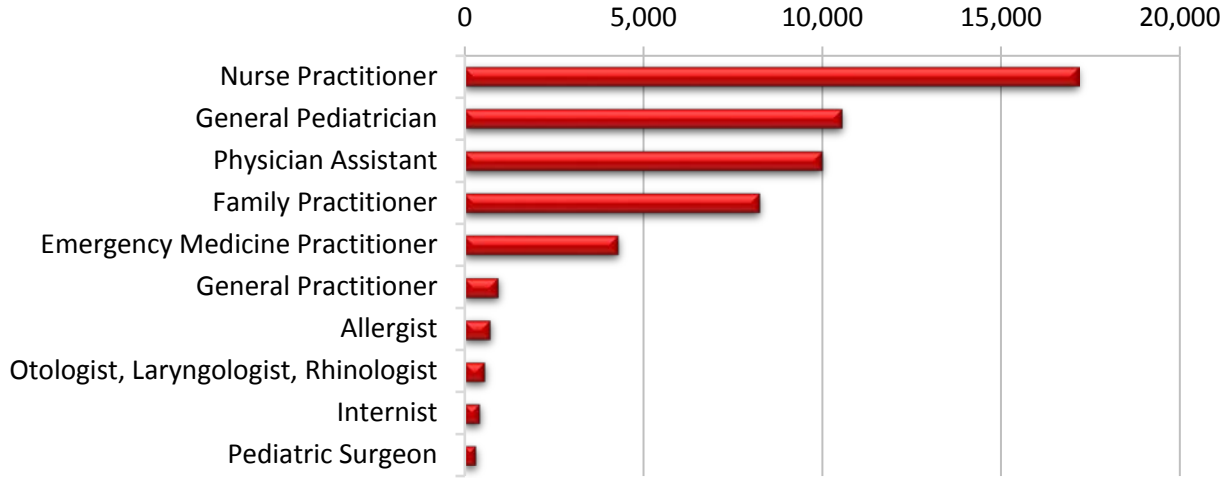
*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.
Table includes data for generic prednisolone solutions/syrups, Millipred™, Veripred™ 20, prednisolone ODT, and dexamethasone oral solutions/elixirs/concentrates.

Demographics of Members Utilizing Prednisolone Special Formulations: October 1, 2015 through March 31, 2016◊



◊Demographics for the October 2014-March 2015 season were similar.

Top Prescriber Specialties of Prednisolone Special Formulations by Number of Claims: October 1, 2015 through March 31, 2016∞

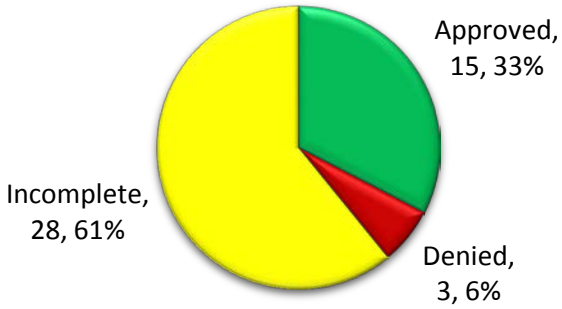


∞Prescriber specialties for the October 2014-March 2015 season were similar.

Prior Authorization of Prednisolone Special Formulations

There were 46 prior authorization requests submitted for prednisolone special formulations from October 1, 2015 through March 31, 2016. During the previous 2014-2015 season there were 21 prior authorization requests submitted for prednisolone special formulations. The prior authorization of Millipred™ and Veripred™ 20 was implemented October 1, 2015. These results indicate there was not a large increase in prior authorization requests despite prior authorization implementation of medications with a large number of claims. The following chart shows the status of the submitted petitions for the 2015-2016 season.

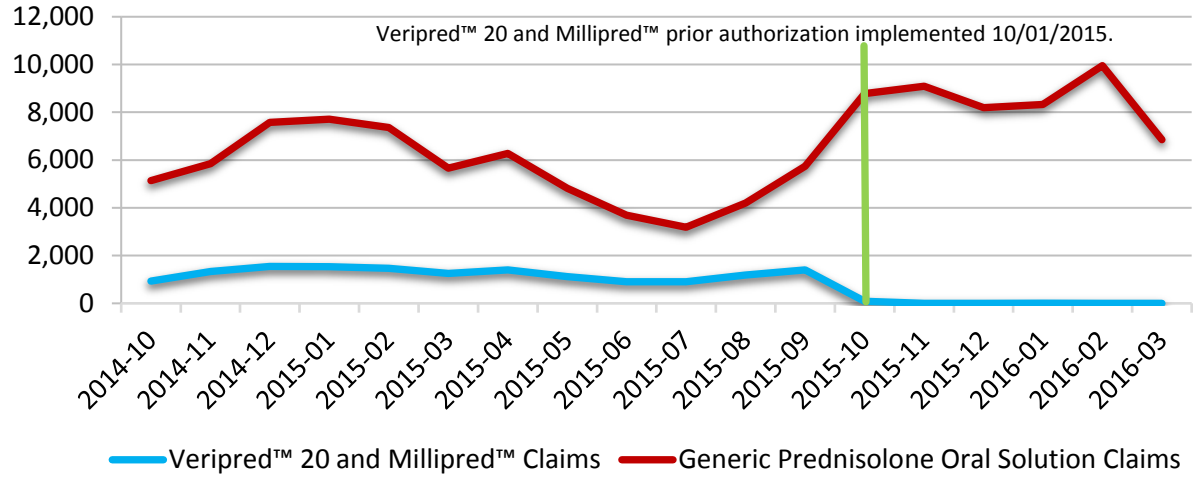
Status of Petitions



Prednisolone Special Formulations Claims Analysis

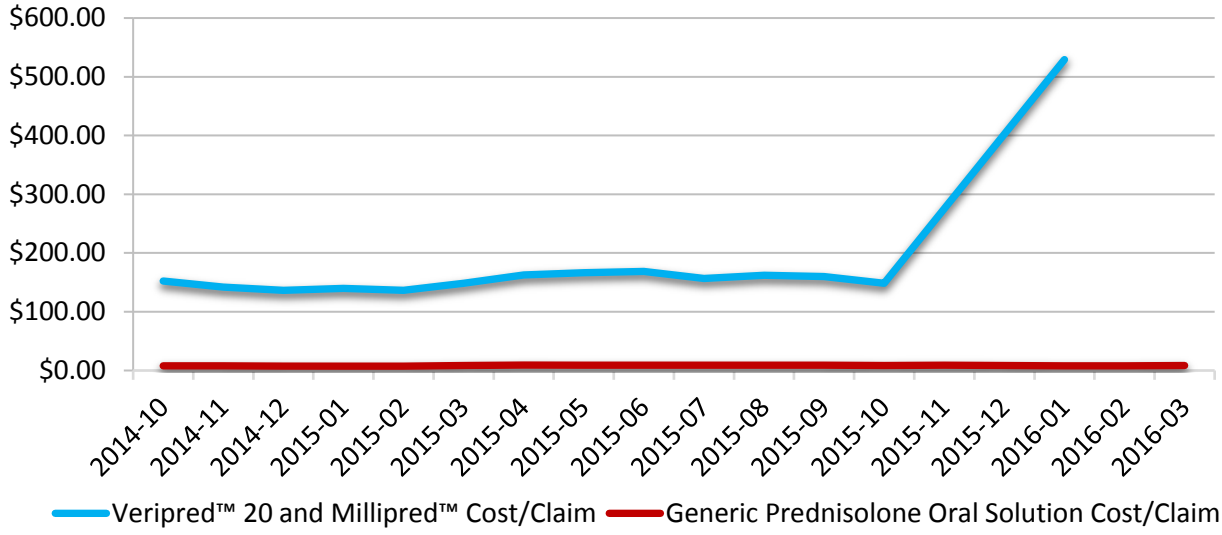
The following line graph shows the number of claims for Veripred™ 20 and Millipred™ in comparison to the generic prednisolone oral solutions from October 1, 2014 to March 31, 2016. The prior authorization implementation of Veripred™ 20 and Millipred™ is noted on the chart. A decrease in claims for Veripred™ 20 and Millipred™ can be seen following prior authorization along with a corresponding increase in claims for the non-prior authorized generic prednisolone oral solutions.

Prednisolone Claims Comparison: October 1, 2014 through March 31, 2016



The following line graph shows the average cost per claim for Veripred™ 20 and Millipred™ in comparison to the generic prednisolone oral solutions from October 1, 2014 to March 31, 2016. The average cost per claim over the time frame noted for Veripred™ 20 and Millipred™ was $179.36 compared to $8.47 for the generic prednisolone oral solution products.

Prednisolone Cost Per Claim Comparison: October 1, 2014 through March 31, 2016



Veripred™ 20 and Millipred™ are both alcohol-free medications. Some generic prednisolone oral solution products are alcohol-free while the remainder contain anywhere from 1.8% to 5% alcohol. If prescribers are concerned about the alcohol content of a generic prednisolone oral solution, they would have to work with their pharmacy to ensure an alcohol-free, generic formulation was selected. The following table shows the number of claims and percentage of use of alcohol-free prednisolone oral solution products comparing the season before the prior authorization was implemented to the season when the prior authorization was in effect.

Alcohol-Free Prednisolone Oral Solution Product Analysis		
Parameter	**10/01/2014-03/31/2015**	**10/01/2015-03/31/2016**
Alcohol-Free Generic Claims	8,327	14,868
Veripred™ 20 and Millipred™ Claims	5,910	82
Total Count of Alcohol-Free Claims	14,237	14,950
Cost of All Alcohol-Free Claims	$957,138.01	$161,976.69
Total Prednisolone Oral Solution Claims	50,631	54,604
Percentage of Alcohol-Free Claims	28.12%	27.38%

Despite implementation of prior authorization of two alcohol-free products, Veripred™ 20 and Millipred™, the number of claims for alcohol-free, generic prednisolone oral solution products increased significantly leading to an increase in overall alcohol-free claims without a significant change in the overall percentage of alcohol-free claims. The most significant change can be seen in the cost difference of the alcohol-free claims between the two seasons.

The poor palatability of the generic prednisolone oral solution products may reduce compliance and subsequently increase emergency room visits for asthma patients unwilling to take them. Emergency room visits were evaluated by season, October 1st to March 31st, both before and after prior authorization. Members 10 years and younger were included in the analysis if they had a paid claim for a prednisolone oral solution (brand or generic) product within 10 days prior to a claim for an emergency room visit which listed asthma in one of the first three diagnosis fields. The proportion of emergency room visits for patients receiving a prednisolone oral solution medication remained similar in the season post prior authorization implementation (Pre: 0.45% to Post: 0.43%).

Millipred™ (Prednisolone Sodium Phosphate Oral Solution 10mg/5mL) Product Summary[4]

Indications: Millipred™ (prednisolone sodium phosphate oral solution 10mg/5mL) is indicated for the following:

- Allergic States
- Dermatologic Diseases
- Edematous States
- Endocrine Disorders
- Gastrointestinal Disease
- Hematologic Disorders
- Neoplastic Diseases
- Nervous System (Multiple Sclerosis exacerbations)
- Ophthalmic Diseases
- Respiratory Diseases
- Rheumatic Disorders
- Miscellaneous

Dosing:

- Millipred™ is available as a grape flavored oral solution; each 5mL contains 13.4mg prednisolone sodium phosphate (10mg prednisolone base).
- The recommended initial dose of Millipred™ oral solution should be individualized depending on the disease being treated and patient response. Typical doses range from 5mg to 60mg prednisolone base per day.
- The National Heart, Lung, and Blood Institute (NHLBI) recommended dosing for systemic prednisolone in children whose asthma is uncontrolled by inhaled corticosteroids and

long-acting bronchodilators is 1 to 2mg/kg/day in single or divided doses. Short course, or "burst" therapy, should be continued until a child achieves a peak expiratory flow rate of 80% of their personal best or symptoms resolve. This usually requires 3 to 10 days of treatment. There is no evidence that tapering the dose after improvement will prevent a relapse.

Cost Comparison:

Product	Strength	Cost Per mL	Cost Per 10 Days[Δ]	Average Cost Per Claim in FY2016
Millipred™ oral solution	**10mg/5mL**	**$3.75[+]**	**$375.00**	**$151.11**
Veripred™ 20 oral solution	20mg/5mL	$5.34[+]	$267.00	$173.98
prednisolone oral solution	5mg/5mL	$0.61*	$122.00[◊]	$32.84
prednisolone oral solution	15mg/5mL	$0.11*	$7.70	$7.62
prednisolone oral solution	25mg/5mL	$1.02*	$40.80	$34.69

Costs do not reflect rebated prices or net costs.
[+]Costs based on estimated acquisition cost (EAC).
*Costs based on state maximum allowable cost (SMAC).
[Δ]Costs based on a regimen of 20mg prednisolone per day for 10 days.
[◊]Members requiring 20mg doses would typically use a higher strength solution to limit volume of solution required.

Recommendations

The College of Pharmacy recommends the prior authorization of Millipred™ (prednisolone sodium phosphate oral solution 10mg/5mL) with criteria similar to Veripred™ 20 (prednisolone sodium phosphate oral solution 20mg/5mL). The recommended criteria can be seen below with additions noted in red.

Veripred™ 20 (Prednisolone Sodium Phosphate Oral Solution 20mg/5mL) and Millipred™ (Prednisolone Sodium Phosphate Oral Solution 10mg/5mL) Approval Criteria:

1. Authorization of Veripred™ 20 or Millipred™ requires a patient-specific, clinically significant reason why the member cannot use a tablet or an alternative strength liquid formulation.

Utilization Details of Prednisolone Special Formulations: October 1, 2015 through March 31, 2016

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM
PREDNISOLONE ORAL SOLUTION PRODUCTS					
PREDNISOLONE SOL 15MG/5ML	24,928	20,876	$188,117.97	1.19	$7.55
PREDNISOLONE SOL 15MG/5ML	23,847	20,095	$169,478.15	1.19	$7.11
PRED SOD PHO SOL 5MG/5ML	2,049	1,914	$64,669.79	1.07	$31.56
PREDNISOLONE SOL 25MG/5ML	371	332	$12,743.22	1.12	$34.35
VERIPRED 20 SOL 20MG/5ML	42	42	$7,184.05	1	$171.05
MILLIPRED SOL 10MG/5ML	40	40	$5,380.37	1	$134.51
SUBTOTAL	**51,277**	**40,337**	**$447,573.55**	**1.27**	**$8.73**
PREDNISOLONE ORALLY DISINTEGRATING PRODUCTS					
PREDNISOLONE TAB 15MG ODT	648	598	$65,448.78	1.08	$101.00
PREDNISOLONE TAB 30MG ODT	369	342	$42,792.00	1.08	$115.97
PREDNISOLONE TAB 10MG ODT	195	179	$15,196.81	1.09	$77.93
SUBTOTAL	**1,212**	**1,103**	**$123,437.59**	**1.1**	**$101.85**
DEXAMETHASONE ORAL SOLUTION PRODUCTS					
DEXAMETHASON ELX 0.5/5ML	894	792	$15,729.33	1.13	$17.59
DEXAMETHASON SOL 0.5/5ML	651	502	$4,358.63	1.3	$6.70
DEXAMETHASON CON 1MG/ML	570	546	$11,067.83	1.04	$19.42
SUBTOTAL	**2,115**	**1,818**	**$31,155.79**	**1.16**	**$14.73**
TOTAL	**54,604**	**42,670***	**$602,166.93**	**1.28**	**$11.03**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

[1] Ishizaka T, Okada S, et al. Suppression of bitterness and improvement of palatability of commercial prednisolone powder. *Chemical and Pharmaceutical Bulletin*. 2008; 56(10):1395-9.
[2] Ortiz B. U.S. Food and Drug Administration (FDA). Giving Medicine to Children. Available online at: http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm291741.htm. Last revised 10/2015. Last accessed 08/22/2016.
[3] Schmitt BD. Pediatric Advisor: Medicines: Helping Children Swallow Them. RelayHealth. Available online at: http://advisor.chsys.org/crsfiles/pa/pa_swallmed_hhg.htm. Last revised 06/2010. Last accessed 08/22/2016.
[4] Millipred™ Prescribing Information. Zylera Pharmaceuticals. Available online at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f4b07528-4ee5-4fce-a30f-00b8426f2762. Last revised 03/2014. Last accessed 08/22/2016.

Appendix K

Fiscal Year 2016 Annual Review of Synagis® (Palivizumab)

Oklahoma Health Care Authority
September 2016

Current Prior Authorization Criteria

A prior authorization is required for all members who receive palivizumab in an outpatient setting. Palivizumab is approved for members who meet the established criteria based on a modified version of the American Academy of Pediatrics (AAP) guidelines.

Synagis® (Palivizumab) Approval Criteria:

A. Member Selection:
   1. Infants less than 12 months old at the start of respiratory syncytial virus (RSV) season:
      a. Born before 29 weeks, 0 days gestation; or
      b. Born before 32 weeks, 0 days gestation and develop chronic lung disease (CLD) of prematurity (require >21% oxygen supplementation for at least 28 days after birth); or
      c. Have hemodynamically significant congenital heart disease (acyanotic heart disease and receiving medication to control Congestive Heart Failure (CHF) and will require surgical procedures, or moderate-to-severe pulmonary hypertension); or
      d. May be considered for:
         i. Infants with neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough
         ii. Infants who undergo cardiac transplantation during RSV season
         iii. Infants who are profoundly immunocompromised during RSV season
         iv. Infants with cystic fibrosis with clinical evidence of CLD and/or nutritionally compromised
   2. Infants 12 to 24 months old at the start of RSV season:
      a. Born before 32 weeks, 0 days gestation and have CLD of prematurity (required at least 28 days of oxygen after birth) and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6 months before the start of the RSV season

B. Length of treatment: Palivizumab is approved for use only during RSV season. Approval dates will be November 1st through March 31st.

C. Units authorized: The maximum duration of therapy is five (5) doses, with a dose to be administered no more often than every 30 days. Members given doses more frequently than every 30 days will not be authorized for additional doses. Doses administered prior to the member's discharge from a hospital will be counted as one of the approved total.

D. Dose-pooling: To avoid unnecessary risk to the patient, multiple patients are not to be treated from a single vial. Failure to follow this recommendation will result in referral of the provider to the Quality Assurance Committee of the Oklahoma Health Care Authority.

Utilization of Palivizumab: Fiscal Year 2016

Comparison of Fiscal Years

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2015	424	1,870	$4,042,343.79	$2,161.68	$72.05	1,595	56,107
2016	253	1,152	$2,628,429.93	$2,281.62	$76.12	976	34,532
% Change	**-40.30%**	**-38.40%**	**-35.00%**	**5.50%**	**5.60%**	**-38.80%**	**-38.50%**
Change	**-171**	**-718**	**-$1,413,913.86**	**$119.94**	**$4.07**	**-619**	**-21,575**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Pharmacy Claim Details for Season 2015-2016

Product Utilized	Total Claims	Total Members	Total Cost	Claims/ Member	Cost/ Claim	% Cost
SYNAGIS INJ 100MG/ML	762	227	$2,079,713.67	3.36	$2,729.28	79.12%
SYNAGIS INJ 50MG/0.5ML	390	176	$548,716.26	2.22	$1,406.96	20.88%
Total	**1,152**	**253***	**$2,628,429.93**	**4.55**	**$2,281.62**	**100%**

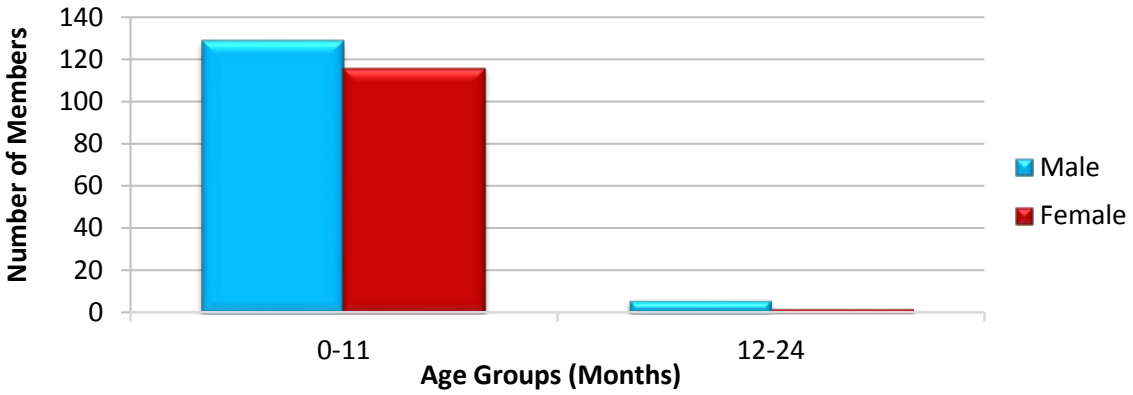
*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Cost per Vial

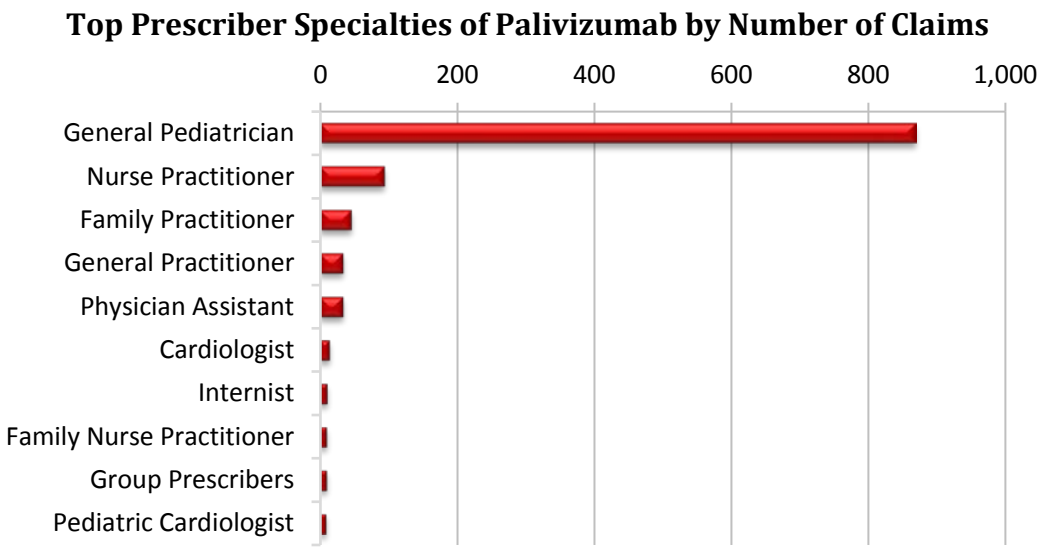
Vial Size	Cost per Vial
Synagis® (palivizumab) 100mg/mL vial	$2,681.72
Synagis® (palivizumab) 50mg/mL vial	$1,420.19

Costs do not reflect rebated prices or net costs.

Demographics of Members Utilizing Palivizumab

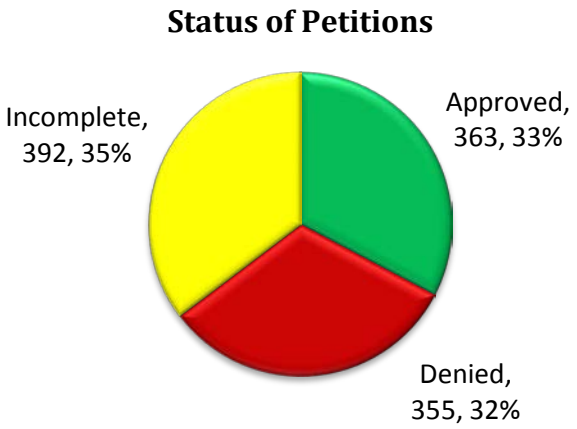


Both age groups saw a decrease in utilization compared to the 2014-2015 palivizumab season. The 0-11 month age group saw a 39.36% decrease in utilization, and the 12-23 month age group saw a 60.00% decrease in utilization.

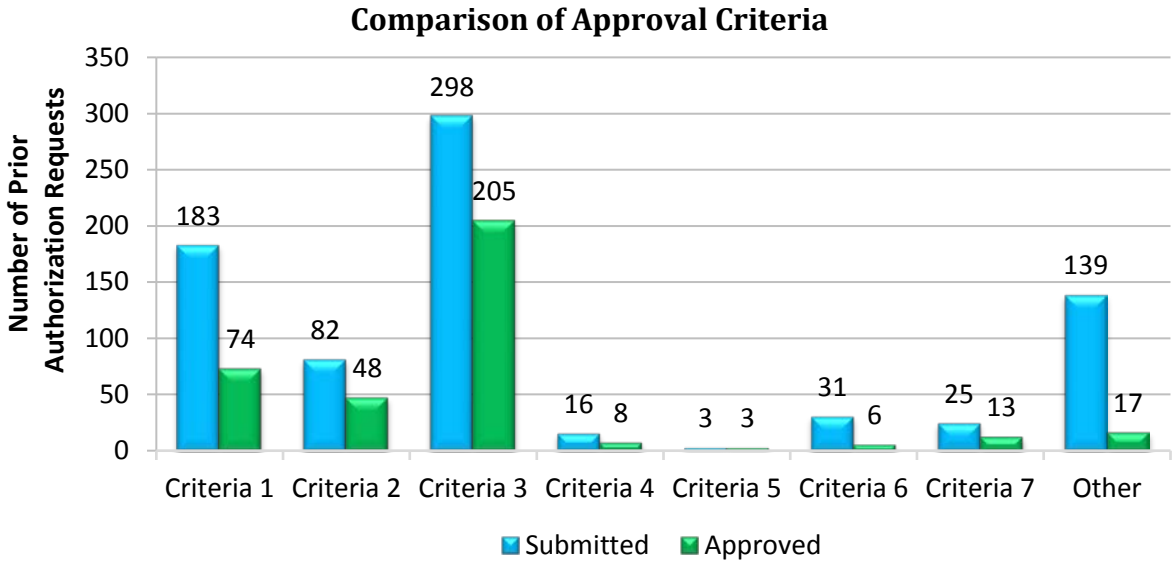


Prior Authorization of Palivizumab

There were 1,110 palivizumab prior authorization requests submitted for 571 unique members during fiscal year 2016. This is a decrease in both submitted petitions and number of members requesting palivizumab compared to fiscal year 2015 when there were 1,335 palivizumab prior authorization requests submitted for 701 unique members. The following chart shows the status of the submitted petitions for fiscal year 2016.



The following graph shows the number of submissions and approvals for each prior authorization criteria. The graph is followed by a numbered list in which the list number corresponds to the criteria number in the graph. The most commonly requested and approved criteria selection during the 2015-2016 RSV season was criteria number three: infants born before 29 weeks, 0 days gestation. Infants born before 32 weeks, 0 days gestation and who had CLD of prematurity was also a commonly requested and approved criteria selection.

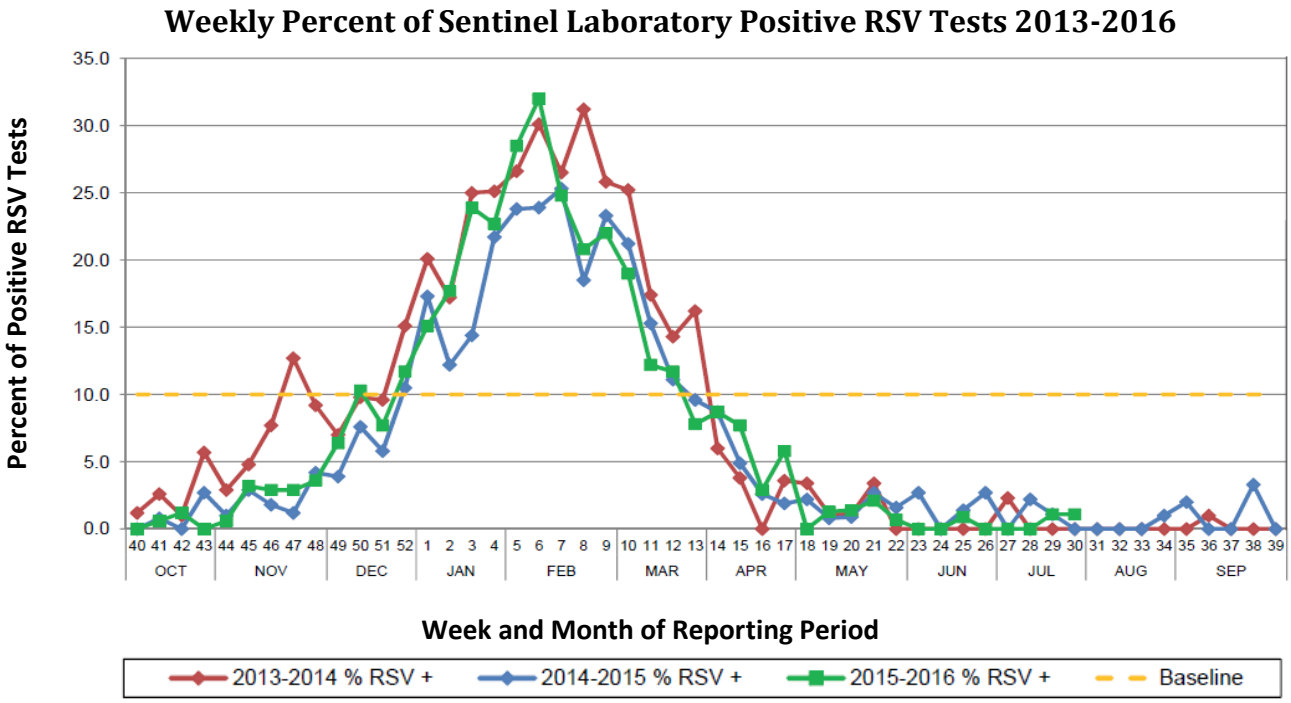


Criteria List:

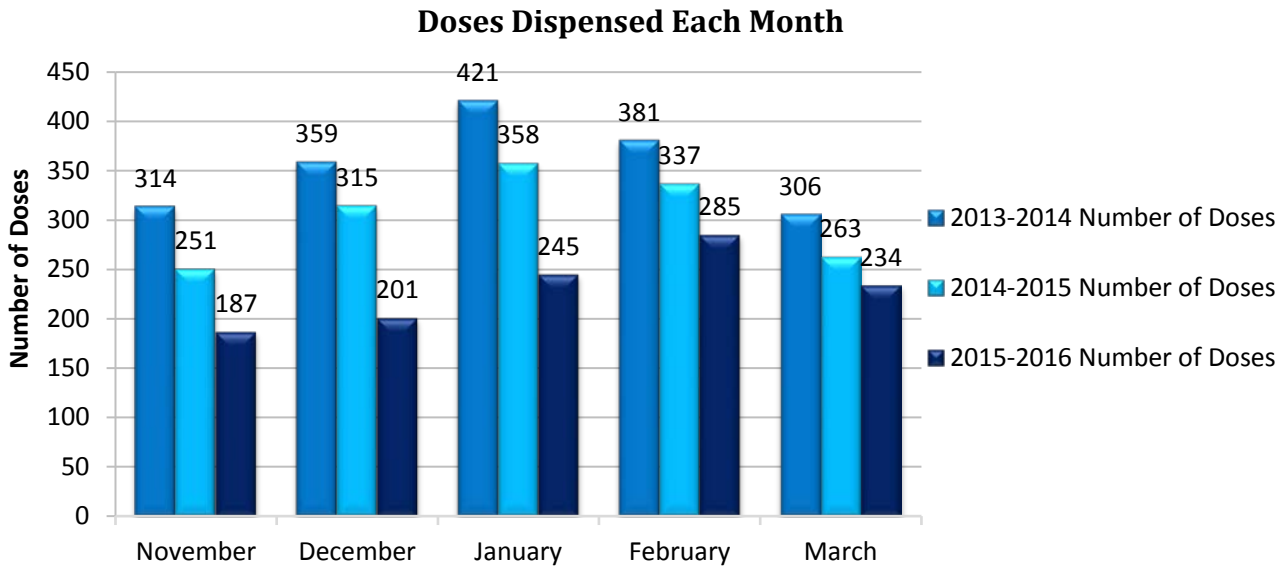
1. Infants 0 to 24 months old at the start of RSV season born before 32 weeks, 0 days gestation and have CLD of prematurity.
2. Infants who have hemodynamically significant congenital heart disease and will require surgical procedures, or moderate-to-severe pulmonary hypertension.
3. Infants born before 29 weeks, 0 days gestation.
4. Infants with neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough.
5. Infants who undergo cardiac transplantation during RSV season.
6. Infants who are profoundly immunocompromised during RSV season.
7. Infants with cystic fibrosis with clinical evidence of CLD and/or nutritionally compromised.

Season Comparison[1,2,3]

The following chart contains the weekly percent of laboratory positive RSV tests in Oklahoma as reported by the Oklahoma State Department of Health (OSDH) Viral Respiratory Illness Sentinel Surveillance System. The chart is included to compare RSV seasons since 2013. RSV is determined to be in season once the percent of positive tests is greater than 10% for two consecutive weeks. Similarly the season is determined to be at an end when the percent of positive tests is below 10% for two consecutive weeks. Since 2013, all RSV seasons appear to be similar with a peak in January or February and a season end by late March. Palivizumab prior authorization approvals are initiated with a start date of November 1st and continue to March 31st; this approval window corresponds to the following state monitoring graph as well as with regional data reported by the Centers for Disease Control and Prevention (CDC). For the 2013-2014 RSV season for Oklahoma's region, the CDC determined the onset week was the week of October 19th with a season offset the week of March 22nd.



The following bar graph shows the number of palivizumab doses paid for by SoonerCare for each month during the last three seasons. The doses dispensed also correspond to the seasonal data from the OSDH and the CDC with a peak in January or February. In 2015, SoonerCare adopted the Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection released by the American Academy of Pediatrics (AAP). The guidance which was released in 2014 urged more limited use than previously recommended in children born after 29 weeks gestation or those in the second year of life. Many hospitals across the state updated their protocols at that time resulting in fewer doses dispensed in the 2014 season as well as in the 2015 season when SoonerCare adopted the updated guidance.



Market News and Updates[4,5]

Guideline Update:

- **December 2014:** The American Academy of Pediatrics issued a correction in the guidance for palivizumab prophylaxis. The following update was made: "A second season of palivizumab prophylaxis is recommended only for preterm infants born at, 32 weeks, 0 days gestation who required at least 28 days of oxygen after birth and who continue to require supplemental oxygen, chronic systemic corticosteroid therapy, or ***diuretic*** therapy within 6 months of the start of the second RSV season. Bronchodilator therapy was removed as a consideration for prophylaxis in the second RSV season."[4] The SoonerCare criteria has been updated to reflect this correction.

Pipeline News:

- **April 2016:** Higgins and colleagues reviewed the growing number of RSV vaccine candidates and found that as of April 2016 there were 60 RSV vaccine candidates in development, 16 of which were found to be in Phase 1 to Phase 3 clinical trials. Novovax, Inc. was determined to have the only candidate currently in Phase 3 trials, a RSV F nanoparticle being developed for both elderly and maternal immunization.

Recommendations

The College of Pharmacy does not recommend any changes to the current Synagis® (palivizumab) criteria at this time.

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[1] Oklahoma State Department of Health. Weekly Percent of Sentinel Laboratory Positive RSV Tests, Oklahoma Viral Respiratory Illness Sentinel Surveillance System, 2013-2016: Week ending July 30, 2016. Available online at: https://www.ok.gov/health2/documents/RSV2011-12andPast2Seasons-10-06-2012.pdf. Last revised 07/30/2016. Last accessed 08/09/2016.

[2] Centers for Disease Control and Prevention (CDC). Respiratory Syncytial Virus — United States, July 2012–June 2014. Available online at: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6348a3.htm. Issued 12/04/2014. Last accessed 08/09/2016.

[3] Committee on Infectious Diseases and Bronchiolitis Guidelines Committee. RSV Policy Statement —Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. *Pediatrics.* 2014; 134 (2): 415–420.

[4] Committee on Infectious Diseases and Bronchiolitis Guidelines Committee. Errata: RSV Policy Statement —Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. *Pediatrics*. 2014; 134 (6): 1221.

[5] Higgins D, Trujillo C, Keech C. Advances in RSV vaccine research and development – A global agenda. *Vaccine.* 2016; 34: 2870–2875.

Appendix L

Fiscal Year 2016 Annual Review of Antihyperlipidemics

Oklahoma Health Care Authority
September 2016

Current Prior Authorization Criteria

Statin Medications and Zetia® (Ezetimibe) Tier-2 Approval Criteria:

1. Member must have a documented trial with atorvastatin, consisting of at least 8 weeks of continuous therapy titrated to 40mg, which did not yield adequate LDL reduction. The minimum starting dose of the Tier-2 medication may only be at the moderate-to-high LDL lowering doses (20mg rosuvastatin or higher); or
2. A documented adverse effect or contraindication to all available lower tiered products; or
3. A clinical exception will apply for Crestor® (rosuvastatin) 40mg for high-risk members hospitalized for recent acute myocardial infarction or acute coronary syndrome; and
4. Clinical exceptions for Zetia® (ezetimibe) include the following:
    a. Documented active liver disease; or
    b. Documented unexplained, persistent elevations of serum transaminases; or
    c. Documented statin-related myopathy.

Statin Medications and Zetia® (Ezetimibe) Special Prior Authorization (PA) Approval Criteria:

1. Use of any Special PA medication will require a patient-specific, clinically significant reason why lower tiered medications with similar or higher LDL reduction cannot be used; and
    a. Simcor® (simvastatin/niacin) and Advicor® (lovastatin/niacin) will also require a patient-specific, clinically significant reason why the member cannot use the individual products separately.

Statin Medications and Zetia® (Ezetimibe)*		
Tier-1	**Tier-2**	**Special PA**
atorvastatin (Lipitor®)	ezetimibe (Zetia®)	fluvastatin (Lescol® & Lescol® XL)
lovastatin (Mevacor®)	rosuvastatin (Crestor®)+	lovastatin (Altoprev®)
pravastatin (Pravachol®)		lovastatin/niacin CR (Advicor®)
simvastatin (Zocor®)		pitavastatin (Livalo®)
		simvastatin/ezetimibe (Vytorin®)
		simvastatin/niacin CR (Simcor®)

*Tier structure based on state maximum allowable cost (SMAC) and/or supplemental rebate participation.
+Crestor® 5mg and Crestor® 10mg require special reason for use.
CR = controlled-release

Omega-3 Fatty Acids Approval Criteria:

1. Laboratory documentation of severe hypertriglyceridemia (fasting triglycerides ≥500mg/dL), and controlled diabetes (fasting glucose <150mg/dL at the time of triglycerides measurement and HgA1c <7.5%); and
2. Previous failure with both nicotinic acid and fibric acid medications; and
3. Use of Vascepa® or Epanova® requires a patient-specific, clinically significant reason why the member cannot use omega-3-acid ethyl esters (generic Lovaza®).

Juxtapid® (Lomitapide) and Kynamro® (Mipomersen) Approval Criteria:

1. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least one of the following criteria:
    a. A documented functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
    b. An untreated total cholesterol >500mg/dL and triglycerides <300mg/dL and at least one of the following:
        i. Documentation that both parents have untreated total cholesterol >250mg/dL; or
        ii. Presence of tendinous/cutaneous xanthoma prior to age 10 years; and
2. Documented failure of high dose statin therapy (LDL reduction capability equivalent to atorvastatin 80mg or higher); and
3. Prescriber must be certified with Juxtapid® or Kynamro® REMS program.

PCSK9 Inhibitors Approval Criteria:

1. An FDA approved diagnosis of heterozygous familial hypercholesterolemia (HeFH) defined by the presence of one of the following criteria:
    a. A documented functional mutation(s) in the LDL receptor (LDLR) gene or other HeFH-related genes via genetic testing; or
    b. Definite HeFH using either the Simon Broome Register criteria or the Dutch Lipid Network criteria; or
2. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least one of the following:
    a. A documented functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
    b. An untreated total cholesterol greater than 500mg/dL and at least one of the following:
        i. Documented evidence of definite HeFH in both parents; or
        ii. Presence of tendinous/cutaneous xanthoma prior to age 10 years; or
3. An FDA approved diagnosis of clinical atherosclerotic cardiovascular disease defined by the presence of one of the following criteria:
    a. High cardiovascular risk confirmed by Framingham risk score; and
        i. Supporting diagnoses/conditions signifying this risk level; or
    b. Documented history of Coronary Heart Disease (CHD); and
        i. Supporting diagnoses/conditions and dates of occurrence signifying history of CHD; and

4. Member must be 18 years of age or older for the diagnosis of HeFH or clinical atherosclerotic cardiovascular disease, or must be 13 years of age or older for the diagnosis of HoFH; and
5. Member must be on high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or on maximally tolerated statin therapy; and
    a. Statin trials must be at least 12 weeks in duration (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
    b. LDL-cholesterol (LDL-C) levels should be included following at least 12 weeks of treatment with each statin medication; and
    c. For statin intolerance due to myalgia, creatine kinase (CK) labs verifying rhabdomyolysis must be provided; and
    d. Tier structure rules still apply; and
6. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
7. Prescriber must verify that member has been counseled on appropriate use, storage of the medication, and administration technique; and
8. Repatha® requests for the dosing regimen of 420mg once monthly require a diagnosis of HoFH or require a patient-specific, clinically significant reason why the member cannot use Repatha® at the dosing regimen of 140mg every 2 weeks; and
9. A quantity limit of 2 syringes or pens per 28 days will apply for Praluent®. A quantity limit of 2 syringes or autoinjectors per 28 days will apply for Repatha®. Patients with the diagnosis of HoFH needing 3 Repatha® syringes or autoinjectors per 30 days (for the dosing regimen of 420mg once monthly) will be approved for a quantity limit override upon meeting PCSK9 inhibitors approval criteria.
10. Initial approvals will be for the duration of 3 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of this medication, and compliance will be checked at that time and every six months thereafter for continued approval.

Utilization of Antihyperlipidemics: Fiscal Year 2016

Comparison of Fiscal Years: Statin Medications and Zetia® (Ezetimibe)

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2015	15,563	63,091	$1,380,209.80	$21.88	$0.49	2,828,393	2,821,139
2016	15,955	63,160	$1,335,963.43	$21.15	$0.47	2,876,270	2,868,909
% Change	**2.50%**	**0.10%**	**-3.20%**	**-3.30%**	**-4.10%**	**1.70%**	**1.70%**
Change	**392**	**69**	**-$44,246.37**	**-$0.73**	**-$0.02**	**47,877**	**47,770**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Comparison of Fiscal Years: Omega-3 Fatty Acids

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2015	48	360	$65,434.95	$181.76	$6.05	37,716	10,812
2016	35	258	$36,783.80	$142.57	$4.67	26,440	7,883
% Change	**-27.10%**	**-28.30%**	**-43.80%**	**-21.60%**	**-22.80%**	**-29.90%**	**-27.10%**
Change	**-13**	**-102**	**-$28,651.15**	**-$39.19**	**-$1.38**	**-11,276**	**-2,929**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Comparison of Fiscal Years: Juxtapid® (Lomitapide) and Kynamro® (Mipomersen)

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2015	1	13	$793,839.42	$61,064.57	$2,035.49	780	390
2016	1	11	$346,364.83	$31,487.71	$1,124.56	308	308
% Change	**0.00%**	**-15.40%**	**-56.40%**	**-48.40%**	**-44.80%**	**-60.50%**	**-21.00%**
Change	**0**	**-2**	**-$447,474.59**	**-$29,576.86**	**-$910.93**	**-472**	**-82**

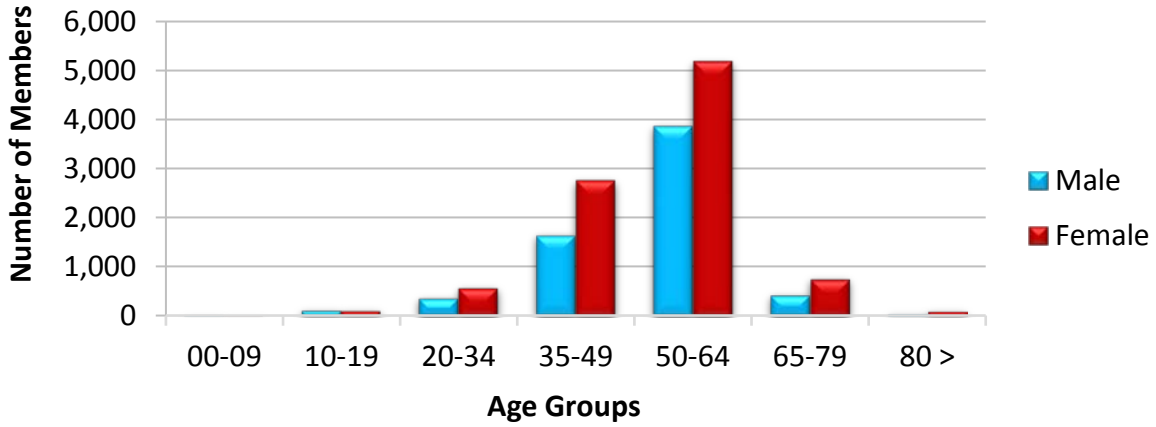
*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Comparison of Fiscal Years: PCSK9 Inhibitors

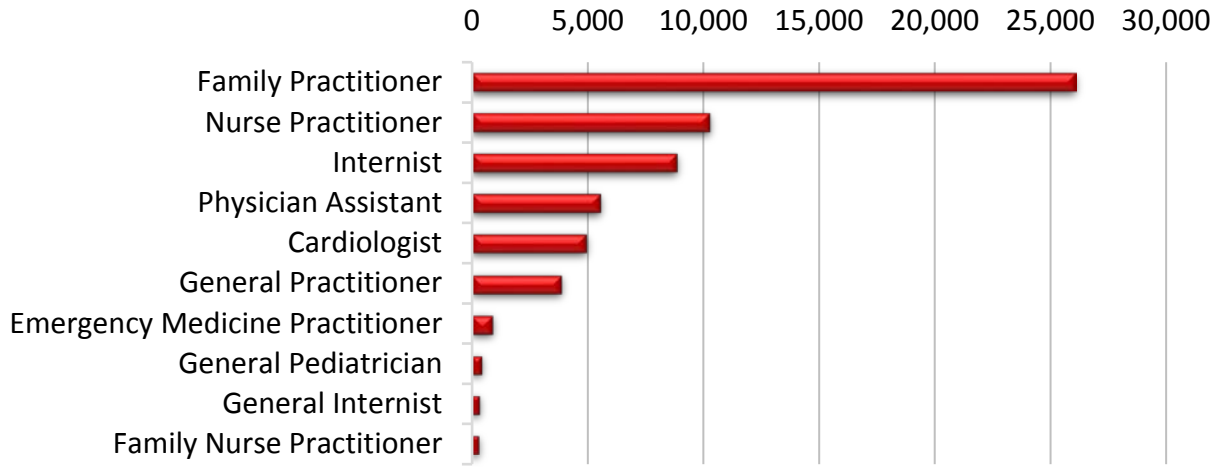
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2016	1	1	$1,186.32	$1,186.32	$39.54	2	30

Please note, Praluent® and Repatha® were FDA approved in July 2015 and August 2015, respectively, within fiscal year 2016; therefore, there was no utilization of Praluent® or Repatha® during fiscal year 2015.
*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Demographics of Members Utilizing Antihyperlipidemics



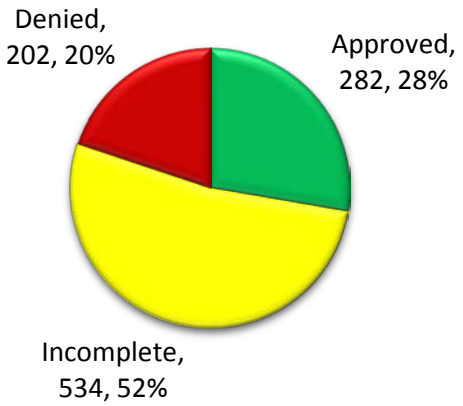
Top Prescriber Specialties of Antihyperlipidemics by Number of Claims



Prior Authorization of Antihyperlipidemics

There were 1,018 prior authorization requests submitted for antihyperlipidemics during fiscal year 2016. Computer edits are in place to detect Tier-1 statin medications in the member's recent claims history and generate automated prior authorizations where possible. The following chart shows the status of the submitted petitions.

Status of Petitions



Market News and Updates[1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17]

Anticipated Patent Expiration(s):

- Vytorin® (simvastatin/ezetimibe): April 2017
- Altoprev® (lovastatin): March 2018
- Livalo® (pitavastatin): February 2024
- Kynamro® (mipomersen): December 2025
- Zetia® (ezetimibe): April 2026
- Juxtapid® (lomitapide): August 2027
- Vascepa® (icosapent ethyl): April 2030
- Epanova® (omega-3-carboxylic acids): January 2033

Discontinued Medication(s):

- **April 2016:** Based on several large cardiovascular outcome trials, the U.S. Food and Drug Administration (FDA) decided that the totality of scientific evidence no longer supports the conclusion that a drug-induced reduction in triglyceride levels and/or increase in HDL-cholesterol levels in statin-treated patients results in a reduction in the risk of cardiovascular events. Consistent with this conclusion, the FDA has determined that the benefits of Simcor® (simvastatin/niacin CR) and Advicor® (lovastatin/niacin CR) no longer outweigh the risks, and FDA approvals were withdrawn for both drugs. Additionally, the FDA has determined that the benefits of niacin ER tablets (Niaspan®) and fenofibric acid delayed-release capsules (Trilipix®) for coadministration with statins no longer outweigh the risks, and the FDA approvals for this indication were withdrawn.
    - Niaspan® is still FDA approved for several indications, including monotherapy for primary hyperlipidemia and mixed dyslipidemia, to reduce the risk of recurrent nonfatal myocardial infarction (MI) in patients with a history of MI and hyperlipidemia, in combination with a bile acid binding resin in patients with primary hyperlipidemia or with a history of coronary artery disease (CAD) and hyperlipidemia to slow the progression or promote regression of atherosclerotic disease, and as adjunctive therapy for adult patients with severe hypertriglyceridemia at risk of pancreatitis and who do not respond adequately to a determined dietary effort.
    - Trilipix® is still FDA approved as adjunctive therapy to diet for severe hypertriglyceridemia, primary hypercholesterolemia, and mixed dyslipidemia.

News:

- **September 2015:** Mylan received FDA approval for its Abbreviated New Drug Application (ANDA) for fluvastatin extended-release tablets (generic Lescol® XL). Other pharmaceutical companies have since received FDA approval or tentative approval for fluvastatin extended-release tablets, and generic fluvastatin extended-release tablets are currently available on the market.
- **February 2016:** The FDA turned down Merck's application to expand the indication for ezetimibe, either by itself (Zetia®) or in combination with simvastatin (Vytorin®). Ezetimibe is indicated to reduce LDL cholesterol in patients with hyperlipidemia. The proposed new indication was for the reduction of cardiovascular risk in patients with coronary heart disease and was based on the results of the IMPROVE-IT trial. The FDA Advisory Panel voted 10-5 against the expanded indication in December 2015. The panel was in broad agreement that the treatment benefit in the trial, though it achieved statistical significance, was too small to support the label upgrade.
- **April 2016:** Watson Pharmaceuticals received FDA approval for its ANDA for rosuvastatin calcium (generic Crestor®). Other pharmaceutical companies have since received FDA approval or tentative approval for rosuvastatin calcium, and generic rosuvastatin calcium tablets are currently available on the market. The current cost of generic rosuvastatin is higher than current Tier-1 products, but as more pharmaceutical companies start to manufacture generic rosuvastatin, the cost typically tends to decrease and stabilize.

- **April 2016:** The HOPE-3 trial showed that statins may lower cardiovascular events in patients considered at intermediate-risk for coronary heart disease (CHD). These results support a risk-based approach to statin use, which has been recommended in recent guidelines, rather than an approach that is based primarily on LDL-cholesterol levels, and adds to the evidence supporting statin use for primary prevention.
- **April 2016:** The GAUSS-3 trial results suggest that six-month treatment with evolocumab (Repatha®) can dramatically reduce LDL-cholesterol levels in patients with both uncontrolled LDL-cholesterol levels and statin intolerance. Questions remain whether PCSK9 inhibitors should really be used in statin-intolerant patients, as PCSK9 inhibitors are not FDA approved for this type of use and although some long-term outcome trials have started, no study has yet shown an association between the treatment and lower cardiovascular events. Additionally, one-fifth of the GAUSS-3 study participants had muscle symptoms even while taking evolocumab.
- **May 2016:** The FDA approved a supplemental New Drug Application (sNDA) for Crestor® (rosuvastatin calcium) for use in pediatric patients 7 to 17 years of age with homozygous familial hypercholesterolemia (HoFH) as adjunct to diet, either alone or with other lipid-lowering treatments. The FDA also expanded the use of Crestor® in pediatric patients 8 to 17 years of age with heterozygous familial hypercholesterolemia (HeFH) after failing a trial of diet therapy.
- **June 2016:** Pfizer announced that two additional Phase 3 bococizumab (a PCSK9 inhibitor) trials, SPIRE-HR and SPIRE-FH, met their primary endpoint, demonstrating a significant reduction in the percent change from baseline in LDL-cholesterol at 12 weeks compared to placebo among adults at high and very high risk for cardiovascular events who were receiving a maximally tolerated dose of a highly effective statin. Two remaining Phase 3 bococizumab trials are anticipated to be completed later in 2016.
- **July 2016:** Amgen received FDA approval for the Repatha® (evolocumab) Pushtronex™ system (on-body infusor with prefilled cartridge), a new, monthly single-dose administration option. The Pushtronex™ system is a hands-free device designed to provide 420mg of Repatha® in a single dose. Repatha® was previously only available as a 140mg/mL solution for subcutaneous injection in single-dose pre-filled autoinjectors and syringes; therefore, patients needing the 420mg monthly dose would have to administer three 140mg/mL subcutaneous injections consecutively within 30 minutes.

Recommendations

The College of Pharmacy recommends the following changes to the Antihyperlipidemics Product Based Prior Authorization (PBPA) category:

1. Update the Statin Medications and Zetia® (ezetimibe) tier chart and criteria to remove the discontinued medications, Simcor® (simvastatin/niacin CR) and Advicor® (lovastatin/niacin CR).
2. Add a clinical exception for Crestor® (rosuvastatin) for pediatric members with homozygous familial hypercholesterolemia (HoFH) based on the newly expanded indication (*shown above in Market News and Updates*). None of the current Tier-1 statin medications are indicated for the treatment of pediatric HoFH.

3. Update the PCSK9 Inhibitors criteria to reflect the new dosage form available for Repatha® (evolocumab).
4. Monitor the state maximum allowable cost (SMAC) of generic rosuvastatin and move it to Tier-1 once the SMAC has stabilized and is comparable to other Tier-1 statin medications.

Statin Medications and Zetia® (Ezetimibe)*		
Tier-1	**Tier-2**	**Special PA**
atorvastatin (Lipitor®)	ezetimibe (Zetia®)	fluvastatin (Lescol® & Lescol® XL)
lovastatin (Mevacor®)	rosuvastatin (Crestor®)+	lovastatin (Altoprev®)
pravastatin (Pravachol®)		~~lovastatin/niacin CR (Advicor®)~~
simvastatin (Zocor®)		pitavastatin (Livalo®)
		simvastatin/ezetimibe (Vytorin®)
		~~simvastatin/niacin CR (Simcor®)~~

*Tier structure based on state maximum allowable cost (SMAC) and/or supplemental rebate participation.
+Crestor® 5mg and Crestor® 10mg require special reason for use.
CR = controlled-release

Statin Medications and Zetia® (Ezetimibe) Tier-2 Approval Criteria:

1. Member must have a documented trial with atorvastatin, consisting of at least 8 weeks of continuous therapy titrated to 40mg, which did not yield adequate LDL reduction. The minimum starting dose of the Tier-2 medication may only be at the moderate-to-high LDL lowering doses (20mg rosuvastatin or higher); or
2. A documented adverse effect or contraindication to all available lower tiered products; or
3. A clinical exception will apply for Crestor® (rosuvastatin) 40mg for high-risk members hospitalized for recent acute myocardial infarction or acute coronary syndrome, or for pediatric members with homozygous familial hypercholesterolemia (HoFH); and
4. Clinical exceptions for Zetia® (ezetimibe) include the following:
    a. Documented active liver disease; or
    b. Documented unexplained, persistent elevations of serum transaminases; or
    c. Documented statin-related myopathy.

Statin Medications and Zetia® (Ezetimibe) Special Prior Authorization (PA) Approval Criteria:

1. Use of any Special PA medication will require a patient-specific, clinically significant reason why lower tiered medications with similar or higher LDL reduction cannot be used~~; and~~
    ~~a. Simcor® (simvastatin/niacin) and Advicor® (lovastatin/niacin) will also require a patient-specific, clinically significant reason why the member cannot use the individual products separately.~~

PCSK9 Inhibitors Approval Criteria:

1. An FDA approved diagnosis of heterozygous familial hypercholesterolemia (HeFH) defined by the presence of one of the following criteria:
    a. A documented functional mutation(s) in the LDL receptor (LDLR) gene or other HeFH-related genes via genetic testing; or
    b. Definite HeFH using either the Simon Broome Register criteria or the Dutch Lipid Network criteria; or
2. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least one of the following:
    a. A documented functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
    b. An untreated total cholesterol greater than 500mg/dL and at least one of the following:
        i. Documented evidence of definite HeFH in both parents; or
        ii. Presence of tendinous/cutaneous xanthoma prior to age 10 years; or
3. An FDA approved diagnosis of clinical atherosclerotic cardiovascular disease defined by the presence of one of the following criteria:
    a. High cardiovascular risk confirmed by Framingham risk score; and
        i. Supporting diagnoses/conditions signifying this risk level; or
    b. Documented history of Coronary Heart Disease (CHD); and
        i. Supporting diagnoses/conditions and dates of occurrence signifying history of CHD; and
4. Member must be 18 years of age or older for the diagnosis of HeFH or clinical atherosclerotic cardiovascular disease, or must be 13 years of age or older for the diagnosis of HoFH; and
5. Member must be on high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or on maximally tolerated statin therapy; and
    a. Statin trials must be at least 12 weeks in duration (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
    b. LDL-cholesterol (LDL-C) levels should be included following at least 12 weeks of treatment with each statin medication; and
    c. For statin intolerance due to myalgia, creatine kinase (CK) labs verifying rhabdomyolysis must be provided; and
    d. Tier structure rules still apply; and
6. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
7. Prescriber must verify that member has been counseled on appropriate use, storage of the medication, and administration technique; and
8. ~~Repatha® requests for the dosing regimen of 420mg once monthly require a diagnosis of HoFH or require a patient-specific, clinically significant reason why the member cannot use Repatha® at the dosing regimen of 140mg every 2 weeks; and~~
9. A quantity limit of 2 syringes or pens per 28 days will apply for Praluent®. A quantity limit of 2 syringes or autoinjectors per 28 days will apply for Repatha® 140mg and a quantity limit of one autoinjector per 28 days for Repatha® 420mg. ~~Patients with the~~

~~diagnosis of HoFH needing 3 Repatha® syringes or autoinjectors per 30 days (for the dosing regimen of 420mg once monthly) will be approved for a quantity limit override upon meeting PCSK9 inhibitors approval criteria.~~ Patients requesting Repatha® 420mg strength will not be approved for multiple 140mg syringes but instead should use one 420mg autoinjector.

10. Initial approvals will be for the duration of 3 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of this medication, and compliance will be checked at that time and every six months thereafter for continued approval.

Utilization Details of Statin Medications and Zetia® (Ezetimibe): Fiscal Year 2016

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ DAY	COST/ CLAIM	% COST
TIER-1 UTILIZATION						
ATORVASTATIN PRODUCTS						
ATORVASTATIN TAB 40MG	10,947	3,206	$107,703.47	$0.22	$9.84	8.06%
ATORVASTATIN TAB 20MG	8,926	2,724	$84,728.46	$0.22	$9.49	6.34%
ATORVASTATIN TAB 10MG	5,663	1,487	$45,700.58	$0.20	$8.07	3.42%
ATORVASTATIN TAB 80MG	4,230	1,236	$47,708.71	$0.24	$11.28	3.57%
SUBTOTAL	**29,766**	**8,653**	**$285,841.22**	**$0.22**	**$9.60**	**21.40%**
SIMVASTATIN PRODUCTS						
SIMVASTATIN TAB 20MG	7,310	1,891	$30,126.37	$0.09	$4.12	2.26%
SIMVASTATIN TAB 40MG	5,370	1,483	$25,350.41	$0.09	$4.72	1.90%
SIMVASTATIN TAB 10MG	2,321	629	$10,422.98	$0.11	$4.49	0.78%
SIMVASTATIN TAB 80MG	498	150	$3,242.88	$0.12	$6.51	0.24%
SIMVASTATIN TAB 5MG	116	35	$591.65	$0.13	$5.10	0.04%
SUBTOTAL	**15,615**	**4,188**	**$69,734.29**	**$0.09**	**$4.47**	**5.22%**
PRAVASTATIN PRODUCTS						
PRAVASTATIN TAB 40MG	6,525	1,730	$127,115.95	$0.41	$19.48	9.51%
PRAVASTATIN TAB 20MG	3,984	1,144	$64,089.62	$0.35	$16.09	4.80%
PRAVASTATIN TAB 80MG	1,104	307	$30,047.26	$0.55	$27.22	2.25%
PRAVASTATIN TAB 10MG	963	289	$15,224.24	$0.37	$15.81	1.14%
SUBTOTAL	**12,576**	**3,470**	**$236,477.07**	**$0.40**	**$18.80**	**17.70%**
LOVASTATIN PRODUCTS						
LOVASTATIN TAB 20MG	1,953	697	$10,234.79	$0.11	$5.24	0.77%
LOVASTATIN TAB 40MG	1,284	358	$8,028.85	$0.13	$6.25	0.60%
SUBTOTAL	**3,237**	**1,055**	**$18,263.64**	**$0.12**	**$5.64**	**1.37%**
TIER-1 SUBTOTAL	**61,194**	**15,662***	**$610,316.22**	**$0.22**	**$9.97**	**45.68%**
TIER-2 UTILIZATION						
ROSUVASTATIN PRODUCTS						
CRESTOR TAB 20MG	627	161	$239,448.22	$8.15	$381.90	17.92%
CRESTOR TAB 40MG	530	121	$188,819.48	$7.79	$356.26	14.13%
CRESTOR TAB 10MG	101	25	$34,476.92	$8.64	$341.36	2.58%
CRESTOR TAB 5MG	28	9	$11,092.04	$8.04	$396.14	0.83%
ROSUVASTATIN TAB 20MG	21	19	$6,439.32	$7.42	$306.63	0.48%
ROSUVASTATIN TAB 40MG	19	19	$8,035.74	$7.24	$422.93	0.60%
ROSUVASTATIN TAB 10MG	6	6	$1,811.21	$7.55	$301.87	0.14%
ROSUVASTATIN TAB 5MG	4	4	$905.20	$7.54	$226.30	0.07%
SUBTOTAL	**1,336**	**364**	**$491,028.13**	**$8.01**	**$367.54**	**36.75%**
EZETIMIBE PRODUCTS						
ZETIA TAB 10MG	507	115	$184,154.11	$8.47	$363.22	13.78%
SUBTOTAL	**507**	**115**	**$184,154.11**	**$8.47**	**$363.22**	**13.78%**
TIER-2 SUBTOTAL	**1,843**	**417***	**$675,182.24**	**$8.13**	**$366.35**	**50.54%**
SPECIAL PA UTILIZATION						

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ DAY	COST/ CLAIM	% COST
EZETIMIBE/SIMVASTATIN PRODUCTS						
VYTORIN TAB 10-40MG	64	14	$26,204.28	$8.16	$409.44	1.96%
VYTORIN TAB 10-80MG	9	3	$6,903.71	$8.52	$767.08	0.52%
VYTORIN TAB 10-20MG	6	2	$3,634.50	$8.65	$605.75	0.27%
SUBTOTAL	**79**	**19**	**$36,742.49**	**$8.28**	**$465.09**	**2.75%**
PITAVASTATIN PRODUCTS						
LIVALO TAB 2MG	23	6	$7,694.32	$6.93	$334.54	0.58%
LIVALO TAB 4MG	11	3	$3,497.50	$6.86	$317.95	0.26%
SUBTOTAL	**34**	**9**	**$11,191.82**	**$6.91**	**$329.17**	**0.84%**
NIACIN/SIMVASTATIN PRODUCTS						
SIMCOR TAB 1000-40	10	1	$2,530.66	$8.44	$253.07	0.19%
SUBTOTAL	**10**	**1**	**$2,530.66**	**$8.44**	**$253.07**	**0.19%**
SPECIAL PA SUBTOTAL	**123**	**28***	**$50,464.97**	**$7.93**	**$410.28**	**3.78%**
TOTAL	**63,160**	**15,955***	**$1,335,963.43**	**$0.47**	**$21.15**	**100.00%**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Utilization Details of Omega-3 Fatty Acids: Fiscal Year 2016

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ DAY	COST/ CLAIM	% COST
OMEGA-3-ACID ETHYL ESTERS PRODUCTS						
OMEGA-3-ACID CAP 1GM	258	35	$36,783.80	$4.67	$142.57	100.00%
TOTAL	**258**	**35***	**$36,783.80**	**$4.67**	**$142.57**	**100.00%**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Utilization Details of Juxtapid® (Lomitapide) and Kynamro® (Mipomersen): Fiscal Year 2016

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ DAY	COST/ CLAIM	% COST
LOMITAPIDE PRODUCTS						
JUXTAPID CAP 60MG	11	1	$346,364.83	$1,124.56	$31,487.71	100.00%
TOTAL	**11**	**1***	**$346,364.83**	**$1,124.56**	**$31,487.71**	**100.00%**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Utilization Details of PCSK9 Inhibitors: Fiscal Year 2016

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ DAY	COST/ CLAIM	% COST
ALIROCUMAB PRODUCTS						
PRALUENT INJ 75MG/ML	1	1	$1,186.32	$39.54	$1,186.32	100.00%
TOTAL	**1**	**1***	**$1,186.32**	**$39.54**	**$1,186.32**	**100.00%**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

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Appendix M

Fiscal Year 2016 Annual Review of Anticoagulants and Platelet Aggregation Inhibitors

Oklahoma Health Care Authority
September 2016

Current Prior Authorization Criteria

Effient® (Prasugrel) Approval Criteria:

1. The first 90 days of therapy do not require prior authorization; and
2. Approved diagnostic criteria: unstable angina/non-ST-segment elevated myocardial infarction (UA/non-STEMI) and ST-segment elevated myocardial infarction (STEMI) patients who are to be managed with percutaneous coronary intervention (PCI), primary or delayed (stent placement); and
3. Effient® (prasugrel) will not be approved for members with the following situations:
    a. Coronary Artery Bypass Graft surgery (CABG); or
    b. Members with a history of transient ischemic attack (TIA) or stroke; and
4. Members greater than 75 years of age will generally not be approved without supporting information; and
5. Approvals will be for the duration of one year; and
6. After the end of 15 months, prescribers should provide supporting information for the continuation of this product.

Plavix® 300mg (Clopidogrel) Approval Criteria:

1. An FDA approved diagnosis of non-ST-segment elevated acute coronary syndrome or ST-segment elevated acute myocardial infarction.
2. Approvals will be for one dose only of 300mg.

Brilinta® (Ticagrelor) Approval Criteria:

1. The first 90 days of therapy do not require prior authorization.
2. Approved diagnostic criteria: acute coronary syndrome (ACS) (unstable angina, non-ST elevation myocardial infarction, or ST elevation myocardial infarction) with or without percutaneous coronary intervention (PCI).
3. Approvals will be for the duration of one year.

Zontivity™ (Vorapaxar) Approval Criteria:

1. An FDA approved diagnosis of one of the following: history of myocardial infarction (MI) or peripheral arterial disease (PAD); and
2. Zontivity™ must be used in combination with aspirin and/or clopidogrel (not monotherapy); and
3. Zontivity™ will not be approved for members with the following situations: history of transient ischemic attack (TIA), stroke, intracranial hemorrhage (ICH), or active pathological bleeding; and
4. A quantity limit of 30 tablets per 30 days will apply.

Pradaxa® (Dabigatran) Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. Non-valvular atrial fibrillation; or
    b. Treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE) after treatment with a parenteral anticoagulant for 5 to 10 days; or
    c. To reduce the risk of recurrent DVT or PE in patients who have been previously treated.

Xarelto® (Rivaroxaban) Approval Criteria:

1. Approved diagnostic criteria: non-valvular atrial fibrillation, treatment of deep vein thrombosis (DVT), pulmonary embolism (PE), or to reduce the risk of recurrent DVT and PE.
2. Xarelto® (rivaroxaban) 15mg and 20mg:
    a. A diagnosis of non-valvular atrial fibrillation, DVT, PE, or prophylaxis of recurrent DVT or PE will be required.
3. Xarelto® (rivaroxaban) 10mg:
    a. One prescription for up to 35 days of therapy is allowed without prior authorization every 6 months to allow for DVT prophylaxis use in patients following hip or knee replacement surgery.

Eliquis® (Apixaban) Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. Non-valvular atrial fibrillation; or
    b. Pulmonary embolism (PE) or deep vein thrombosis (DVT) prophylaxis in patients who have had hip or knee replacement surgery; or
    c. Treatment of DVT and PE and for the reduction in the risk of recurrent DVT or PE.

Savaysa™ (Edoxaban) Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. To reduce the risk of stroke and systemic embolism (SE) in patients with non-valvular atrial fibrillation; or
    b. For the treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE) following 5 to 10 days of initial therapy with a parenteral anticoagulant; and
2. Requests for therapy for the treatment of DVT and PE must verify that the member has undergone 5 to 10 days of initial therapy with a parenteral anticoagulant; and
3. Member must not have a creatinine clearance (CrCl) greater than 95mL/min because of increased risk of ischemic stroke compared to warfarin at the highest dose studied (60mg); and
4. A quantity limit of 30 tablets per 30 days will apply.

Aggrenox® (Aspirin/Dipyridamole ER) Approval Criteria:

1. An FDA approved indication for the prophylaxis of recurrent thromboembolic stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis; and
2. Member must be 18 years of age or older; and

3. A patient-specific, clinically significant reason why member cannot use immediate-release dipyridamole and over-the-counter (OTC) aspirin in place of Aggrenox® must be provided.
4. A quantity limit of 60 capsules for a 30 day supply will apply.

Utilization of Anticoagulants and Platelet Aggregation Inhibitors: Fiscal Year 2016

Comparison of Fiscal Years: Anticoagulants

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2015	2,202	11,752	$1,017,137.52	$86.55	$2.62	452,965	387,971
2016	2,151	12,133	$1,514,326.03	$124.81	$3.78	482,380	400,096
% Change	**-2.30%**	**3.20%**	**48.90%**	**44.20%**	**44.30%**	**6.50%**	**3.10%**
Change	**-51**	**381**	**$497,188.51**	**$38.26**	**$1.16**	**29,415**	**12,125**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

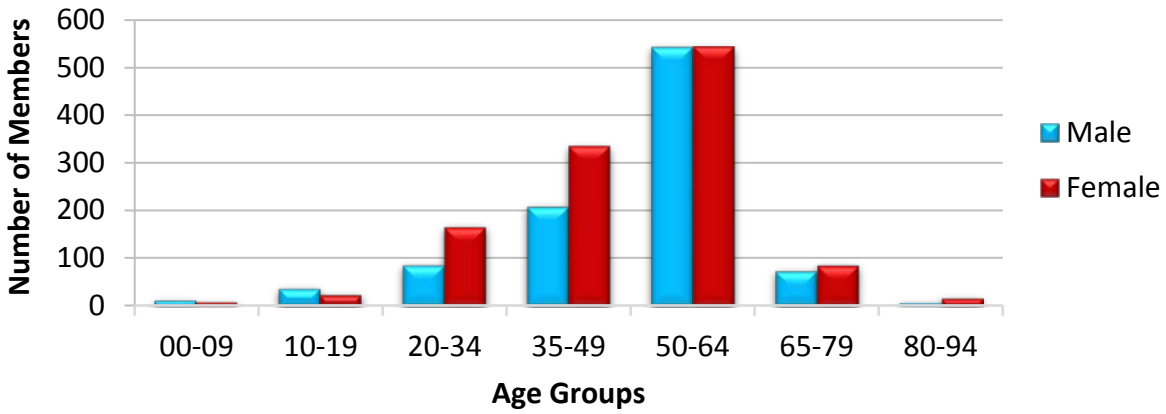
Comparison of Fiscal Years: Platelet Aggregation Inhibitors

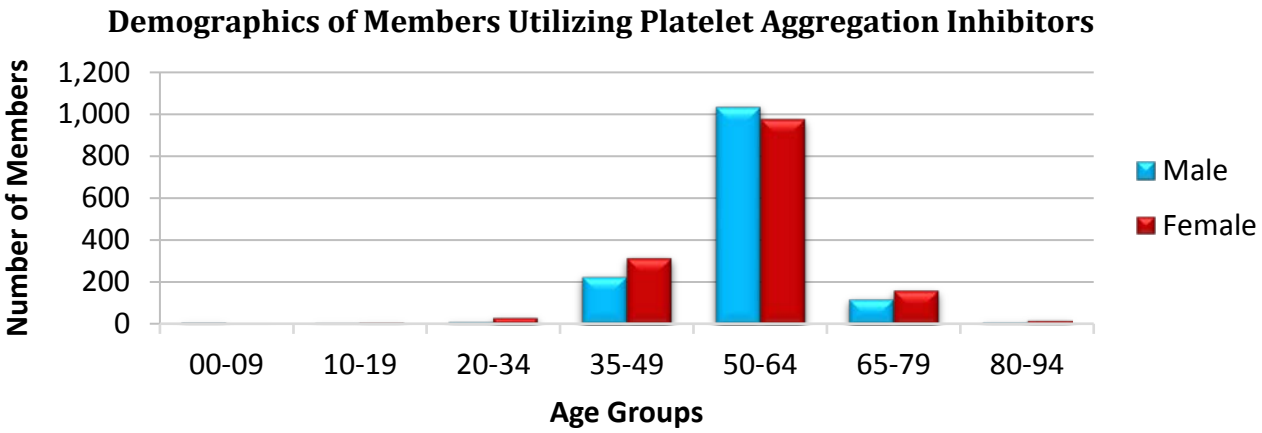
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2015	2,818	12,699	$650,458.27	$51.22	$1.24	552,301	524,619
2016	2,926	13,179	$777,946.06	$59.03	$1.42	580,800	549,668
% Change	**3.80%**	**3.80%**	**19.60%**	**15.20%**	**14.50%**	**5.20%**	**4.80%**
Change	**108**	**480**	**$127,487.79**	**$7.81**	**$0.18**	**28,499**	**25,049**

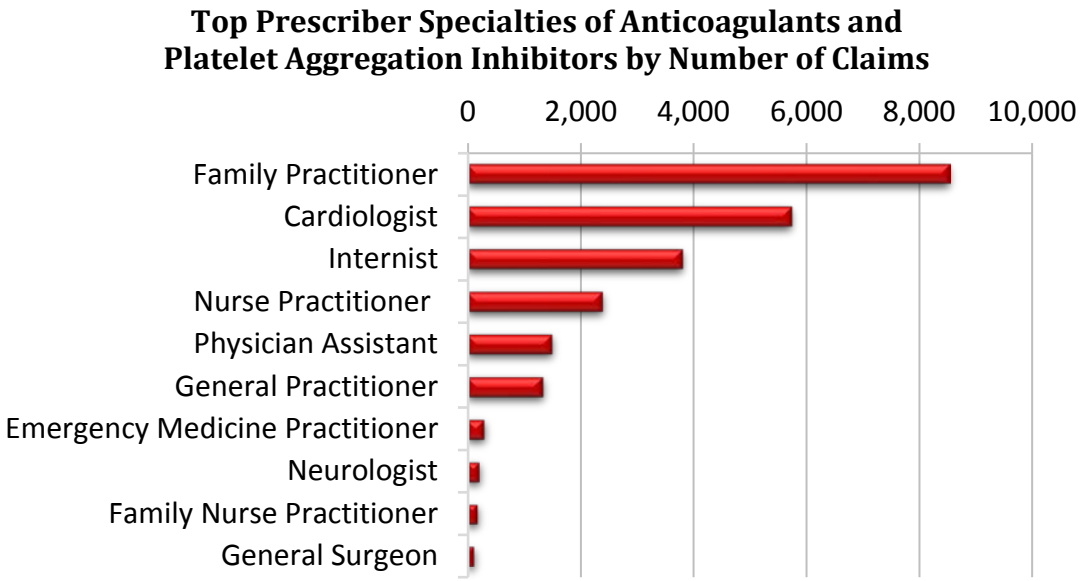
*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

- Please note that federal and state supplemental rebates are significant and the total costs above do not reflect rebated net costs.

Demographics of Members Utilizing Anticoagulants

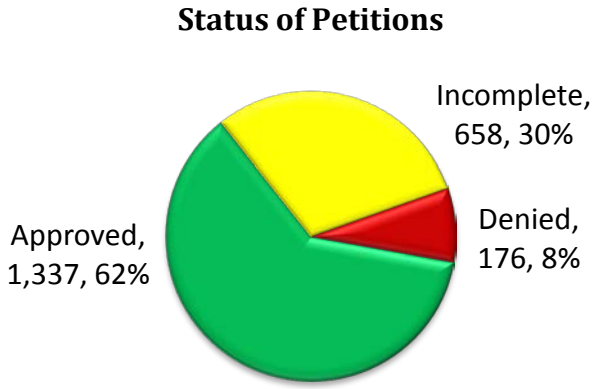






Prior Authorization of Anticoagulants and Platelet Aggregation Inhibitors

There were 2,171 prior authorization requests submitted for the anticoagulants and platelet aggregation inhibitors category during fiscal year 2016. The following chart shows the status of the submitted petitions.



Market News and Updates[1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16]

Anticipated Patent Expiration(s):

- Xarelto® (rivaroxaban): February 2021
- Effient® (prasugrel): July 2021
- Brilinta® (ticagrelor): July 2021
- Eliquis® (apixaban): February 2023
- Zontivity® (vorapaxar): April 2024
- Pradaxa® (dabigatran): August 2027
- Savaysa™ (edoxaban): March 2028

New Safety Information and Update(s):

- **September 2015:** The U.S. Food and Drug Administration (FDA) approved Durlaza™ (aspirin extended-release capsules) in September 2015 to reduce the risk of death and myocardial infarction (MI) in patients with chronic coronary artery disease (CAD), such as patients with a history of MI or unstable angina pectoris or with chronic stable angina; and to reduce the risk of death and recurrent stroke in patients who have had an ischemic stroke or transient ischemic attack (TIA). Durlaza™ has a limitation of use in situations where a rapid onset of action is required such as acute treatment of MI or before percutaneous coronary intervention in which immediate-release aspirin should be used.
- **October 2015:** The FDA approved Praxbind® (idarucizumab injection) in October 2015 in patients treated with dabigatran when reversal of the anticoagulant effects of dabigatran is needed for emergency surgery, urgent procedures, or in life-threatening or uncontrolled bleeding.
- **November 2015:** Pradaxa® (dabigatran) was FDA approved for a new indication in November of 2015 for prophylaxis of deep-vein thrombosis (DVT) and pulmonary embolism (PE) after hip replacement surgery. The FDA originally approved dabigatran in 2010 to reduce the risk for stroke and systemic embolism in those with nonvalvular atrial fibrillation. The FDA approved two additional indications for the drug for the treatment of DVT and PE in patients who have received treatment with a parenteral anticoagulant for 5 to 10 days, and to lower the risk for recurrent DVT and PE in those who have been treated previously.
- **January 2016:** A small prospective observational study was published in *Neurology* that compared intracerebral hemorrhage (ICH) volume and clinical outcome of direct oral anticoagulants (DOAC) to warfarin-associated ICH. The study showed patients with DOAC-associated ICH had smaller ICH volumes and better clinical outcomes compared with warfarin-associated ICH.
- **January 2016:** *The American College of Chest Physicians* (CHEST) issued new antithrombotic guideline updates for the treatment of venous thromboembolism (VTE). In this latest evidence-based guideline, *Antithrombotic Therapy for VTE Disease: CHEST Guideline*, from the American College of Chest Physicians, experts provide 54 updated recommendations for appropriate treatment of patients with VTE. For VTE patients, non-vitamin K antagonist oral anticoagulants (NOACs) are suggested over warfarin for initial and long-term treatment of VTE in patients without cancer due to recent studies

that show NOACs are as effective as vitamin K antagonist therapy with reduced risk of bleeding and increased convenience for patients and health-care providers. SoonerCare criteria is in line with the current guideline recommendations.

- **March 2016:** AstraZeneca announced top-line results from the SOCRATES trial, assessing the efficacy of Brilinta® (ticagrelor) 90mg tablets twice daily compared to aspirin 100mg once daily in patients with acute ischemic stroke or TIA. The primary efficacy endpoint of time to first occurrence of any event from the composite of stroke (ischemic or hemorrhagic), MI, and death was not met. Fewer events were observed on Brilinta® versus the comparator in the overall trial population but the trend did not reach statistical significance.
- **March 2016:** The updated 2016 ACC/AHA Guideline Focused Update on Duration of Dual Antiplatelet Therapy (DAPT) in Patients with Coronary Artery Disease was published in the *Journal of the American College of Cardiology* in March of 2016. For patients with acute coronary syndromes (ACS), at least 12 months of DAPT are recommended as a Class I level of recommendation. At the one year mark, DAPT may be continued if the ACS patient did not have any overt bleeding that first year and does not have a high bleeding risk (Class IIb). SoonerCare recommended criteria is in line with current guideline recommendations.
- **May 2016:** Results from the APEX study for betrixaban, an oral Factor Xa inhibitor anticoagulant, were published in *The New England Journal of Medicine*. APEX evaluated the superiority of extended-release oral betrixaban compared with the standard of care anticoagulation with injectable enoxaparin for the prevention of VTE in acute medically ill patients. The study found there was no significant difference between betrixaban and a standard regimen of enoxaparin in the primary efficacy outcome, however, a pre-specified exploratory analyses provided evidence suggesting a benefit for betrixaban in the two larger cohorts. Portola Pharmaceuticals Inc. plans to submit the data in a New Drug Application to the FDA in the second half of 2016. The FDA granted Fast Track designation to betrixaban in October of 2015.
- **May 2016:** In a recent observational study in more than 10,000 patients with different diseases who were receiving warfarin therapy to prevent clots and stroke, those who had atrial fibrillation (AF) as opposed to thromboembolism or a mechanical heart valve were more likely to develop dementia, including Alzheimer's disease, during about a 7-year follow-up. A total of 2.8% of patients with AF versus 0.9% of the other patients developed Alzheimer's disease. In addition, the risk of dementia was higher when warfarin was poorly controlled, regardless of whether or not the patients had AF.
- **July 2016:** *JAMA Cardiology* published a secondary analysis of the randomized controlled trial ARISTOTLE (Apixaban for Reduction of Stroke and Other Thromboembolic Complications in Atrial Fibrillation) to determine the frequency of one dose-reduction criterion and whether the effects of the 5mg twice daily dose of apixaban on stroke or systemic embolism and bleeding varied. Patients with atrial fibrillation and isolated advanced age, low body weight, or renal dysfunction have a higher risk of stroke or systemic embolism and major bleeding but show consistent benefits with the 5mg twice daily dose of apixaban versus warfarin compared with patients without those characteristics. The study determined the 5mg twice daily dose

of apixaban is safe, efficacious, and appropriate for patients with only one dose-reduction criteria.

- **July 2016:** The FDA approved a brand name change for the antidepressant Brintellix (vortioxetine) to Trintellix® to decrease the risk of prescribing and dispensing errors resulting from name confusion with the blood-thinning medicine Brilinta® (ticagrelor).
- **August 2016:** The FDA issued a Complete Response Letter (CRL) regarding the FDA-designated Breakthrough Therapy AndexXa™ (andexanet alfa) New Drug Application. AndexXa™ is in development for patients treated with a direct (apixaban, rivaroxaban, or edoxaban) or indirect (enoxaparin) Factor Xa inhibitor when reversal of anticoagulation is needed due to life-threatening or uncontrolled bleeding. Currently, there is no FDA-approved antidote for Factor Xa inhibitors available. In the CRL, the FDA requested additional information regarding manufacturing, additional data to support inclusion of edoxaban and enoxaparin in the label, and indicated it needs to finalize its review of the clinical amendments to Portola Pharmaceuticals post-marketing commitments. Portola Pharmaceuticals intends to resolve the outstanding questions and find the most expedient path to approval.

Recommendations

The College of Pharmacy recommends updating the Pradaxa® (dabigatran), Brilinta® (ticagrelor), Xarelto® (rivaroxaban), and Effient® (prasugrel) approval criteria as seen in red:

Pradaxa® (Dabigatran) Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. Non-valvular atrial fibrillation; or
    b. Treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE) after treatment with a parenteral anticoagulant for 5 to 10 days; or
    c. To reduce the risk of recurrent DVT or PE in patients who have been previously treated.
    d. For the prophylaxis of DVT and PE in patients who have undergone hip replacement surgery.

Brilinta® (Ticagrelor) Approval Criteria:

1. The first 90 days of therapy do not require prior authorization.
2. Approved diagnostic criteria include:
    a. Acute coronary syndrome (ACS) (unstable angina, non-ST elevation myocardial infarction, or ST elevation myocardial infarction) with or without percutaneous coronary intervention (PCI), or
    b. History of myocardial infarction (MI)
3. Approvals will be for the duration of one year.

Xarelto® (Rivaroxaban) Approval Criteria:

1. Approved diagnostic criteria: non-valvular atrial fibrillation, treatment of deep vein thrombosis (DVT), pulmonary embolism (PE), to reduce the risk of recurrent DVT and PE, or for the prophylaxis of DVT, which may lead to PE in patients undergoing knee or hip replacement surgery.

2. Xarelto® (rivaroxaban) 15mg and 20mg:
    a. A diagnosis of non-valvular atrial fibrillation, DVT, PE, or prophylaxis of recurrent DVT or PE will be required.
3. Xarelto® (rivaroxaban) 10mg:
    a. One prescription for up to 35 days of therapy is allowed without prior authorization every 6 months to allow for DVT prophylaxis use in patients following hip or knee replacement surgery.

Effient® (Prasugrel) Approval Criteria:

1. The first 90 days of therapy do not require prior authorization; and
2. Approved diagnostic criteria: unstable angina/non-ST-segment elevated myocardial infarction (UA/non-STEMI) and ST-segment elevated myocardial infarction (STEMI) patients who are to be managed with percutaneous coronary intervention (PCI), primary or delayed (stent placement); and
3. Effient® (prasugrel) will not be approved for members with the following situations:
    a. Coronary Artery Bypass Graft surgery (CABG); or
    b. Members with a history of transient ischemic attack (TIA) or stroke; and
4. Members greater than 75 years of age will generally not be approved without supporting information; and
5. Approvals will be for the duration of one year; and
6. ~~After the end of 15 months, prescribers should provide supporting information for the continuation of this product~~.

Utilization Details of Anticoagulants: Fiscal Year 2016

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ DAY	COST/ CLAIM
WARFARIN PRODUCTS					
WARFARIN TAB 5MG	2,566	724	$22,223.73	$0.24	$8.66
WARFARIN TAB 1MG	761	235	$7,423.21	$0.28	$9.75
WARFARIN TAB 4MG	750	205	$6,515.64	$0.26	$8.69
WARFARIN TAB 3MG	700	194	$6,595.49	$0.28	$9.42
WARFARIN TAB 6MG	642	174	$6,131.36	$0.27	$9.55
WARFARIN TAB 7.5MG	603	179	$5,039.25	$0.20	$8.36
WARFARIN TAB 2MG	497	170	$3,899.16	$0.24	$7.85
WARFARIN TAB 10MG	472	147	$4,379.60	$0.22	$9.28
WARFARIN TAB 2.5MG	368	129	$2,894.17	$0.22	$7.86
WARFARIN SOD TAB 10MG	97	34	$965.56	$0.25	$9.95
COUMADIN TAB 1MG	53	15	$1,748.78	$1.63	$33.00
JANTOVEN TAB 5MG	42	9	$410.75	$0.26	$9.78
COUMADIN TAB 5MG	38	13	$1,792.53	$1.57	$47.17
COUMADIN TAB 3MG	37	5	$397.15	$0.58	$10.73
COUMADIN TAB 2MG	30	6	$508.59	$0.97	$16.95
COUMADIN TAB 10MG	29	3	$1,168.29	$2.63	$40.29
JANTOVEN TAB 1MG	23	4	$219.83	$0.31	$9.56
JANTOVEN TAB 3MG	20	6	$159.18	$0.30	$7.96
COUMADIN TAB 4MG	15	6	$438.16	$1.77	$29.21
COUMADIN TAB 2.5MG	14	3	$87.38	$0.28	$6.24
JANTOVEN TAB 4MG	14	2	$89.02	$0.22	$6.36
COUMADIN TAB 6MG	11	4	$438.94	$2.40	$39.90
JANTOVEN TAB 7.5MG	7	2	$42.79	$0.20	$6.11
JANTOVEN TAB 2MG	5	4	$45.88	$0.14	$9.18
JANTOVEN TAB 2.5MG	5	2	$41.99	$0.28	$8.40
COUMADIN TAB 7.5MG	4	2	$24.22	$0.78	$6.06
JANTOVEN TAB 6MG	2	2	$23.56	$0.26	$11.78
SUBTOTAL	**7,805**	**2,279**	**$73,704.21**	**$0.63**	**$14.37**
DABIGATRAN PRODUCTS					
PRADAXA CAP 150MG	233	38	$76,699.18	$11.21	$329.18
PRADAXA CAP 75MG	40	6	$12,708.84	$11.68	$317.72
SUBTOTAL	**273**	**44**	**$89,408.02**	**$11.45**	**$323.45**
RIVAROXABAN PRODUCTS					
XARELTO TAB 10MG	225	134	$60,374.02	$11.92	$268.33
XARELTO TAB 15MG	214	83	$80,448.91	$14.16	$375.93
XARELTO TAB 20MG	2,183	414	$741,533.32	$11.83	$339.69
XARELTO STAR TAB	5	5	$3,040.84	$20.27	$608.17
SUBTOTAL	**2,627**	**636**	**$885,397.09**	**$14.55**	**$398.03**
APIXABAN PRODUCTS					
ELIQUIS TAB 2.5MG	191	58	$53,671.30	$11.05	$281.00
ELIQUIS TAB 5MG	1,236	273	$411,852.98	$11.68	$333.21

SUBTOTAL	**1,427**	**331**	**$465,524.28**	**$11.37**	**$307.11**
EDOXABAN PRODUCTS					
SAVAYSA TAB 60MG	1	1	$292.43	$9.75	$292.43
SUBTOTAL	**1**	**1**	**$292.43**	**$9.75**	**$292.43**
TOTAL	**12,133**	**2,151***	**$1,514,326.03**	**$3.63**	**$98.16**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Utilization Details of Platelet Aggregation Inhibitors: Fiscal Year 2016

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ DAY	COST/ CLAIM
CLOPIDOGREL PRODUCTS					
CLOPIDOGREL TAB 75MG	11,227	2,617	$88,348.38	$0.18	$7.87
PLAVIX TAB 75MG	1	1	$7.96	$0.27	$7.96
SUBTOTAL	**11,228**	**2,618**	**$88,356.34**	**$0.23**	**$7.92**
PRASUGREL PRODUCTS					
EFFIENT TAB 10MG	882	171	$319,073.14	$12.05	$361.76
EFFIENT TAB 5MG	7	3	$2,501.91	$11.91	$357.42
SUBTOTAL	**889**	**174**	**$321,575.05**	**$11.98**	**$359.59**
TICAGRELOR PRODUCTS					
BRILINTA TAB 90MG	541	156	$167,870.17	$10.42	$310.30
BRILINTA TAB 60MG	12	3	$3,913.80	$10.87	$326.15
BRILINTA 90MG TAB	3	1	$750.78	$8.34	$250.26
SUBTOTAL	**556**	**160**	**$172,534.75**	**$9.88**	**$295.57**
VORAPAXAR PRODUCTS					
ZONTIVITY TAB 2.08MG	21	4	$6,270.52	$9.95	$298.60
SUBTOTAL	**21**	**4**	**$6,270.52**	**$9.95**	**$298.60**
ASPIRIN-DIPYRIDAMOLE PRODUCTS					
ASA/DIPYRIDA CAP 25-	321	56	$114,472.13	$11.50	$356.61
AGGRENOX CAP 25-200MG	164	40	$74,737.27	$14.18	$455.72
SUBTOTAL	**485**	**96**	**$189,209.40**	**$12.84**	**$406.17**
TOTAL	**13,179**	**2,926***	**$777,946.06**	**$8.98**	**$273.57**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

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Appendix N

Fiscal Year 2016 Annual Review of Dry Eye Disease Products and 30-Day Notice to Prior Authorize Xiidra™ (Lifitegrast 5% Ophthalmic Solution)

Oklahoma Health Care Authority
September 2016

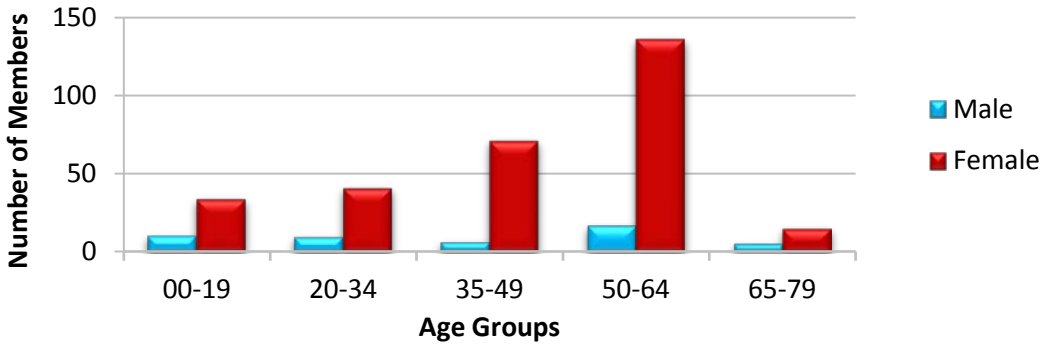
Utilization of Dry Eye Disease Products: Fiscal Year 2016

Comparison of Fiscal Years

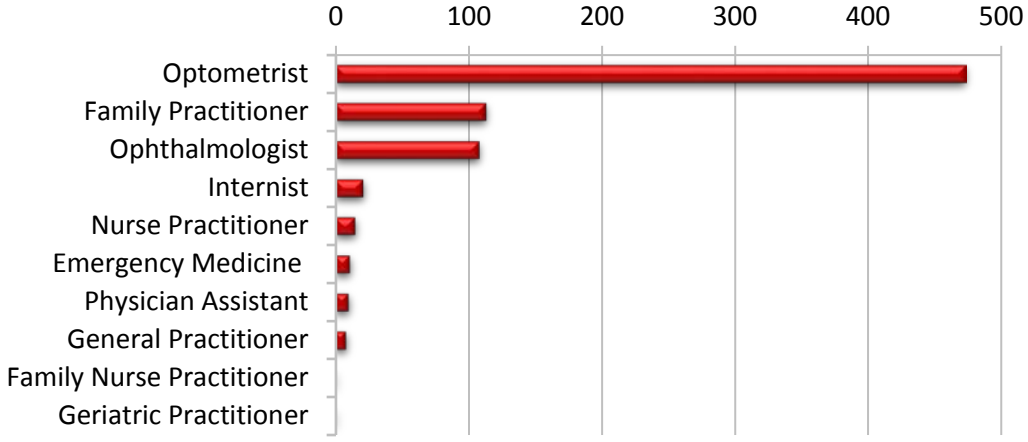
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2015	323	799	$269,010.57	$336.68	$12.08	45,210	22,275
2016	343	762	$328,362.01	$430.92	$14.37	46,230	22,856
% Change	**6.20%**	**-4.60%**	**22.10%**	**28.00%**	**19.00%**	**2.30%**	**2.60%**
Change	**20**	**-37**	**$59,351.44**	**$94.24**	**$2.29**	**1,020**	**581**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

Demographics of Members Utilizing Dry Eye Disease Products



Top Prescriber Specialties of Dry Eye Disease Products by Number of Claims



Dry Eye Disease[1,2,3,4,5]

Dry eye disease (DED) also known as dry eye syndrome (DES), keratoconjunctivitis sicca (KCS), and keratitis sicca refers to a group of disorders of the tear film. It is caused by reduced tear production or excessive tear evaporation, associated with ocular discomfort and/or visual symptoms and possible disease of the ocular surface. DED is a common form of ocular surface disease (OSD) and may overlap with other causes of OSD, such as ocular allergy and meibomian gland dysfunction (MGD). Dry eye syndrome is very common in the United States, affecting a significant percentage of the population, especially those older than 40 years. Prevalence estimates range from approximately 10% to 30% of the population. An estimated 3.23 million women and 1.68 million men aged 50 years and older are affected.

The ocular surface and tear-secreting glands function as an integrated unit. Disease or dysfunction of this functional unit results in an unstable and poorly maintained tear film that causes ocular irritation symptoms and possible damage to the ocular surface epithelium. Dysfunction of this unit may develop from aging, a decrease in supportive factors (such as androgen hormones), systemic inflammatory diseases (such as Sjögren syndrome or rheumatoid arthritis), ocular surface diseases (such as herpes simplex virus [HSV] keratitis) or surgeries that disrupt the trigeminal afferent sensory nerves (e.g., LASIK), and systemic diseases or medications that disrupt the efferent cholinergic nerves that stimulate tear secretion. Decreased tear secretion and clearance initiates an inflammatory response on the ocular surface that involves both soluble and cellular mediators. The signs and symptoms of DED include: foreign-body sensation, ocular dryness and grittiness, hyperemia, mucoid discharge, ocular irritation, excessive tearing (secondary to reflex secretion), photophobia, and fluctuating or blurry vision. There is no single definitive test or consensus of criteria to diagnose dry eye. A variety of symptom questionnaires and diagnostic tests are often used in an attempt to standardize the identification and classification of dry eye disease. Dry eye is diagnosed primarily on the basis of patient symptoms and supporting findings on the physical examination. The diagnosis can often be made at the office of the primary care clinician. If ophthalmologist evaluation is sought, a thorough slit lamp evaluation along with other testing to assess the status of the patient's lacrimal functional unit will be performed to determine the severity of dry eye disease and possible etiologies.

The 2013 Dry Eye Syndrome Preferred Practice Pattern guidelines classify DED as mild, moderate, or severe based on both symptoms and signs, with emphasis on symptoms. However, due to the nature of DED and the overlap of symptoms, this classification is imprecise. Classification is further complicated by the lack of an agreed upon diagnostic tool(s) among practitioners. Current treatment for dry eye disease is aimed at increasing or supplementing tear production, slowing tear evaporation, and reducing tear resorption. Artificial tears are considered first-line treatment for dry eye and have been shown to improve irritative symptoms in patients with dry eye. The guidelines recommend solution, gel or ointment which are three of the most common types of artificial tears. The package labeling of each variation of artificial tears recommends use for three days. Additionally, environmental strategies, such as frequent blinking and use of humidifiers is often recommended. Topical cyclosporine, Restasis®, is an immunosuppressive agent approved by the U.S. Food and Drug

Administration (FDA) in December 2002. It is indicated to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with DED. Increased tear production was not seen in patients currently taking topical anti-inflammatory drugs or using punctal plugs. Restasis® is dosed as one drop into each eye twice daily. It has been found to be relatively safe, well-tolerated, and to improve signs and symptoms of dry eyes significantly in some populations. Other treatments for DED are available but are not commonly used and should be adjunctive treatment for patients followed by eye specialists. These treatments include: sodium hyaluronate, topical glucocorticoids, autologous serum tears, tear stimulation, omega-3 and omega-6 fatty acids, oral antioxidants, vitamin A, punctal occlusion, scleral contact lenses, acupuncture, and surgery. In July 2016, Xiidra™ (lifitegrast 5% ophthalmic solution) became the only FDA approved eye drop indicated for the treatment of both the signs and symptoms of DED. Like Restasis®, it is dosed as one drop in each eye twice daily.

Xiidra™ (Lifitegrast Ophthalmic Solution) Product Summary[6,7,8]

FDA Approved: July 2016

Indications: Xiidra™ (lifitegrast ophthalmic solution) is a lymphocyte function-associated antigen-1 (LFA-1) antagonist indicated for the treatment of the signs and symptoms of DED.

Dosing:

- Xiidra™ (lifitegrast ophthalmic solution) is available as a 5% ophthalmic solution.
- It is supplied in a foil pouch containing five 0.2mL single-use containers. It is available in a carton of 60 single-use containers.
- The recommended dosing is one drop into each eye twice daily, approximately 12 hours apart.
- Contact lenses should be removed prior to the administration of lifitegrast ophthalmic solution and may be reinserted 15 minutes following administration.

Mechanism of Action: Lifitegrast binds to the integrin lymphocyte function-associated antigen-1 (LFA-1), a cell surface protein found on leukocytes, and blocks the interaction of LFA-1 with its cognate ligand intercellular adhesion molecule-1 (ICAM-1). ICAM-1 may be overexpressed in corneal and conjunctival tissues in dry eye disease. LFA-1/ICAM-1 interaction can contribute to the formation of an immunological synapse resulting in T-cell activation and migration to target tissues. Lifitegrast may inhibit T-cell adhesion to ICAM-1 in a human T-cell line and may inhibit secretion of inflammatory cytokines in human peripheral blood mononuclear cells.

Contraindications:

- None

Adverse Reactions: The most common adverse reactions during clinical trials (5% to 25% of patients) included the following:

- Instillation site irritation
- Dysgeusia
- Reduced visual acuity

Other adverse reactions reported in 1% to 5% of the patients studied include:

- Blurred vision
- Conjunctival hyperemia
- Increased lacrimation
- Eye discharge
- Eye discomfort
- Eye irritation
- Headache
- Eye pruritus
- Sinusitis

Use in Special Populations:

- Pregnancy: There are no available data on lifitegrast use in pregnant women to inform any drug associated risks. Intravenous (IV) administration of lifitegrast to pregnant rats, from pre-mating through gestation day 17, did not produce teratogenicity at clinically relevant systemic exposures. IV administration of lifitegrast to pregnant rabbits during organogenesis produced an increased incidence of omphalocele at the lowest dose tested, 3mg/kg/day (400-fold the human plasma exposure at the recommended human ophthalmic dose [RHOD], based on the area under the curve [AUC] level). Since human systemic exposure to lifitegrast following ocular administration of lifitegrast at the RHOD is low, the applicability of animal findings to the risk of lifitegrast use in humans during pregnancy is unclear.
- Lactation: There are no data on the presence of lifitegrast in human milk, the effects on the breastfed infant, or the effects on milk production. However, systemic exposure to lifitegrast from ocular administration is low. The developmental and health benefits of breastfeeding should be considered, along with the mother's clinical need for lifitegrast and any potential adverse effects on the breastfed child from lifitegrast.
- Pediatric Use: The safety and efficacy in pediatric patients below the age of 17 years have not been established.
- Geriatric Use: No overall differences in safety or effectiveness have been observed between elderly and younger adult patients.

Efficacy:

The safety and efficacy of lifitegrast for the treatment of dry eye disease were assessed in a total of 1,181 patients (1,067 of which received lifitegrast 5%) in four 12-week, randomized, multi-center, double-masked, vehicle-controlled studies. Patients were randomized to lifitegrast or vehicle in dosed twice a day. Exclusion criteria was not provided in the prescribing information. The mean age was 59 years (range, 19 to 97 years). The majority of patients were female (76%). Enrollment criteria included, minimal signs [i.e., Corneal Fluorescein Staining (CFS) and non-anesthetized Schirmer Tear Test (STT)] and symptom [i.e., Eye Dryness Score (EDS) and Ocular Discomfort Score (ODS)] severity scores at baseline.

- CFS is a test that uses orange dye (fluorescein) and a blue light to detect damage to the cornea or foreign bodies in the eye. Any problems on the surface of the cornea will be stained by the dye and appear green under the blue light.
- The STT determines whether the eye produces enough tears to keep it moist. A special paper strip is placed inside the lower eyelid of each eye, the eyes are closed for 5 minutes then the paper is removed. More than 10mm of moisture on the filter paper after 5 minutes is a sign of normal tear production.

- The symptoms of dry eye were determined using EDS, which is a rating of dry eye symptoms within the ODS. The patients rated their dry eye discomfort using a visual analogue scale. No discomfort was rated as zero and maximal discomfort was rated as 100.

The primary endpoints were significant improvement in patient-reported symptoms of dry-eye disease utilizing EDS from baseline versus placebo, and significant improvement in the inferior fluorescein corneal staining score (ICSS) from baseline versus placebo. A larger reduction in EDS favoring lifitegrast was observed in all studies at Day 42 and Day 84. At Day 42, the mean differences between lifitegrast and the vehicle in the four studies performed ranged from 4.2 to 10.0. At Day 84, the mean differences ranged from 4.7 to 12.3. A larger reduction in the mean ICSS favoring lifitegrast was observed in three of the four studies, at day 84. At Day 84, the mean differences between lifitegrast and the vehicle in three studies ranged from 0.17 to 0.25.

Cost Comparison:

Medication	EAC Per Vial	EAC for 30 Days of Therapy
Xiidra™ (lifitegrast 5% ophthalmic solution)	**$7.51**	**$450.60**
Restasis® (cyclosporine 0.05% ophthalmic emulsion)	$7.51*	$450.60*

EAC = estimated acquisition cost

*Cost does not reflect rebated price or net cost

Recommendations

The College of Pharmacy recommends the prior authorization of Xiidra™ (lifitegrast ophthalmic solution) with the following criteria:

Xiidra™ (Lifitegrast Ophthalmic Solution) Approval Criteria:

1. Member must be 17 years of age or older and have an FDA approved diagnosis of dry eye disease (DED); and
2. Prescriber must verify that environmental factors (e.g. humidity, fans) have been addressed; and
3. Member must have trials with at least three over-the-counter (OTC) products for three days in the last 30 days that failed to relieve signs and symptoms of dry eyes; and
4. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine ophthalmic emulsion), which is available without a prior authorization; and
5. A quantity limit of two vials per day will apply.

[1] American Academy of Ophthalmology Cornea/External Disease Panel. Preferred Practice Pattern® Guidelines. Dry Eye Syndrome. San Francisco, CA: American Academy of Ophthalmology; 2013. Available online at: www.aao.org/ppp. Last revised 09/21/2013. Last accessed 08/01/2016.

[2] Foster, C. Stephen. Dry Eye Syndrome. *Medscape*. Available online at: http://emedicine.medscape.com/article/1210417-overview#a6. Last revised 07/14/2016. Last accessed 08/04/2016.

[3] Shtein, Roni. Dry eyes. *Up-To-Date*. Available online at: http://www.uptodate.com/contents/dry-eyes?source=machineLearning&search=dry+eye+disease&selectedTitle=1%7E150&sectionRank=1&anchor=H16#H16. Last revised 12/22/2015. Last accessed 08/02/2016.

[4] Restais® Prescribing Information. Allergan, Inc. Available online at: http://www.allergan.com/assets/pdf/restasis_pi.pdf. Last revised 06/2013. Last accessed 08/26/2016.

[5] U.S. Food and Drug Administration (FDA): Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm. Last revised 07/2016. Last accessed 08/26/2016.

[6] Xiidra™ Prescribing Information. Shire US, Inc. Available online at: http://www.shirecontent.com/PI/PDFs/Xiidra_USA_ENG.pdf. Last revised 07/2016. Last accessed 08/04/2016.

[7] MedlinePlus. Bethesda (MD): National Library of Medicine (US). Fluorescein Eye Stain. Available online at: https://medlineplus.gov/ency/article/003845.htm. Last revised 01/31/2015. Last accessed 08/26/2016.

[8] MedlinePlus. Bethesda (MD): National Library of Medicine (US). Schirmer Test. Available online at: https://medlineplus.gov/ency/article/003501.htm. Last revised 02/23/2015. Last accessed 08/26/2016.

Appendix O

Fiscal Year 2016 Annual Review of Butalbital Products and 30-Day Notice to Prior Authorize Allzital® (Butalbital/Acetaminophen 25mg/325mg) & Esgic® Capsules (Butalbital/Acetaminophen/Caffeine 50mg/325mg/40mg)

Oklahoma Health Care Authority
September 2016

Current Prior Authorization Criteria

Butalbital Medications Approval Criteria:

1. An FDA approved indication for the treatment of tension-type headache; and
2. Member must be 12 years of age or older; and
3. Failure within the previous 60 days of the following:
    a. All available formulations of butalbital/acetaminophen medications that do not require prior authorization (medications available without prior authorization contain butalbital/acetaminophen/caffeine in the standard 50mg/325mg/40mg dose); and
    b. Trials of at least two nonsteroidal anti-inflammatory drugs (NSAIDs), unless contraindicated.

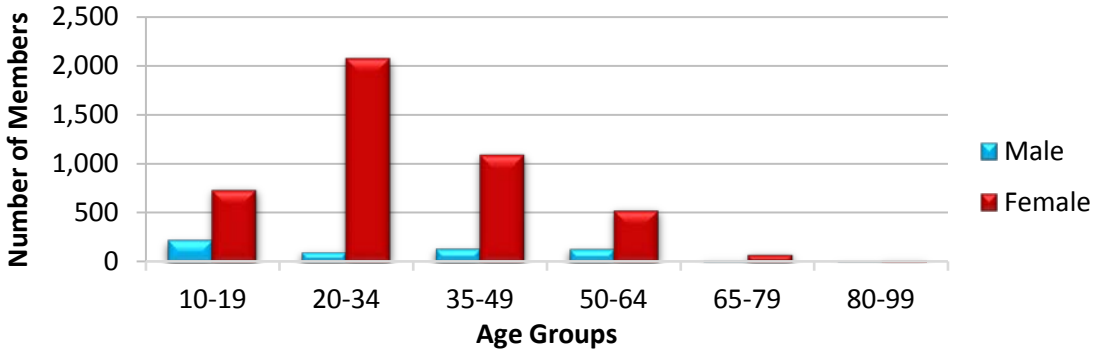
Utilization of Butalbital Products: Fiscal Year 2016

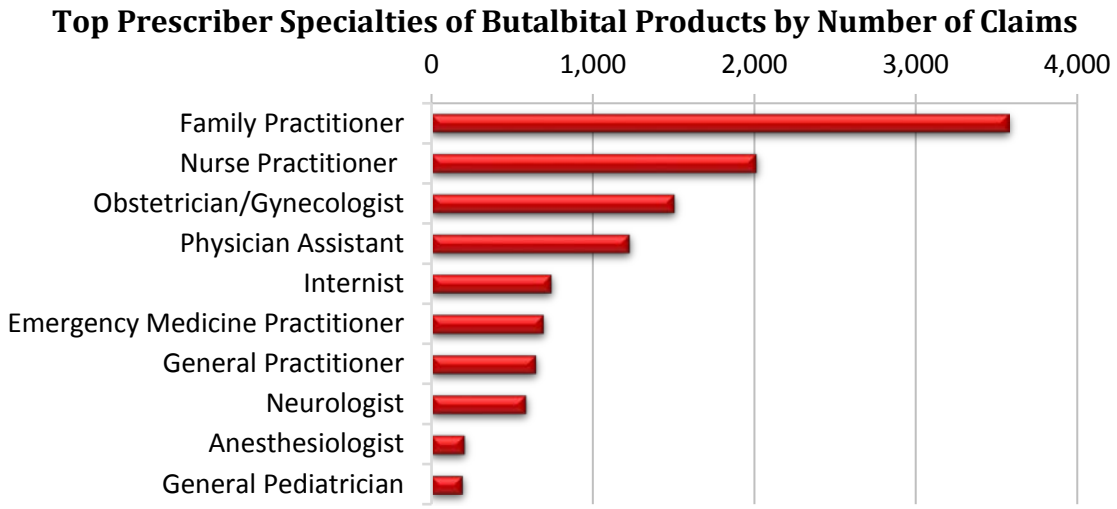
Comparison of Fiscal Years

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2015	5,989	14,215	$513,592.49	$36.13	$2.53	696,163	202,708
2016	5,111	12,048	$537,190.85	$44.59	$2.88	581,199	186,348
% Change	**-14.70%**	**-15.20%**	**4.60%**	**23.40%**	**13.80%**	**-16.50%**	**-8.10%**
Change	**-878**	**-2,167**	**$23,598.36**	**$8.46**	**$0.35**	**-114,964**	**-16,360**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.

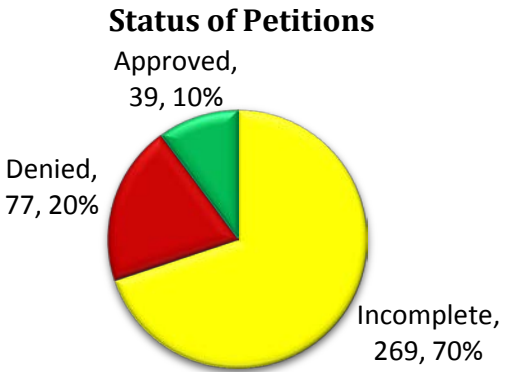
Demographics of Members Utilizing Butalbital Products





Prior Authorization of Butalbital Products

There were 385 prior authorization requests submitted for the Butalbital Products during fiscal year 2016. The following chart shows the status of the submitted petitions.



Pricing Trend(s)

Based on the current state maximum allowable cost (SMAC), updated August 2016, the price for Esgic® capsules (butalbital/acetaminophen/caffeine 50mg/325mg/40mg) is $1.58 per capsule. After the SMAC update in August 2016, the price of Fioricet® tablets (butalbital/acetaminophen/caffeine 50mg/325mg/40mg) is $0.75 per tablet. This results in a price difference of 71.25% between the tablet and capsule formulation. The capsule formulation has increased by 172.41% since September 2013.

Allzital® (Butalbital/Acetaminophen 25mg/325mg) Product Summary[1,2,3,4]

FDA Approved: December 4, 2015. There are no unexpired patents for this product; however, this strength combination is only available as a brand name product.

Indications: Allzital® (butalbital/acetaminophen 25mg/325mg) is a combination drug product intended as a treatment for tension (or muscle contraction) headache. It consists of a fixed

combination of butalbital and acetaminophen. The role each component plays in the relief of the complex of symptoms known as tension headache is not completely understood.

Dosing:

- Allzital® is available as oral tablets containing 25mg of butalbital and 325mg of acetaminophen.
- The recommended dose is two tablets by mouth every four hours.
- The total daily dosage should not exceed 12 tablets.

Mechanism of Action:

- Butalbital: Butalbital is a short-to-intermediate-acting barbiturate that depresses the sensory cortex, decreases motor activity, alters cerebellar function, and produces drowsiness, sedation, hypnosis, and dose-dependent respiratory depression.
- Acetaminophen: Acetaminophen inhibits the synthesis of prostaglandins in the central nervous system (CNS) and peripherally blocks pain impulse generation.

Contraindications:

- Hypersensitivity or intolerance to any component
- Patients with porphyria

Warnings and Precautions:

- Potential for Abuse: Butalbital is habit-forming and has the potential for abuse. Consequently, the extended use of this product is not recommended.
- Hepatotoxicity: Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with the use of acetaminophen at doses that exceed 4,000 milligrams per day, and often involve more than one acetaminophen-containing product. The excessive intake of acetaminophen may be intentional to cause self-harm or unintentional as patients attempt to obtain more pain relief or unknowingly take other acetaminophen-containing products.
- Serious Skin Reactions: Rarely, acetaminophen may cause serious skin reactions such as acute generalized exanthematous pustulosis (AGEP), Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. Use of the drug should be discontinued at the first appearance of skin rash or any other sign of hypersensitivity.
- Hypersensitivity/Anaphylaxis: There have been post-marketing reports of hypersensitivity and anaphylaxis associated with use of acetaminophen. Clinical signs included swelling of the face, mouth, and throat, respiratory distress, urticaria, rash, pruritus, and vomiting. There were infrequent reports of life-threatening anaphylaxis requiring emergency medical attention. It is recommended that patients discontinue Allzital® tablets immediately and seek medical care if they experience these symptoms. Allzital® is not to be prescribed for patients with an acetaminophen allergy.

Adverse Reactions: The most common adverse reactions include the following:

- Drowsiness
- Lightheadedness
- Dizziness
- Sedation
- Shortness of breath
- Nausea
- Vomiting
- Abdominal pain
- Intoxicated feeling

Drug Interactions:

- The CNS effects of butalbital may be enhanced by monoamine oxidase (MAO) inhibitors.
- Butalbital and acetaminophen may enhance the effects of the following: other narcotic analgesics, alcohol, general anesthetics, tranquilizers such as chlordiazepoxide, sedative-hypnotics, or other CNS depressants, causing increased CNS depression.

Use in Special Populations:

- Pregnancy: Animal reproduction studies have not been conducted with this combination product. It is also not known whether butalbital and acetaminophen can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. These products should be given to a pregnant woman only when clearly needed (pregnancy category C). Withdrawal seizures were reported in a two-day-old male infant whose mother had taken a butalbital containing drug during the last two months of pregnancy. Butalbital was found in the infant's serum. The infant was given phenobarbital 5mg/kg, which was tapered without further seizure or other withdrawal symptoms.
- Lactation: Barbiturates and acetaminophen are excreted in breast milk in small amounts, but the significance of their effects on nursing infants is not known. Because of potential for serious adverse reactions in nursing infants from butalbital and acetaminophen, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.
- Pediatric Use: The safety and effectiveness in children below the age of 12 years have not been established.
- Geriatric Use: Clinical studies of butalbital and acetaminophen tablets did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.
- Renal Impairment: Butalbital is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Additionally, since elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

Efficacy: Evidence supporting the efficacy and safety of this combination product in the treatment of multiple recurrent headaches is unavailable. Caution in this regard is required because butalbital is habit-forming and has the potential for abuse. There are no clinical trials cited in the prescribing information.

Cost Comparison:

Medication	Cost Per Tablet	Cost for 30 Days of Therapy*
Allzital® (butalbital/acetaminophen 25mg/325mg)	**$12.70[+]**	**$457.20[+]**
butalbital/acetaminophen (50mg/325mg)	$1.28[Δ]	$23.04[Δ]
butalbital/acetaminophen/caffeine (50mg/325mg/40mg)	$0.75[Δ]	$13.50[Δ]

*Quantity for 30 day supply based on recommended use of 3 or fewer days a month and maximum recommended daily dose.

[+]EAC = Estimated Acquisition Cost

[Δ]SMAC = State Maximum Allowable Cost

Recommendations

The College of Pharmacy recommends the following changes to the Butalbital Products category:

1. The prior authorization of Allzital® (butalbital/acetaminophen 25mg/325mg) with criteria similar to the other butalbital containing medications.
    a. An FDA approved indication for the treatment of tension-type headache; and
    b. Member must be 12 years of age or older; and
    c. Failure within the previous 60 days of the following:
        i. All available formulations of butalbital/acetaminophen medications that do not require prior authorization (medications available without prior authorization contain butalbital/acetaminophen/caffeine in the standard 50mg/325mg/40mg dose); and
        ii. Trials of at least two nonsteroidal anti-inflammatory drugs (NSAIDs), unless contraindicated.
2. The prior authorization of Esgic® capsules (butalbital/acetaminophen/caffeine 50mg/325mg/40mg) based on SMAC with the following criteria:
    a. A patient-specific, clinically significant reason why the member cannot use Fioricet® tablets (butalbital/acetaminophen/caffeine 50mg/325mg/40mg).

Utilization Details of Butalbital Products: Fiscal Year 2016

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ DAY	COST/ CLAIM
BUTALBITAL/APAP PRODUCTS					
BUTALBITAL-APAP-CAFF TAB 50-325-40	9,987	4438	$387,746.95	$2.57	$38.83
BUTALBITAL-APAP-CAFF CAP 50-325-40	123	94	$7,244.11	$4.43	$58.90
BUTALBITAL-APAP TAB 50-325 MG	76	31	$6,917.35	$4.28	$91.02
BUTALBITAL-APAP-CAFF CAP 50-325-40	5	4	$235.68	$5.48	$47.14
BUTALBITAL-APAP-CAFF CAP 50-325-40	2	2	$83.13	$3.61	$41.57
BUTALBITAL-APAP-CAFF CAP 50-500-40	1	1	$74.27	$3.71	$74.27
SUBTOTAL	**10,194**	**4,570**	**$402,301.49**	**$2.61**	**$39.46**
BUTALBITAL/APAP/CAFFEINE/CODEINE PRODUCTS					
BUTAL-APAP-CAFF-COD 50-325-40-30	797	325	$50,259.88	$3.82	$63.06
SUBTOTAL	**797**	**325**	**$50,259.88**	**$3.82**	**$63.06**
BUTALBITAL/ASA PRODUCTS					
BUTALBITAL-ASA-CAFF CAP 50-325-40	650	329	$36,835.85	$3.23	$56.67
BUTALBITAL-ASA-CAFF TAB 50-325-40	1	1	$12.90	$0.43	$12.90
SUBTOTAL	**651**	**330**	**$36,848.75**	**$3.22**	**$56.60**
BUTALBITAL/ASA/CAFFEINE/CODEINE PRODUCTS					
BUTAL-ASA-CAFF-COD 50-325-40-30	231	89	$26,407.92	$6.17	$114.32
BUTAL-ASA-CAFF-COD 50-325-40-30	175	57	$21,372.81	$6.56	$122.13
SUBTOTAL	**406**	**146**	**$47,780.73**	**$6.34**	**$117.69**
TOTAL	**12,048**	**5,111***	**$537,190.85**	**$2.88**	**$44.59**

*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.
APAP = acetaminophen; ASA = aspirin; CAFF = caffeine; COD = Codeine; BUTAL = butalbital

[1] U.S. Food and Drug Administration (FDA): Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm. Last revised 06/2016. Last accessed 08/02/2016.
[2] Allzital® Prescribing Information. Larken Laboratories, Inc. Available online at: http://medlibrary.org/lib/rx/meds/butalbital-and-acetaminophen-6/. Last revised 12/10/2015. Last accessed 07/22/2016.
[3] Butalbital/acetaminophen. Drug Facts and Comparisons. *Facts & Comparisons* [database online]. St. Louis, MO: Wolters Kluwer Health, Inc; Last revised 04/2016. Last accessed 07/21/2016.
[4] Taylor FR. Tension-type headache in adults: Acute treatment. In: UpToDate, Swanson JW, Dashe JF (Eds). *UpToDate*. Waltham, MA. Last updated 07/06/2016. Last accessed 08/30/2016.

Appendix P

FDA & DEA Updates (additional information can be found at http://www.fda.gov/Drugs/default.htm)

FDA NEWS RELEASE

For Immediate Release: August 3rd, 2016

The FDA approves first generic version of widely used influenza drug, Tamiflu

On August 3, 2016, the U.S. Food and Drug Administration approved the first generic version of Tamiflu (oseltamivir phosphate), a widely used medication for the treatment of the flu (influenza A and B) in patients two weeks of age and older who have had flu symptoms for no more than 48 hours; and prevention of the flu in patients one year of age and older. Tamiflu was approved in 1999.

The FDA is committed to improving patient access to safe and effective generic drugs. Generic drugs approved by the FDA have the same high-quality and strength as brand-name drugs. The generic manufacturing and packaging sites must pass the same quality standards as those of brand-name drugs.

The most common side effects reported by people using oseltamivir phosphate in clinical trials included nausea and vomiting.

Patients must use oseltamivir phosphate as directed by their health care provider. Oseltamivir phosphate does not take the place of receiving a flu vaccination.

Oseltamivir phosphate does not treat or prevent illness caused by infections other than the influenza virus, and oseltamivir phosphate does not prevent bacterial infections that may happen with the flu. The FDA does not know if oseltamivir phosphate is effective in people who start treatment after two days of developing symptoms, or have weakened immune systems.

Patients and health care providers may find more information on oseltamivir phosphate in the drug label.

FDA NEWS RELEASE

For Immediate Release: August 30th, 2016

FDA approves Erelzi, a biosimilar to Enbrel

The U.S. Food and Drug Administration approved Erelzi, (etanercept-szzs) for multiple inflammatory diseases. Erelzi is a biosimilar to Enbrel (etanercept), which was originally licensed in 1998.

Erelzi is administered by injection for the treatment of:

- moderate to severe rheumatoid arthritis, either as a standalone therapy or in combination with methotrexate (MTX);
- moderate to severe polyarticular juvenile idiopathic arthritis in patients ages two and older;
- active psoriatic arthritis, including use in combination with MTX in psoriatic arthritis patients who do not respond adequately to MTX alone;
- active ankylosing spondylitis (an arthritis that affects the spine); and
- chronic moderate to severe plaque psoriasis in adult patients (18 years or older) who are candidates for systemic therapy or phototherapy.

Health care professionals should review the prescribing information in the labeling for detailed information about the approved uses.

Biological products are generally derived from a living organism and can come from many sources, including humans, animals, microorganisms or yeast. A biosimilar is a biological product that is approved based on a showing that it is highly similar to an already-approved biological product and has no clinically meaningful differences in terms of safety and effectiveness from the reference product, in addition to meeting other criteria specified by law.

The FDA's approval of Erelzi is based on review of evidence that included structural and functional characterization, animal study data, human pharmacokinetic and pharmacodynamics data, clinical immunogenicity data and other clinical safety and effectiveness data that demonstrates Erelzi is biosimilar to Enbrel. Erelzi has been approved as a biosimilar, not as an interchangeable product.

Erelzi should not be administered to patients with sepsis.

The most serious known side effects with Erelzi are infections, neurologic events, congestive heart failure and hematologic events. The most common expected adverse reactions with Erelzi are infections and injection site reactions.

Erelzi contains a Boxed Warning to alert health care professionals and patients about an increased risk of serious infections leading to hospitalization or death, including tuberculosis, invasive fungal infections (such as histoplasmosis) and others. The Boxed Warning also notes that lymphoma and other malignancies, some

fatal, have been reported in children and adolescent patients treated with tumor necrosis factor blockers, including etanercept products. The drug must be dispensed with a patient Medication Guide that describes important information about its uses and risks.
Erelzi is manufactured by Sandoz Inc., based in Princeton, New Jersey, at Novartis Pharma in Stein, Switzerland. Enbrel is manufactured by Amgen Inc., of Thousand Oaks, California.

Safety Announcements

FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning

[8/31/16] An FDA review has found that the growing combined use of opioid medicines with benzodiazepines or other drugs that depress the central nervous system has resulted in serious side effects, including slowed or difficult breathing and deaths. Opioids are used to treat pain and cough; benzodiazepines are used to treat anxiety, insomnia, and seizures. In an effort to decrease the use of opioids and benzodiazepines, or opioids and other CNS depressants, together, the FDA is adding *Boxed Warnings* to the drug labeling of prescription opioid pain and prescription opioid cough medicines, and benzodiazepines.
Health care professionals should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. Avoid prescribing prescription opioid cough medicines for patients taking benzodiazepines or other CNS depressants, including alcohol.
Patients taking opioids with benzodiazepines, other CNS depressant medicines, or alcohol, and caregivers of these patients, should seek medical attention immediately if they or someone they are caring for experiences symptoms of unusual dizziness or lightheadedness, extreme sleepiness, slowed or difficult breathing, or unresponsiveness. Unresponsiveness means that the person doesn't answer or react normally or can't be woken up. Opioids are a class of powerful narcotic medicines that are used to treat pain severe enough to warrant use of an opioid when other pain medicines cannot be taken or are not able to provide enough pain relief. They also have serious risks including misuse and abuse, addiction, overdose, and death. Opioids such as codeine and hydrocodone are also approved in combination with other medicines to reduce coughing. Benzodiazepines are a class of medicines that are widely used to treat conditions including anxiety, insomnia, and seizures.
The FDA conducted and reviewed several studies showing that serious risks are associated with the combined use of opioids and benzodiazepines, other drugs that depress the CNS, or alcohol. Based on the data, the FDA is requiring several changes to reflect these risks in the opioid and benzodiazepine labeling, and new or revised patient Medication Guides. These changes include the new Boxed Warnings and revisions to the *Warnings and Precautions, Drug Interactions, and Patient Counseling Information* sections of the labeling.
The FDA is continuing to evaluate the evidence regarding combined use of benzodiazepines or other CNS depressants with medication-assisted therapy (MAT) drugs used to treat opioid addiction and dependence. The FDA is also evaluating whether labeling changes are needed for other CNS depressants, and will update the public when more information is available.
The FDA urges patients and health care professionals to report side effects involving opioids, benzodiazepines, or other medicines to the FDA MedWatch program.

Current Drug Shortages Index (as of September 1st, 2016):

The information provided in this section is provided voluntarily by manufacturers.

Acetohydroxamic Acid (Lithostat) Tablets	***Currently in Shortage***
Ammonium Chloride Injection	***Currently in Shortage***
Anagrelide Hydrochloride Capsules	***Currently in Shortage***
Atropine Sulfate Injection	***Currently in Shortage***
Bleomycin Sulfate for Injection	***Currently in Shortage***
Caffeine Anhydrous (125mg/mL); Sodium Benzoate (125mg/mL) Injection	***Currently in Shortage***
Calcium Chloride Injection, USP	***Currently in Shortage***
Calcium Gluconate Injection	***Currently in Shortage***
Cefepime Injection	***Currently in Shortage***

Cefotaxime Sodium (Claforan) Injection	***Currently in Shortage***
Cefotetan Disodium Injection	***Currently in Shortage***
Ceftazidime and Avibactam (AVYCAZ) for Injection, 2.5g	***Currently in Shortage***
Chloramphenicol Sodium Succinate Injection	***Currently in Shortage***
Desmopressin Acetate Injection	***Currently in Shortage***
Dexamethasone Sodium Phosphate Injection	***Currently in Shortage***
Dextrose 5% Injection Bags	***Currently in Shortage***
Dextrose Injection USP, 70%	***Currently in Shortage***
Dihydroergotamine Mesylate Injection	***Currently in Shortage***
Disopyramide Phosphate (Norpace) Capsules	***Currently in Shortage***
Doxorubicin Lyophilized Powder for Injection	***Currently in Shortage***
Epinephrine Injection	***Currently in Shortage***
Estradiol Valerate Injection, USP	***Currently in Shortage***
Ethiodized Oil (Lipiodol) Injection	***Currently in Shortage***
Fentanyl Citrate (Sublimaze) Injection	***Currently in Shortage***
Fomepizole Injection	***Currently in Shortage***
Gemifloxacin Mesylate (Factive) Tablets	***Currently in Shortage***
Imipenem and Cilastatin for Injection, USP	***Currently in Shortage***
Indigotindisulfonate Sodium (Indigo Carmine) Injection	***Currently in Shortage***
L-Cysteine Hydrochloride Injection	***Currently in Shortage***
Leucovorin Calcium Lyophilized Powder for Injection	***Currently in Shortage***
Leuprolide Acetate Injection	***Currently in Shortage***
Lidocaine Hydrochloride (Xylocaine) Injection	***Currently in Shortage***
LifeCare PCA™ Sterile Empty Vial and Injector	***Currently in Shortage***
Liotrix (Thyrolar) Tablets	***Currently in Shortage***
Mecasermin [rDNA origin] (Increlex) Injection	***Currently in Shortage***
Methyldopate Hydrochloride Injection	***Currently in Shortage***
Methylprednisolone Sodium Succinate for Injection, USP	***Currently in Shortage***
Morphine Sulfate Injection, USP, CII, (Preservative-Free)(For PCA Use Only)	***Currently in Shortage***
Multi-Vitamin Infusion (Adult and Pediatric)	***Currently in Shortage***
Mupirocin Calcium Nasal Ointment	***Currently in Shortage***
Nimodipine (Nymalize) Oral Solution	***Currently in Shortage***
Penicillin G Benzathine (Bicillin L-A) Injection	***Currently in Shortage***
Penicillin G Procaine Injection	***Currently in Shortage***
Peritoneal Dialysis Solutions	***Currently in Shortage***
Piperacillin and Tazobactam (Zosyn) Injection	***Currently in Shortage***
Potassium Chloride Injection	***Currently in Shortage***
Sacrosidase (Sucraid) Oral Solution	***Currently in Shortage***
Sodium Acetate Injection, USP	***Currently in Shortage***
Sodium Bicarbonate Injection, USP	***Currently in Shortage***
Sodium Chloride 0.9% Injection Bags	***Currently in Shortage***
Sodium Chloride 23.4% Injection	***Currently in Shortage***
Sufentanil Citrate (Sufenta) Injection	***Currently in Shortage***
Sumatriptan (Imitrex) Nasal Spray	***Currently in Shortage***
Technetium Tc99m Succimer Injection (DMSA)	***Currently in Shortage***
Theophylline Extended Release Tablets and Capsules	***Currently in Shortage***
Tigecycline (Tygacil) Injection	***Currently in Shortage***
Tobramycin Injection	***Currently in Shortage***
Tretinoin Capsules	***Currently in Shortage***
Trimipramine Maleate (SURMONTIL) Capsules	***Currently in Shortage***
Vancomycin Hydrochloride for Injection, USP	***Currently in Shortage***