OKLAHOMA
Health Care Authority

Drug Utilization Review Board

Wednesday,
October 13, 2021
4:00pm

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

Viewing Access Only:
Please register for the webinar at:
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The University of Oklahoma
Health Sciences Center
COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS

MEMORANDUM

TO: Drug Utilization Review (DUR) Board Members

FROM: Michyla Adams, Pharm.D.

SUBJECT: Packet Contents for DUR Board Meeting – October 13, 2021

DATE: October 6, 2021

NOTE: The DUR Board will meet at 4:00pm at the Oklahoma Health Care Authority (OHCA) at 4345 N. Lincoln Blvd. in Oklahoma City, Oklahoma.

There will be Zoom access to this meeting; however, Zoom access will be set up in view-only mode with no voting, speaking, video, or chat box privileges. Zoom access will allow for viewing of the presentation slides as well as audio of the presentations and discussion during the meeting; however, the DUR Board meeting will not be delayed or rescheduled due to any technical issues that may arise.

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Enclosed are the following items related to the October 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

Update on the Medication Coverage Authorization Unit/Fall 2021 Pipeline Update – Appendix B

Action Item – Vote to Prior Authorize Herceptin® (Trastuzumab) and Margenza® (Margetuximab-cmbk) and Update the Approval Criteria for the Breast Cancer Medications – Appendix C

Action Item – Vote to Prior Authorize Orgovyx™ (Relugolix) – Appendix D

Action Item – Annual Review of Spinal Muscular Atrophy (SMA) Medications – Appendix E

Action Item – Annual Review of Hepatitis C Medications – Appendix F

Annual Review of Ovarian Cancer Medications – Appendix G

30-Day Notice to Prior Authorize Jakafi® (Ruxolitinib) and Rezurock™ (Belumosudil) – Appendix H

Annual Review of Targeted Immunomodulator Agents and 30-Day Notice to Prior Authorize Lupkynis™ (Voclosporin) and Saphnelo™ (Anifrolumab-fnia) – Appendix I

30-Day Notice to Prior Authorize Bylvay™ (Odevixibat) – Appendix J

Annual Review of Beta Thalassemia and Sickle Cell Disease (SCD) Medications – Appendix K

U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates – Appendix L

Future Business

Adjournment

Oklahoma Health Care Authority

Drug Utilization Review Board
(DUR Board)
Meeting – October 13, 2021 @ 4:00pm
at the
Oklahoma Health Care Authority (OHCA)
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma 73105

NOTE: ***The DUR Board will meet at 4:00pm at OHCA (see address above). There will be Zoom access to this meeting; however, Zoom access will be set up in view-only mode with no voting, speaking, video, or chat box privileges. Zoom access will allow for viewing of the presentation slides as well as audio of the presentations and discussion during the meeting; however, the DUR Board meeting will not be delayed or rescheduled due to any technical issues that may arise.***

AGENDA

Discussion and action on the following items:

Items to be presented by Dr. Muchmore, Chairman:

1. **Call to Order**

A. Roll Call – Dr. Wilcox

DUR Board Members:

Dr. Stephen Anderson –	participating in person
Dr. Jennifer de los Angeles –	participating in person
Ms. Jennifer Boyett –	participating in person
Dr. Markita Broyles –	participating in person
Dr. Megan Hanner –	participating in person
Dr. Lynn Mitchell –	participating in person
Dr. John Muchmore –	participating in person
Dr. Lee Muñoz –	participating in person
Dr. James Osborne –	participating in person

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Or join by phone:
Dial: +1-602-753-0140 or +1-669-219-2599
Webinar ID: 932 1996 4037
Passcode: 31508686

Public Comment for Meeting:

- Speakers who wish to sign up for public comment at the OHCA DUR Board meeting may do so in writing by visiting the DUR Board page on the OHCA website at www.oklahoma.gov/ohca/about/boards-and-committees/drug-utilization-review/dur-board and completing the Speaker Registration Form. Completed Speaker Registration forms should be submitted to DURPublicComment@okhca.org. Forms must be received after the DUR Board agenda has been posted and no later than 24 hours before the meeting.
- The DUR Board meeting will allow public comment and time will be limited to 40 minutes total for all speakers during the meeting. Each speaker will be given 5 minutes to speak at the public hearing. If more than 8 speakers properly request to speak, time will be divided evenly.
- Only 1 speaker per manufacturer will be allowed.
- Any speakers who sign up for public comment must attend the DUR Board meeting in person at OHCA (see above address). Public comment through Zoom will not be allowed for the DUR Board meeting.

Items to be presented by Dr. Muchmore, Chairman:

2. **Public Comment Forum**
   A. Acknowledgement of Speakers for Public Comment

Items to be presented by Dr. Muchmore, Chairman:

3. **Action Item – Approval of DUR Board Meeting Minutes – See Appendix A**
   A. September 8, 2021 DUR Board Meeting Minutes
   B. September 8, 2021 DUR Board Recommendations Memorandum

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

4. **Update on Medication Coverage Authorization Unit/Fall 2021 Pipeline Update – See Appendix B**
   A. Pharmacy Helpdesk Activity for September 2021
   B. Medication Coverage Activity for September 2021
   C. Fall 2021 Pipeline Update

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

5. **Action Item – Vote to Prior Authorize Herceptin® (Trastuzumab) and Margenza® (Margetuximab-cmkb) and Update the Approval Criteria for the Breast Cancer Medications – See Appendix C**
   A. Market News and Updates
   B. Margenza® (Margetuximab-cmkb) Product Summary
   C. College of Pharmacy Recommendations

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

6. **Action Item – Vote to Prior Authorize Orgovyx™ (Relugolix) – See Appendix D**
   A. Market News and Updates
   B. Orgovyx™ (Relugolix) Product Summary
   C. College of Pharmacy Recommendations

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

7. **Action Item – Annual Review of Spinal Muscular Atrophy (SMA) Medications – See Appendix E**
   A. Current Prior Authorization Criteria
   B. Utilization of SMA Medications
   C. Prior Authorization of SMA Medications
   D. Market News and Updates
   E. College of Pharmacy Recommendations
   F. Utilization Details of SMA Medications

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

8. **Action Item – Annual Review of Hepatitis C Mediations – See Appendix F**
   A. Introduction
   B. Current Prior Authorization Criteria
   C. Utilization of Hepatitis C Medications
   D. Prior Authorization of Hepatitis C Medications
   E. Market News and Updates
   F. College of Pharmacy Recommendations
   G. Utilization Details of Hepatitis C Medications

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

9. **Annual Review of Ovarian Cancer Medications – See Appendix G**
   A. Introduction
   B. Current Prior Authorization Criteria
   C. Utilization of Ovarian Cancer Medications
   D. Prior Authorization of Ovarian Cancer Medications
   E. College of Pharmacy Recommendations
   F. Utilization Details of Ovarian Cancer Medications

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

10. **30-Day Notice to Prior Authorize Jakafi® (Ruxolitinib) and Rezurock™ (Belumosudil) – See Appendix H**
    A. Introduction
    B. Market News and Updates
    C. Jakafi® (Ruxolitinib) Product Summary
    D. Rezurock™ (Belumosudil) Product Summary
    E. College of Pharmacy Recommendations

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

11. **Annual Review of Targeted Immunomodulator Agents and 30-Day Notice to Prior Authorize Lupkynis™ (Voclosporin) and Saphnelo™ (Anifrolumab-fnia) – See Appendix I**
    A. Current Prior Authorization Criteria
    B. Utilization of Targeted Immunomodulator Agents
    C. Prior Authorization of Targeted Immunomodulator Agents
    D. Market News and Updates
    E. Lupkynis™ (Voclosporin) Product Summary
    F. Saphnelo™ (Anifrolumab-fnia) Product Summary
    G. College of Pharmacy Recommendations
    H. Utilization Details of Targeted Immunomodulator Agents

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

12. **30-Day Notice to Prior Authorize Bylvay™ (Odevixibat) – See Appendix J**
    A. Introduction
    B. Bylvay™ (Odevixibat) Product Summary
    C. College of Pharmacy Recommendations

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

13. **Annual Review of Beta Thalassemia and Sickle Cell Disease (SCD) Medications – See Appendix K**
    A. Introduction
    B. Current Prior Authorization Criteria
    C. Utilization of Beta Thalassemia and SCD Medications
    D. Prior Authorization of Beta Thalassemia and SCD Medications
    E. Market News and Updates
    F. College of Pharmacy Recommendations
    G. Utilization Details of Beta Thalassemia and SCD Medications

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

14. **U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates – See Appendix L**

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

15. **Future Business* (Upcoming Product and Class Reviews)**
    A. Asthma and Chronic Obstructive Pulmonary Disease (COPD) Maintenance Medications
    B. Atopic Dermatitis Medications
    C. Botulinum Toxins
    D. Multiple Myeloma Medications

    *Future product and class reviews subject to change.

16. **Adjournment**

NOTE: An analysis of the atypical [Aged, Blind, and Disabled (ABD)] patient subgroup of the Oklahoma Medicaid population has been performed pertaining to all recommendations included in this DUR Board meeting packet to ensure fair and knowledgeable deliberation of the potential impact of the recommendations on this patient population.

Appendix A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
MINUTES OF MEETING SEPTEMBER 8, 2021

DUR BOARD MEMBERS:	PRESENT	ABSENT
Stephen Anderson, Pharm.D.		X
Jennifer de los Angeles, Pharm.D., BCOP		X
Jennifer Boyett, MHS; PA-C	X	
Markita Broyles, D.Ph.; MBA	X	
Megan A. Hanner, D.O.	X	
Lynn Mitchell, M.D.; Vice Chairwoman	X	
John Muchmore, M.D.; Ph.D.; Chairman	X	
Lee Muñoz, D.Ph.	X	
James Osborne, Pharm.D.		X

COLLEGE OF PHARMACY STAFF:	PRESENT	ABSENT
Michyla Adams, Pharm.D.; DUR Manager	X	
Wendi Chandler, Pharm.D.; Clinical Pharmacist	X	
Erin Ford, Pharm.D.; Clinical Pharmacist		X
Beth Galloway; Business Analyst	X	
Thomas Ha, Pharm.D.; Clinical Pharmacist	X	
Katrina Harris, Pharm.D.; Clinical Pharmacist		X
Robert Klatt, Pharm.D.; Clinical Pharmacist		X
Morgan Masterson, Pharm.D.; Clinical Pharmacist		X
Brandy Nawaz, Pharm.D.; Clinical Pharmacist	X	
Alicia O'Halloran, Pharm.D; Clinical Pharmacists		X
Wynn Phung, Pharm.D.; Clinical Pharmacist		X
Leslie Robinson, D.Ph.; Pharmacy PA Coordinator		X
Vickie Sams, CPhT.; Quality/Training Coordinator		X
Grant H. Skrepnek, Ph.D.; Associate Professor	X	
Regan Smith, Pharm.D.; Clinical Pharmacist	X	
Ashley Teel, Pharm.D.; Clinical Pharmacist		X
Jacquelyn Travers, Pharm.D.; Practice Facilitating Pharmacist	X	
Devin Wilcox, D.Ph.; Pharmacy Director	X	
Justin Wilson, Pharm.D.; Clinical Pharmacist	X	
PA Oncology Pharmacists: Allison Baxley, Pharm.D., BCOP		X
Emily Borders, Pharm.D., BCOP	X	
Sarah Schmidt, Pharm.D., BCPS, BCOP		X
Graduate Students: Matthew Dickson, Pharm.D.		X
Michael Nguyen, Pharm.D.		X
Corby Thompson, Pharm.D.	X	
Laura Tidmore, Pharm.D.	X	
Visiting Pharmacy Student(s): N/A		

OKLAHOMA HEALTH CARE AUTHORITY STAFF:	PRESENT	ABSENT
Melody Anthony, Chief State Medicaid Director; Chief Operating Officer		X
Mark Brandenburg, M.D., MSC; Medical Director	X	
Ellen Buettner; Chief of Staff		X

Kevin Corbett, C.P.A.; Chief Executive Officer		X
Terry Cothran, D.Ph.; Pharmacy Director	X	
Michael Herndon, D.O.; Chief Medical Officer		X
Jill Ratterman, D.Ph.; Clinical Pharmacist	X	
Paula Root, M.D.; Senior Medical Director	X	
Kara Smith, J.D.; General Counsel	X	
Michelle Tahah, Pharm.D.; Clinical Pharmacist	X	
Toney Welborn, M.D., MPH, MS; Medical Director	X	

OTHERS PRESENT:	
Doug Pierce, Genentech	Burl Beasley, OMES
David Prather, Novo Nordisk	Janie Huff, Kala
Melissa Duvall, Sobi	Jomy Joseph, Sanofi
Gina Heinen, Novo Nordisk	Kristi Kemp, AbbVie
Mark Kaiser, Otsuka	Marc Parker, Sunovion
Madeline Shurtleff, Otsuka	Maribel Borvsyuk, Sanofi
Joe Garcia, AbbVie	Andrew Delgado, Bristol Myers Squibb
Melanie Curlett, Takeda	Brian Maves, Pfizer
Nima Nabavi, Amgen	Brenda McLaughlin, Viking Healthcare Solns
Scott Robeson, Sanofi	Kenneth Berry, Alkermes
Evie Knisely, Novartis	Robert Greely, Biogen
Tara McKinley, Otsuka	Charlie Collins, Sanofi
Christopher Voyiatt, Corium	Dave Miley, Teva
Lindsey Walter, Novartis	Stormy Cameron, Artia Solutions
Michael Chen, Aimmune	Jeff Knappen, Spark Therapeutics
Jennifer Davis, Gilead	Audrey Rattan, Alkermes
Shellie Keast, Mercer	Dave Poskey, UCB
Todd Dickerson, Jazz Pharmaceuticals	Doug Wood, ViiV Healthcare
Frank Alvarado, Johnson & Johnson	

PRESENT FOR PUBLIC COMMENT:	
N/A	

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

1A: ROLL CALL

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

ACTION: NONE REQUIRED

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

ACTION: NONE REQUIRED

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

3A: JUNE 9, 2021 DUR MINUTES

Materials included in agenda packet; presented by Dr. Muchmore

Dr. Broyles moved to approve; seconded by Dr. Muñoz

ACTION: MOTION CARRIED

3B: JUNE 9, 2021 DUR RECOMMENDATIONS MEMORANDUM

3C: JULY 14, 2021 DUR MINUTES

Materials included in agenda packet; presented by Dr. Muchmore

Dr. Broyles moved to approve; seconded by Dr. Muñoz
ACTION: MOTION CARRIED
3D: JULY 14, 2021 DUR RECOMMENDATIONS MEMORANDUM

AGENDA ITEM NO. 4: UPDATE ON MEDICATION COVERAGE AUTHORIZATION UNIT/PEDIATRIC ANTIPSYCHOTIC MONITORING PROGRAM UPDATE
4A: PHARMACY HELPDESK ACTIVITY FOR JULY 2021
4B: MEDICATION COVERAGE ACTIVITY FOR JULY 2021
4C: PHARMACY HELPDESK ACTIVITY FOR AUGUST 2021
4D: MEDICATION COVERAGE ACTIVITY FOR AUGUST 2021
4E: PEDIATRIC ANTIPSYCHOTIC MONITORING PROGRAM UPDATE
Materials included in agenda packet; presented by Dr. Ha, Dr. Travers
ACTION: NONE REQUIRED

AGENDA ITEM NO. 5: ANNUAL REVIEW OF THE MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM
5A: BACKGROUND
5B: WORKFLOW
5C: RESULTS
5D: CASE STUDY
5E: SUMMARY
Materials included in agenda packet; presented by Dr. Smith
ACTION: NONE REQUIRED

AGENDA ITEM NO. 6: APPROVAL OF JULY 2021 DUR BOARD RECOMMENDATIONS
6A: VOTE TO PRIOR AUTHORIZE LYBALVI™ (OLANZAPINE/SAMIDORPHAN)
- **I. MARKET NEWS AND UPDATES**
- **II. LYBALVI™ (OLANZAPINE/SAMIDORPHAN) PRODUCT SUMMARY**
- **III. COLLEGE OF PHARMACY RECOMMENDATIONS**

Materials included in agenda packet; presented by Dr. Nawaz
Dr. Muñoz moved to approve; seconded by Dr. Broyles
ACTION: MOTION CARRIED
6B: VOTE TO PRIOR AUTHORIZE AZSTARYS™ (SERDEXMETHYLPHENIDATE/ DEXMETHYLPHENIDATE), QELBREE™ (VILOXAZINE), AND XYWAV® (CALCIUM/ MAGNESIUM/POTASSIUM/SODIUM OXYBATES)
- **I. MARKET NEWS AND UPDATES**
- **II. PRODUCT SUMMARIES**
- **III. COLLEGE OF PHARMACY RECOMMENDATIONS**

Materials included in agenda packet; presented by Dr. Wilson
Dr. Muñoz moved to approve; seconded by Dr. Broyles
ACTION: MOTION CARRIED
6C: VOTE TO PRIOR AUTHORIZE HELIDAC® THERAPY (BISMUTH SUBSALICYLATE/METRONIDAZOLE/TETRACYCLINE DOSE PACK) AND PYLERA® (BISMUTH SUBCITRATE POTASSIUM/METRONIDAZOLE/ TETRACYCLINE CAPSULE)
- **I. MARKET NEWS AND UPDATES**
- **II. *HELICOBACTER PYLORI (H. PYLORI)* PRODUCT SUMMARIES**
- **III. COST COMPARISON: *H. PYLORI* REGIMENS**
- **IV. COLLEGE OF PHARMACY RECOMMENDATIONS**

Materials included in agenda packet; presented by Dr. Ha
Dr. Broyles moved to approve; seconded by Dr. Muñoz
ACTION: MOTION CARRIED

6D: VOTE TO PRIOR AUTHORIZE ALKINDI® SPRINKLE (HYDROCORtISONE ORAL GRANULE), EYSUVIS® (LOTEPREDNOL 0.25% OPHTHALMIC SUSPENSION), GIMOTI® (METOCLOPRAMIDE NASAL SPRAY), NEXTSTELLIS® (DROSPIRENONE/ESTETROL), OZOBAX™ (BACLOFEN 5MG/ML ORAL SOLUTION), PHEXXI® (LACTIC ACID/CITRIC ACID/POTASSIUM BITARTRATE VAGINAL GEL), REDITREX™ (METHOTREXATE INJECTION), RELTONE™ (URSODIOL CAPSULE), AND THYQUIDITY™ (LEVOTHYROXINE ORAL SOLUTION)

I. INTRODUCTION

II. COLLEGE OF PHARMACY RECOMMENDATIONS

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

<u>AGENDA ITEM NO. 7:</u> VOTE TO PRIOR AUTHORIZE QDOLO™ (TRAMADOL 5MG/ML ORAL SOLUTION)

7A: MARKET NEWS AND UPDATES
7B: QDOLO™ (TRAMADOL 5MG/ML ORAL SOLUTION) PRODUCT SUMMARY
7C: COLLEGE OF PHARMACY RECOMMENDATIONS

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

<u>AGENDA ITEM NO. 8:</u> VOTE TO PRIOR AUTHORIZE IMPEKLO® (CLOBETASOL PROPIONATE 0.05% LOTION)

8A: MARKET NEWS AND UPDATES
8B: IMPEKLO® (CLOBETASOL PROPIONATE 0.05% LOTION) PRODUCT SUMMARY
8C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Nawaz
Dr. Muñoz moved to approve; seconded by Dr. Broyles
ACTION: MOTION CARRIED

<u>AGENDA ITEM NO. 9:</u> VOTE TO UPDATE THE APPROVAL CRITERIA FOR THE OPHTHALMIC ANTI-INFLAMMATORY PRODUCTS

9A: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Ha
Dr. Broyles moved to approve; seconded by Dr. Muñoz
ACTION: MOTION CARRIED

<u>AGENDA ITEM NO. 10:</u> VOTE TO PRIOR AUTHORIZE NULIBRY™ (FOSDENOPTERIN)

10A: MARKET NEWS AND UPDATES
10B: NULIBRY™ (FOSDENOPTERIN) PRODUCT SUMMARY
10C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Ha
Dr. Muñoz moved to approve; seconded by Dr. Broyles
ACTION: MOTION CARRIED

<u>AGENDA ITEM NO. 11:</u> VOTE TO PRIOR AUTHORIZE DANYELZA® (NAXITAMAB-GQGK) AND TRUSELTIQ™ (INFIGRATINIB)

11A: MARKET NEWS AND UPDATES
11B: PRODUCT SUMMARIES
11C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Borders
Dr. Broyles moved to approve; seconded by Dr. Muñoz
ACTION: MOTION CARRIED

<u>AGENDA ITEM NO. 12:</u> VOTE TO PRIOR AUTHORIZE FERAHEME® (FERUMOXYTOL), INJECTAFER® (FERRIC CARBOXYMALTOSE), AND MONOFERRIC® (FERRIC DERISOMALTOSE)
12A: MARKET NEWS AND UPDATES
12B: PRODUCT SUMMARIES
12C: COST COMPARISON
12D: COLLEGE OF PHARMACY RECOMMENDATIONS
Materials included in agenda packet; presented by Dr. Wilson
Dr. Muñoz moved to approve; seconded by Dr. Broyles
ACTION: MOTION CARRIED

<u>AGENDA ITEM NO. 13:</u> ANNUAL REVIEW OF SYNAGIS® (PALIVIZUMAB)
13A: CURRENT PRIOR AUTHORIZATION CRITERIA
13B: UTILIZATION OF SYNAGIS® (PALIVIZUMAB)
13C: PRIOR AUTHORIZATION OF SYNAGIS® (PALIVIZUMAB)
13D: RESPIRATORY SYNCYTIAL VIRUS (RSV) SEASON COMPARISON
13E: MARKET NEWS AND UPDATES
13F: OKLAHOMA UPDATES
13G: COLLEGE OF PHARMACY RECOMMENDATIONS
Materials included in agenda packet; presented by Dr. Wilson
Dr. Broyles moved to approve; seconded by Dr. Muñoz
ACTION: MOTION CARRIED

<u>AGENDA ITEM NO. 14:</u> ANNUAL REVIEW OF CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) MODULATORS
14A: CURRENT PRIOR AUTHORIZATION CRITERIA
14B: UTILIZATION OF CFTR MODULATORS
14C: PRIOR AUTHORIZATION OF CFTR MODULATORS
14D: MARKET NEWS AND UPDATES
14E: COLLEGE OF PHARMACY RECOMMENDATIONS
14F: UTILIZATION DETAILS OF CFTR MODULATORS
Materials included in agenda packet; presented by Dr. Nawaz
Dr. Muñoz moved to approve; seconded by Dr. Broyles
ACTION: MOTION CARRIED

<u>AGENDA ITEM NO. 15:</u> ANNUAL REVIEW OF BREAST CANCER MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE HERCEPTIN® (TRASTUZUMAB) AND MARGENZA® (MARGETUXIMAB-CMKB)
15A: INTRODUCTION
15B: CURRENT PRIOR AUTHORIZATION CRITERIA
15C: UTILIZATION OF BREAST CANCER MEDICATIONS
15D: PRIOR AUTHORIZATION OF BREAST CANCER MEDICATIONS
15E: MARKET NEWS AND UPDATES
15F: MARGENZA® (MARGETUXIMAB-CMKB) PRODUCT SUMMARY
15G: COLLEGE OF PHARMACY RECOMMENDATIONS
15H: UTILIZATION DETAILS OF BREAST CANCER MEDICATIONS
Materials included in agenda packet; presented by Dr. Borders
ACTION: NONE REQUIRED

AGENDA ITEM NO. 16: **ANNUAL REVIEW OF PROSTATE CANCER MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE ORGOVYX™ (RELUGOLIX)**

16A: INTRODUCTION
16B: CURRENT PRIOR AUTHORIZATION CRITERIA
16C: UTILIZATION OF PROSTATE CANCER MEDICATIONS
16D: PRIOR AUTHORIZATION OF PROSTATE CANCER MEDICATIONS
16E: MARKET NEWS AND UPDATES
16F: ORGOVYX™ (RELUGOLIX) PRODUCT SUMMARY
16G: COLLEGE OF PHARMACY RECOMMENDATIONS
16H: UTILIZATION DETAILS OF PROSTATE CANCER MEDICATIONS

Materials included in agenda packet; presented by Dr. Borders
ACTION: NONE REQUIRED

AGENDA ITEM NO. 17: **ANNUAL REVIEW OF CYSTADROPS® (CYSTEAMINE 0.37% OPHTHALMIC SOLUTION AND CYSTARAN® (CYSTEAMINE 0.44% OPHTHALMIC SOLUTION)**

17A: CURRENT PRIOR AUTHORIZATION CRITERIA
17B: UTILIZATION OF CYSTADROPS® AND CYSTARAN®
17C: PRIOR AUTHORIZATION OF CYSTADROPS® AND CYSTARAN®
17D: MARKET NEWS AND UPDATES
17E: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Ha
ACTION: NONE REQUIRED

AGENDA ITEM NO. 18: **U.S. FOOD AND DRUG ADMINISTRATION (FDA) AND DRUG ENFORCEMENT ADMINISTATION (DEA) UPDATES**

Materials included in agenda packet; presented by Dr. Ha
ACTION: NONE REQUIRED

AGENDA ITEM NO. 19: **FUTURE BUSINESS* (UPCOMING PRODUCT AND CLASS REVIEWS)**

19A: HEPATITIS C MEDICATIONS
19B: OVARIAN CANCER MEDICATIONS
19C: SPINAL MUSCULAR ATROPHY (SMA) MEDICATIONS
19D: TARGETED IMMUNOMODULATOR AGENTS

*Future product and class reviews subject to change.
Materials included in agenda packet; presented by Dr. Adams
ACTION: NONE REQUIRED

AGENDA ITEM NO. 20: **ADJOURNMENT**

The meeting was adjourned at 5:20pm.

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

Memorandum

Date: September 10, 2021

To: Terry Cothran, D.Ph.
Pharmacy Director
Oklahoma Health Care Authority

From: Michyla Adams, Pharm.D.
Drug Utilization Review (DUR) Manager
Pharmacy Management Consultants

Subject: DUR Board Recommendations from Meeting on September 8, 2021

Recommendation 1: Pediatric Antipsychotic Monitoring Program Update

NO ACTION REQUIRED.

Recommendation 2: Annual Review of the Medication Therapy Management (MTM) Program

NO ACTION REQUIRED.

Recommendation 3A: Approval of July 2021 DUR Board Recommendations: Vote to Prior Authorize Lybalvi™ (Olanzapine/Samidorphan)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends adding Lybalvi™ (olanzapine/ samidorphan) to Tier-3 of the Atypical Antipsychotic Medications Product Based Prior Authorization (PBPA) category (changes noted in red):

Atypical Antipsychotic Medications*		
Tier-1	**Tier-2**	**Tier-3**
aripiprazole (Abilify®)¥	asenapine (Saphris®)	aripiprazole tablets with sensor (Abilify MyCite®)~
aripiprazole IM inj (Abilify Maintena®)	lurasidone (Latuda®)	asenapine transdermal system (Secuado®)+
aripiprazole lauroxil IM inj (Aristada®)		brexpiprazole (Rexulti®)
aripiprazole lauroxil IM inj (Aristada Initio®)		cariprazine (Vraylar®)
clozapine (Clozaril®)◊		clozapine ODT (Fazaclo®)+
olanzapine (Zyprexa®)		clozapine oral susp (Versacloz®)+
paliperidone IM inj (Invega Sustenna®)		iloperidone (Fanapt®)
paliperidone IM inj (Invega Trinza®)**		lumateperone (Caplyta®)
quetiapine (Seroquel®)		olanzapine/fluoxetine (Symbyax®)+
quetiapine ER (Seroquel XR®)		**olanzapine/samidorphan (Lybalvi™)**
risperidone (Risperdal®)		paliperidone (Invega®)
risperidone IM inj (Risperdal Consta®)		
risperidone ER sub-Q inj (Perseris®)		
ziprasidone (Geodon®)		

ER = extended-release; IM = intramuscular; inj = injection; ODT = orally disintegrating tablet; sub-Q = subcutaneous; susp = suspension
*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC). Placement of products shown in blue is based on net cost after federal and/or supplemental rebates, and products may be moved to a higher tier if the net cost changes in comparison to other available products.
¥Aripiprazole (Abilify®) orally disintegrating tablet (ODT) is considered a special formulation and requires a patient-specific, clinically significant reason why a special formulation product is needed in place of the regular tablet formulation.
◊Clozapine does not count towards a Tier-1 trial.
**Use of Invega Trinza® requires members to have been adequately treated with the 1-month paliperidone ER injection (Invega Sustenna®) for at least 4 months.
~Unique criteria applies to Abilify MyCite® (aripiprazole tablets with sensor).
+Unique criteria applies in addition to tier trial requirements.

Atypical Antipsychotic Medications Tier-3 Approval Criteria:

1. A Tier-1 trial at least 14 days in duration, titrated to recommended dose, which did not yield adequate response or resulted in intolerable adverse effects; and
   a. Clozapine does not count towards a Tier-1 trial; and
2. Trials of all oral 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; or

3. A manual prior authorization may be submitted for consideration of a Tier-3 medication when the member has had at least 4 trials of Tier-1 and Tier-2 medications (2 trials must be from Tier-1) that did not yield an adequate response or resulted in intolerable adverse effects; and
4. Use of Versacloz® (clozapine oral suspension) or Fazaclo® (clozapine orally disintegrating tablet) requires a patient-specific, clinically significant reason why the member cannot use the oral tablet formulation; and
5. Use of Secuado® (asenapine transdermal system) requires a patient-specific, clinically significant reason why the member cannot use the oral sublingual tablet formulation. Tier structure rules continue to apply; and
6. Use of Symbyax® (olanzapine/fluoxetine) requires a patient-specific, clinically significant reason why the member cannot use olanzapine and fluoxetine as individual components.

Recommendation 3B: Approval of July 2021 DUR Board Recommendations: Vote to Prior Authorize Azstarys™ (Serdexmethylphenidate/Dexmethylphenidate), Qelbree™ (Viloxazine), and Xywav® (Calcium/Magnesium/Potassium/ Sodium Oxybates)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the ADHD and Narcolepsy Medications product based prior authorization (PBPA) category (changes noted in red in the following PBPA Tier chart and approval criteria):

1. The prior authorization of Azstarys™ (serdexmethylphenidate/ dexmethylphenidate) and placement into Tier-3 of the Long-Acting Methylphenidate category of the ADHD Medications PBPA Tier chart; current Tier-3 criteria will apply
2. The prior authorization of Qelbree™ (viloxazine) and placement into Tier-3 of the Non-Stimulants category of the ADHD Medications PBPA Tier chart; the following additional criteria will also apply
3. The prior authorization of Xywav® (calcium/magnesium/potassium/ sodium oxybates) in the Narcolepsy Medications category with criteria similar to the current approval criteria for Xyrem® (sodium oxybate); the following additional criteria will also apply
4. Moving Quillivant XR® (methylphenidate ER suspension) from Tier-2 to Tier-3, moving Adderall XR® from Tier-2 to Tier-1, and moving Metadate ER® (methylphenidate ER tablet), Methylin ER® (methylphenidate ER tablet), and Ritalin SR® (methylphenidate ER tablet) from Tier-3 to Tier-1 of the ADHD Medications PBPA Tier chart based on net costs

5. Moving Kapvay® (clonidine ER tablet) from Tier-3 to Tier-2 of the Non-Stimulants category of the ADHD Medications PBPA Tier chart based on net cost, and updating the following additional criteria for Kapvay®

ADHD Medications			
Tier-1*	**Tier-2***	**Tier-3***	**Special PA**
Amphetamine			amphetamine ER susp (Adzenys ER™) amphetamine ER ODT (Adzenys XR-ODT®) amphetamine ER susp (Dyanavel® XR) amphetamine (Evekeo®) amphetamine ODT (Evekeo ODT™) amphetamine/ dextroamphetamine ER (Mydayis®) dextroamphetamine (Dexedrine®) dextroamphetamine ER (Dexedrine Spansules®) dextroamphetamine soln (ProCentra®) dextroamphetamine (Zenzedi®) methamphetamine (Desoxyn®) methylphenidate ER ODT (Cotempla XR-ODT®) methylphenidate chew tab (Methylin®)
Short-Acting			
amphetamine/ dextroamphetamine (Adderall®)			
Long-Acting			
amphetamine/ dextroamphetamine ER (Adderall XR®) lisdexamfetamine cap and chew tab (Vyvanse®)+	~~**amphetamine/ dextroamphetamine ER (Adderall XR®)**~~		
Methylphenidate			
Short-Acting			
dexmethylphenidate (Focalin®) methylphenidate tab and soln (Methylin®) methylphenidate (Ritalin®)			
Long-Acting			
dexmethylphenidate ER (Focalin XR®) – **Brand Preferred** methylphenidate ER (Daytrana®) methylphenidate ER (Metadate CD®) **methylphenidate ER (Metadate ER®)** **methylphenidate ER (Methylin ER®)**	dexmethylphenidate ER (generic Focalin XR®) methylphenidate ER (Concerta®) ~~**methylphenidate ER susp (Quillivant XR®)**~~	methylphenidate ER 72mg methylphenidate ER (Adhansia XR®) methylphenidate ER (Aptensio XR®) methylphenidate ER (Jornay PM®) ~~**methylphenidate ER (Metadate ER®)**~~ ~~**methylphenidate ER (Methylin ER®)**~~	

ADHD Medications			
Tier-1*	**Tier-2***	**Tier-3***	**Special PA**
methylphenidate ER chew tab (QuilliChew ER®) methylphenidate ER (Ritalin LA®) **methylphenidate ER (Ritalin SR®)**		**methylphenidate ER susp (Quillivant XR®)** ~~**methylphenidate ER (Ritalin SR®)**~~ **serdexmethylphen-idate/dexmethylphe-nidate (Azstarys™)**	
Non-Stimulants			
atomoxetine (Strattera®) guanfacine ER (Intuniv®)	**clonidine ER (Kapvay®)Δ**	~~**clonidine ER (Kapvay®)Δ**~~ **viloxazine (Qelbree™)Δ**	

*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC). Placement of products shown in blue is based on net cost after federal and/or supplemental rebates, and products may be moved to a higher tier if the net cost changes in comparison to other available products.
+Unique criteria applies for the diagnosis of binge eating disorder (BED).
ΔUnique criteria applies in addition to tier trial requirements.
ADHD = attention-deficit/hyperactivity disorder; cap = capsule; chew tab = chewable tablet; ER = extended-release; ODT = orally disintegrating tablet; PA = prior authorization; soln = solution; susp = suspension; tab = tablet

ADHD Medications Tier-2 Approval Criteria:

1. A covered diagnosis; and
2. A previously failed trial with at least 1 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; and

~~3. For Quillivant XR®, an age restriction of 10 years and younger will apply. Members older than 10 years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.~~

4. Kapvay® [Clonidine Extended-Release (ER) Tablet] Approval Criteria:
   a. An FDA approved diagnosis; and
   b. Previously failed trials (within the last 180 days) with a long-acting Tier-1 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 must be provided.

ADHD Medications Tier-3 Approval Criteria:

1. A covered diagnosis; and
2. A previously failed trial with at least 1 long-acting Tier-1 stimulant that resulted in an inadequate response; and
3. A previously failed trial with at least 1 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 lower tiered formulations.

~~5. Kapvay® [Clonidine Extended-Release (ER) Tablet] Approval Criteria:~~
~~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 must be provided.~~

6. Qelbree™ [Viloxazine Extended-Release (ER) Capsule] Approval Criteria:
    a. An FDA approved diagnosis; and
    b. Member must be 6 to 17 years of age; and
    c. Previously failed trials (within the last 365 days) with a long-acting Tier-1 stimulant, a long-acting Tier-2 stimulant, Intuniv®, Strattera®, and Kapvay®, unless contraindicated, that did not yield adequate results; and
    d. Member must not be taking a monoamine oxidase inhibitor (MAOI) or have taken an MAOI within the last 14 days; and
    e. Member must not be taking sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range (e.g., alosetron, duloxetine, ramelteon, tasimelteon, tizanidine, theophylline) concomitantly with Qelbree™; and
    f. A quantity limit of 30 capsules per 30 days will apply for the 100mg and 150mg strengths and 60 capsules per 30 days will apply for the 200mg strength.
7. For Quillivant XR®, an age restriction of 10 years and younger will apply. Members older than 10 years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.

Narcolepsy Medications Approval Criteria:

1. An FDA approved diagnosis; and
2. Use of Nuvigil® (armodafinil) requires a patient-specific, clinically significant reason why the member cannot use stimulant medications to improve wakefulness during the daytime; and
    a. Nuvigil® is brand name preferred due to net cost after rebates; however, brand name preferred status may be removed if the net cost changes and brand name is more costly than generic; or
3. Use of Provigil® (modafinil) requires a previously failed trial (within the last 180 days) with Nuvigil® and a patient-specific, clinically significant reason why the member cannot use stimulant medications to improve wakefulness during the daytime; or
4. Use of Sunosi® (solriamfetol), Wakix® (pitolisant), ~~or~~ Xyrem® (sodium oxybate), or Xywav® (calcium/magnesium/potassium/sodium oxybates) 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; and
5. Additionally, use of Xywav® (calcium/magnesium/potassium/sodium oxybates) requires a patient-specific, clinically significant reason why the member cannot use Xyrem®; and
    a. For members requesting Xywav® due to lower sodium content in comparison to Xyrem®, a patient-specific, clinically significant reason why the member requires a low-sodium product must be provided; and
6. The diagnosis of obstructive sleep apnea (OSA) requires concurrent treatment for the OSA; and
7. The diagnosis of shift work sleep disorder requires the member's work schedule to be included with the prior authorization request.

Recommendation 3C: Approval of July 2021 DUR Board Recommendations: Vote to Prior Authorize Helidac® Therapy (Bismuth Subsalicylate/Metronidazole/Tetracycline Dose Pack) and Pylera® (Bismuth Subcitrate Potassium/Metronidazole/ Tetracycline Capsule)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the Anti-Ulcer Medications Product Based Prior Authorization (PBPA) category (changes noted in red in the following PBPA Tier chart and approval criteria):

1. Moving rabeprazole tablets and brand name Prevacid® ODT from Tier-2 to Tier-1 based on net costs
2. The prior authorization of Helidac® Therapy (bismuth subsalicylate/ metronidazole/tetracycline dose pack) and Pylera® (bismuth subcitrate potassium/metronidazole/tetracycline capsule) and placement into the

Special Prior Authorization (PA) Tier with the following additional criteria

3. Updating the current approval criteria for sucralfate suspension unit dose cups based on net costs
4. Removing all ranitidine products from the Tier chart and Special PA criteria based on the FDA-requested market withdrawal
5. Updating the trial requirements for Axid® (nizatidine solution) based on the market withdrawal of ranitidine products

Anti-Ulcer Medications*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA⁺**
dexlansoprazole (Dexilant® caps)	~~**lansoprazole (Prevacid® ODT)**~~	esomeprazole (Nexium® I.V.)	**bismuth subcitrate potassium/ metronidazole/ tetracycline (Pylera® capsule)**
esomeprazole (Nexium® caps)	pantoprazole (Protonix® I.V.)	esomeprazole strontium caps	**bismuth subsalicylate/ metronidazole/ tetracycline (Helidac® Therapy dose pack)**
esomeprazole (Nexium® packet) – **Brand Preferred**	~~**rabeprazole (Aciphex® tabs)**~~	omeprazole (Prilosec® susp, powder)	cimetidine (Tagamet® tabs)
lansoprazole (Prevacid® caps)		pantoprazole (Protonix® susp)	esomeprazole kit (ESOMEP-EZS™)
lansoprazole (Prevacid® ODT) – Brand Preferred		rabeprazole (Aciphex® sprinkles)	famotidine (Pepcid® susp)
omeprazole (Prilosec® caps)			glycopyrrolate (Glycate® tabs)
pantoprazole (Protonix® tabs)			nizatidine (Axid® caps & soln)
rabeprazole (Aciphex® tabs)			omeprazole/ amoxicillin/rifabutin (Talicia® caps)
sucralfate susp (Carafate®) – **Brand Preferred**			omeprazole/sodium bicarbonate (Zegerid® caps & pack)
			~~**ranitidine caps**~~
			sucralfate susp **(generic)** ~~**(unit dose cups)**~~

caps = capsules; I.V. = intravenous; ODT = orally disintegrating tablet; PA = prior authorization; soln = solution; susp = suspension; tabs = tablets
*Special formulations including ODTs, granules, suspension, sprinkle capsules, and solution for IV require special reasoning for use.
⁺Individual criteria specific to each product applies.

Axid® (Nizatidine Capsules) Approval Criteria:

1. A previous 14-day trial of ~~ranitidine and~~ famotidine or a patient-specific, clinically significant reason why ~~ranitidine and~~ famotidine ~~are~~ is not appropriate for the member must be provided.

Axid® (Nizatidine Solution) Approval Criteria:

1. A previous 14-day trial of ~~ranitidine syrup~~ famotidine suspension or a patient-specific, clinically significant reason why ~~ranitidine syrup~~ famotidine suspension is not appropriate for the member must be provided; and
2. Nizatidine solution (Axid®) will have an age restriction of 6 years of age and younger. Members older than 6 years of age will require a patient-specific, clinically significant reason why the member needs the liquid formulation and cannot use the oral capsule formulation.

Generic Sucralfate Suspension ~~Unit Dose Cups~~ Approval Criteria:

1. Authorization consideration requires a patient specific, clinically significant reason why the member cannot use ~~the bulk medication~~ brand name Carafate® (sucralfate) suspension.

Helidac® Therapy (Bismuth Subsalicylate/Metronidazole/Tetracycline Dose Pack) and Pylera® (Bismuth Subcitrate Potassium/Metronidazole/ Tetracycline Capsule) Approval Criteria:

1. An FDA approved indication for the treatment of members with *Helicobacter pylori* (*H. pylori*) infection and active or previous duodenal ulcer disease; and
2. A patient-specific, clinically significant reason why the member cannot use the individual components [bismuth subsalicylate, metronidazole, and tetracycline plus a histamine type 2 receptor (H_2) antagonist], must be provided; and
3. A patient-specific, clinically significant reason why the member cannot use the individual components of guideline recommended concomitant therapy for *H. pylori* infection (e.g., proton pump inhibitor/H_2 antagonist, amoxicillin, clarithromycin, and metronidazole), which are available without prior authorization, must be provided; and
4. A patient-specific, clinically significant reason why the member cannot use the individual components of triple-therapy treatments for *H. pylori* infection (e.g., omeprazole, amoxicillin, and clarithromycin), which are available without prior authorization, must be provided; and
5. For Helidac® Therapy a quantity limit of 224 tablets/capsules per 14 days will apply; and
6. For Pylera® a quantity limit of 120 capsules per 10 days will apply.

Pepcid® (Famotidine Suspension) Approval Criteria:

1. ~~A previous 14-day trial of ranitidine syrup or a patient-specific, clinically significant reason why ranitidine syrup is not appropriate for the member must be provided; and~~
2. Famotidine suspension will have an age restriction of 6 years of age and younger. Members older than 6 years of age will require a patient-specific, clinically significant reason why the member needs the liquid formulation and cannot use the oral tablet formulation.

~~**Ranitidine Capsules Approval Criteria:**~~

~~1. A patient-specific, clinically significant reason why the member cannot use ranitidine tablets must be provided.~~

Tagamet® (Cimetidine Tablets) Approval Criteria:

1. A previous 14-day trial of ~~ranitidine and~~ famotidine or a patient-specific, clinically significant reason why ~~ranitidine and~~ famotidine ~~are~~ is not appropriate for the member must be provided.

Recommendation 3D: Approval of July 2021 DUR Board Recommendations: Vote to Prior Authorize Alkindi® Sprinkle (Hydrocortisone Oral Granule), Eysuvis® (Loteprednol 0.25% Ophthalmic Suspension), Gimoti® (Metoclopramide Nasal Spray), Nextstellis® (Drospirenone/Estetrol Tablet), Ozobax® (Baclofen 5mg/5mL Oral Solution), Phexxi® (Lactic Acid/Citric Acid/Potassium Bitartrate Vaginal Gel), ReditTrex® (Methotrexate Injection), Reltone™ (Ursodiol Capsule), and Thyquidity™ (Levothyroxine Oral Solution)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Alkindi® Sprinkle (hydrocortisone oral granule), Eysuvis® (loteprednol 0.25% ophthalmic suspension), and Gimoti® (metoclopramide nasal spray) with the following criteria:

Alkindi® Sprinkle (Hydrocortisone Oral Granule) Approval Criteria:

1. An FDA approved indication of replacement therapy in pediatric members with adrenocortical insufficiency; and
2. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use hydrocortisone tablets, even when tablets are crushed, must be provided.

Eysuvis® (Loteprednol 0.25% Ophthalmic Suspension) Approval Criteria:

1. An FDA approved indication for the short-term (up to 2 weeks) treatment of the signs and symptoms of dry eye disease (DED); and
2. A documented trial of intermittent or regular artificial tear use within the past 3 months; and
3. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine 0.05% ophthalmic emulsion), which is available without a prior authorization, must be provided; and
4. A patient-specific, clinically significant reason why the member cannot use Tier-1 ophthalmic corticosteroids including Lotemax® (loteprednol 0.5% suspension) must be provided; and
5. Member must not have any contraindications to Eysuvis®; and

6. A quantity limit of 8.3mL per 15 days will apply (Eysuvis® for the treatment of DED is not indicated for use beyond 15 days).

Gimoti® (Metoclopramide Nasal Spray) Approval Criteria:

1. An FDA approved indication of acute or recurrent diabetic gastroparesis in adult members; and
2. A patient-specific, clinically significant reason why the member cannot use metoclopramide oral tablets and metoclopramide oral solution must be provided; and
3. For members 65 years of age or older, approvals will not be granted for initiation of metoclopramide therapy; and
4. For members 65 years of age or older requesting to switch from an alternative metoclopramide product to Gimoti®:
    a. Member must be taking a stable dose of metoclopramide 10mg 4 times daily for at least 10 days; and
    b. Duration of current metoclopramide treatment must be provided; and
5. A maximum approval duration of 8 weeks total from all sources will apply; and
6. A quantity limit of 9.8mL per 28 days will apply.

Additionally, the College of Pharmacy recommends the prior authorization of Ozobax® (baclofen 5mg/5mL oral solution), Phexxi® (lactic acid/citric acid/potassium bitartrate vaginal gel), and Reltone™ (ursodiol capsule) with the following criteria:

Ozobax® (Baclofen 5mg/5mL Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of spasticity resulting from multiple sclerosis (relief of flexor spasms and concomitant pain, clonus, and muscular rigidity) or spinal cord injuries/diseases; and
2. Members older than 10 years of age require a patient-specific, clinically significant reason (beyond convenience) why the member cannot use baclofen oral tablets, even when tablets are crushed.

Phexxi® (Lactic Acid/Citric Acid/Potassium Bitartrate Vaginal Gel) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use an over-the-counter (OTC) spermicide and all other forms of contraception (e.g., condoms, oral contraceptives) must be provided. Various OTC spermicides containing nonoxynol 9 are covered by SoonerCare without prior authorization.

Reltone™ (Ursodiol Capsule) Approval Criteria:

1. An FDA approved indication for the dissolution of radiolucent, noncalcified gallstones <20mm in greatest diameter or the prevention of gallstone formation in obese members experiencing rapid weight loss; and

2. For the indication of dissolution of radiolucent, noncalcified gallstones <20mm in greatest diameter:
    a. Prescriber must confirm member is not a candidate for elective cholecystectomy due to 1 or more of the following:
        i. Increased surgical risk due to systemic disease; or
        ii. Advanced age; or
        iii. Idiosyncratic reaction to general anesthesia; or
        iv. Member refuses surgery; and
    b. Prescriber must confirm the member does not have compelling reasons for cholecystectomy including unremitting acute cholecystitis, cholangitis, biliary obstruction, gallstone pancreatitis, or biliary-gastrointestinal fistula; and
3. For the indication of prevention of gallstone formation in obese members experiencing rapid weight loss:
    a. Member's baseline body mass index (BMI) and weight must be provided; and
    b. Member's current weight must be provided supporting rapid weight loss compared to baseline; and
4. For both FDA approved indications, a patient-specific, clinically significant reason why the member cannot use other generic formulations of ursodiol must be provided; and
5. Initial approvals for the indication of dissolution of gallstones will be for the duration of 6 months, after which time the prescriber must confirm (via ultrasound imaging) partial or complete dissolution of gallstone(s). Subsequent approvals will be for the duration of 12 months; and
6. Approvals for prevention of gallstone formation in obese members experiencing rapid weight loss will be for 6 months, after which time the member's current weight must be provided to justify continued rapid weight loss and need for preventative treatment; and
7. Treatment duration will be limited to a maximum of 24 months for all diagnoses.

Finally, the College of Pharmacy recommends the addition of Nextstellis® (drospirenone/estetrol tablet) to the current Slynd® (drospirenone tablet) approval criteria, the addition of RediTrex® (methotrexate injection) to the current Otrexup® (methotrexate injection) and Rasuvo® (methotrexate injection) approval criteria along with updates due to net costs and to be consistent with current treatment guidelines, and the addition of Thyquidity™ (levothyroxine oral solution) to the current Tirosint® (levothyroxine capsule) and Tirosint®-SOL (levothyroxine oral solution) approval criteria along with the recommended Drug Utilization Review (DUR) Board update to redefine the dosing for the required 8 week trial of levothyroxine (proposed changes shown in red):

Nextstellis® (Drospirenone/Estetrol Tablet) and Slynd® (Drospirenone Tablet) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use all alternative formulations of hormonal contraceptives available without a prior authorization must be provided.

Rasuvo®, RediTrex®, and Otrexup® (Methotrexate Injection Solutions) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
   a. Adults with severe, active rheumatoid arthritis (RA); or
   b. Children with active polyarticular juvenile idiopathic arthritis (pJIA); or
   c. Severe, recalcitrant, disabling psoriasis confirmed by biopsy or dermatologic consultation; and
2. ~~Members with a diagnosis of RA or pJIA must have had an adequate trial of full dose nonsteroidal anti-inflammatory drugs (NSAIDs); and~~
3. A patient-specific, clinically significant reason why the oral tablets ~~or~~ and the generic injectable formulation cannot be used must be provided; and
4. Authorization of Otrexup® will also require a patient-specific, clinically significant reason why the member cannot use Rasuvo® or RediTrex®.

Thyquidity™ (Levothyroxine Oral Solution), Tirosint® (Levothyroxine Capsule), and Tirosint®-SOL (Levothyroxine Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
   a. Hypothyroidism: As replacement therapy in primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) congenital or acquired hypothyroidism; or
   b. Pituitary Thyrotropin (thyroid-stimulating hormone, TSH) Suppression: As an adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer; and
2. A patient-specific, clinically significant reason why the member cannot use all other formulations of levothyroxine must be provided. For the oral solutions, a reason why the member cannot use the levothyroxine tablet, even when the tablets are crushed, must be provided; and
3. Prescriber must verify member has been compliant with levothyroxine tablets at ~~maximum dose~~ a greatly increased dose for at least 8 weeks; and
4. Prescriber must verify that member has not been able to achieve normal thyroid lab levels despite ~~maximum dosing~~ a greatly increased dose and compliance with levothyroxine tablets.

Recommendation 4: Vote to Prior Authorize Qdolo™ (Tramadol 5mg/mL Oral Solution)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the Opioid Analgesics Product Based Prior Authorization (PBPA) category (changes noted in red in the following Tier chart and approval criteria; only criteria and with changes are listed):

1. Placement of Qdolo™ (tramadol 5mg/mL oral solution) into the Short-Acting Special Prior Authorization (PA) category of the Opioid Analgesics Tier chart
2. Removal of Combunox™ (oxycodone/ibuprofen tablet), Embeda® [morphine/naltrexone extended-release (ER) capsule], Oxecta® (oxycodone tablet), Primlev™ [oxycodone/acetaminophen (APAP) tablet], Vantrela™ ER (hydrocodone ER tablet), and Xolox® (oxycodone/APAP tablet) from the Opioid Analgesics Tier chart due to product discontinuation

Opioid Analgesics*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
Long-Acting			
buprenorphine patch (Butrans®) – **Brand Preferred**	fentanyl patch (Duragesic®)	buprenorphine ER buccal film (Belbuca®)	oxycodone/APAP ER tab (Xartemis® XR)
oxycodone ER tab 10mg, 15mg, 20mg only (OxyContin®) – **Brand Preferred**	morphine ER tab (MS Contin®)	hydrocodone ER cap (Zohydro® ER)	oxymorphone ER tab
	~~**morphine/ naltrexone ER cap (Embeda®)**~~	hydrocodone ER tab (Hysingla® ER)	tramadol ER cap (ConZip®)
	oxycodone ER tab 30mg, 40mg, 60mg, 80mg (OxyContin®) – **Brand Preferred**	~~**hydrocodone ER tab (Vantrela™ ER)**~~	
	tramadol ER tab (Ultram ER®, Ryzolt®)	hydromorphone ER tab (Exalgo®)	
		methadone tab and oral soln (Dolophine®)	
		morphine ER cap (Avinza®, Kadian®)	
		morphine ER tab (Arymo™ ER)	
		morphine ER tab (MorphaBond™)	

Opioid Analgesics*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
		oxycodone ER cap (Xtampza® ER)	
		oxycodone/ naltrexone ER cap (Troxyca® ER)	
Short-Acting			
APAP/butalbital/ caff/codeine cap (Fioricet® with Codeine)	oxymorphone IR tab (Opana®)	benzhydrocodone/ APAP tab (Apadaz®)	levorphanol tab
ASA/butalbital/caff/ codeine cap (Fiorinal® with Codeine)	tapentadol IR tab (Nucynta®)	dihydrocodeine/ APAP/caff cap (Trezix®)	tramadol 100mg tab
Short-Acting			
codeine tab		hydrocodone/ APAP oral soln (Zamicet®, Liquicet®)	**tramadol oral soln (Qdolo™)**
codeine/APAP tab (Tylenol® with Codeine)		hydrocodone/ APAP tab (Xodol®)	
dihydrocodeine/ ASA/caff cap (Synalgos-DC®)		~~**oxycodone/APAP tab (Primlev™, Xolox®)**~~	
hydrocodone/ APAP tab (Norco®)		oxycodone tab (Oxaydo®)	
hydrocodone/IBU tab (Vicoprofen®, Ibudone®, Reprexain™)		~~**oxycodone tab (Oxecta®)**~~	
hydromorphone tab (Dilaudid®)		oxycodone tab (RoxyBond™)	
morphine IR tab (MSIR®)			
oxycodone/APAP tab (Percocet®)			***Oncology Only:***
oxycodone/ASA tab (Percodan®)			fentanyl buccal film (Onsolis®)
~~**oxycodone/IBU tab (Combunox™)**~~			fentanyl buccal tab (Fentora®)
oxycodone IR cap (Oxy IR®)			fentanyl nasal spray (Lazanda®)
oxycodone IR tab (Roxicodone®)			fentanyl SL spray (Subsys®)
tramadol 50mg tab (Ultram®)			fentanyl SL tab (Abstral®)

Opioid Analgesics*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
tramadol/APAP tab (Ultracet®)			fentanyl transmucosal lozenge (Actiq®)

*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
APAP = acetaminophen; ASA = aspirin; caff = caffeine; cap = capsule; ER = extended-release; IBU = ibuprofen; IR = immediate-release; PA = prior authorization; SL = sublingual; soln = solution; tab = tablet

Opioid Analgesics Special Prior Authorization (PA) Approval Criteria:

1. Abstral®, Actiq®, Fentora®, Lazanda®, Onsolis®, and Subsys® are approved for oncology-related diagnoses only.
2. Unique Strengths of Hydrocodone/Acetaminophen (APAP) Approval Criteria:
    a. A patient-specific, clinically significant reason why the member cannot use generic Norco® (hydrocodone/APAP 5/325mg, 7.5/325mg, or 10/325mg) must be provided.
3. ConZip® [Tramadol Extended-Release (ER) Capsule] Approval Criteria:
    a. A patient-specific, clinically significant reason why the member cannot use the ER tablet formulation must be provided. Tier structure rules apply.
4. Xartemis® XR (Oxycodone/APAP ER Tablet) Approval Criteria:
    a. An acute pain condition requiring around-the-clock opioid treatment; and
    b. A patient-specific, clinically significant reason must be provided for all of the following:
        i. Why the member cannot use any other opioid medication for treatment of acute pain; and
        ii. Why the member requires a long-acting medication for an acute pain condition; and
        iii. Why the member cannot use OxyContin® (oxycodone ER) and over-the-counter (OTC) APAP individual products in place of this combination product; and
    c. A quantity limit of 4 tablets per day will apply with a maximum approval duration of 10 days; and
    d. The member must not exceed 3,250mg of APAP per day from all sources; and
    e. Tier structure rules still apply.
5. Levorphanol Tablet Approval Criteria:
    a. A patient-specific, clinically significant reason why the member cannot use alternative treatment options for pain (e.g., non-opioid analgesics, lower-tiered opioid analgesics) must be provided.
6. Tramadol 100mg Tablet Approval Criteria:

a. A patient-specific, clinically significant reason why the member cannot use 2 tramadol 50mg tablets to achieve a 100mg dose must be provided; and
b. An age restriction will apply for members younger than 12 years of age. For members younger than 12 years of age, the provider must submit patient-specific, clinically significant information supporting the use of tramadol despite the medication being contraindicated for the member's age.

7. Qdolo™ (Tramadol 5mg/mL Oral Solution) Approval Criteria:
   a. A patient-specific, clinically significant reason why the member cannot use tramadol 50mg tablets, even when tablets are crushed, must be provided; and
   b. An age restriction will apply for members younger than 12 years of age. For members younger than 12 years of age, the prescriber must provide patient-specific, clinically significant information supporting the use of tramadol despite the medication being contraindicated for the member's age; and
   c. A quantity limit of 2,400mL per 30 days will apply.

Additionally, the College of Pharmacy recommends the following changes to the Medication Assisted Treatment (MAT) medications approval criteria (changes noted in red in the following criteria; only criteria with changes are listed):

1. Removal of Cassipa® [buprenorphine/naloxone sublingual (SL) film] and Probuphine® (buprenorphine implant) based on product discontinuation

Bunavail® (Buprenorphine/Naloxone Buccal Film), ~~Cassipa® [Buprenorphine/Naloxone Sublingual (SL) Film]~~, Suboxone® (Buprenorphine/Naloxone SL Tablet and Film), Subutex® (Buprenorphine SL Tablet), and Zubsolv® (Buprenorphine/Naloxone SL Tablet) Approval Criteria:

1. Generic buprenorphine/naloxone SL tablet is the preferred product. Authorization consideration of Bunavail®, Zubsolv®, ~~Cassipa®;~~ and Suboxone® films (brand and generic) requires a patient-specific, clinically significant reason why generic buprenorphine/naloxone SL tablets are not appropriate.
2. Subutex® (buprenorphine) 2mg and 8mg SL tablets will only be approved if the member is pregnant or has a documented serious allergy or adverse reaction to naloxone; and
3. ~~For Cassipa®, the member must have been titrated to a dose of 16mg buprenorphine using another buprenorphine product prior to approval; and~~
4. Buprenorphine products FDA approved for a diagnosis of opioid abuse/dependence must be prescribed by a licensed practitioner 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 Drug Enforcement Agency (DEA) X number; and

5. Member must have an FDA approved diagnosis of opioid abuse/ dependence; and
6. Concomitant treatment with opioid analgesics (including tramadol) will be denied; and
7. Approvals will be for the duration of 90 days to allow for concurrent medication monitoring; and
8. The following limitations will apply:
    a. Bunavail® 2.1mg/0.3mg buccal films: A quantity limit of 90 buccal films per 30 days will apply.
    b. Bunavail® 4.2mg/0.7mg buccal films: A quantity limit of 60 buccal films per 30 days will apply.
    c. Bunavail® 6.3mg/1mg buccal films: A quantity limit of 30 buccal films per 30 days will apply.
    ~~d. Cassipa® 16mg/4mg SL films: A quantity limit of 30 SL films per 30 days will apply.~~
    e. Suboxone® 2mg/0.5mg and 4mg/1mg SL tablets and films: A quantity limit of 90 SL units per 30 days will apply.
    f. Suboxone® 8mg/2mg SL tablets and films: A quantity limit of 60 SL units per 30 days will apply.
    g. Suboxone® 12mg/3mg SL films: A quantity limit of 30 SL films per 30 days will apply.
    h. Subutex® 2mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    i. Subutex® 8mg SL tablets: A quantity limit of 60 SL tablets per 30 days will apply.
    j. Zubsolv® 0.7mg/0.18mg, 1.4mg/0.36mg, and 2.9mg/0.71mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    k. Zubsolv® 5.7mg/1.4mg SL tablets: A quantity limit of 60 SL tablets per 30 days will apply.
    l. Zubsolv® 8.6mg/2.1mg and 11.4mg/2.9mg SL tablets: A quantity limit of 30 SL tablets per 30 days will apply.

~~**Probuphine® (Buprenorphine Implant) Approval Criteria:**~~

~~1. An FDA approved indication of maintenance treatment of opioid dependence; and~~
~~2. Member must be currently on a maintenance dose of ≤8mg per day 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) for 3 months or longer without any need for supplemental dosing or adjustments; and~~

4. Member must have had no positive urine toxicology results or paid claims for opioids within the last 3 months. Concomitant treatment with opioids (including tramadol) will be denied; and
5. Probuphine® must be prescribed by a licensed practitioner 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 Drug Enforcement Agency (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; and
   b. Stability of living environment; and
   c. Participation in a structured activity/job; and
   d. Consistency in participation in recommended behavioral therapy/peer support program; and
   e. Consistency in compliance with clinic visit requirements; and
   f. Minimal to no desire or need to use illicit opioids; and
   g. Period without episodes of hospitalizations (addiction or mental health issues), emergency room visits, or crisis interventions; and
   h. Social support system; and
7. The prescriber must verify enrollment in the Probuphine® Risk Evaluation and Mitigation Strategy (REMS) program; and
8. Approvals will be for 1 kit (4 implants) per 6 months. Reauthorizations for an additional 6 months may be granted if the member does not have ongoing use of supplemental dosing with transmucosal buprenorphine or opioid analgesics while utilizing Probuphine®.

Recommendation 5: Vote to Prior Authorize Impeklo® (Clobetasol Propionate 0.05% Lotion)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends moving clobetasol propionate 0.05% lotion (Clobex®) from Tier-2 to Tier-1 and recommends adding Impeklo® (clobetasol propionate 0.05% lotion) to Tier-3 of the Ultra-High to High Potency Topical Corticosteroids Product Based Prior Authorization (PBPA) category; current Tier-3 criteria will apply for Impeklo® (changes noted in red in the following Tier chart):

Topical Corticosteroids					
Tier-1		**Tier-2**		**Tier-3**	
Ultra-High to High Potency					
augmented betamethasone dipropionate 0.05% (Diprolene AF®)	C,G	amcinonide 0.1%	C,L	clobetasol propionate 0.05% (Clobex®)	Sh,Spr

Topical Corticosteroids					
Tier-1		**Tier-2**		**Tier-3**	
clobetasol propionate 0.05% (Clobex®)	**L**	augmented betamethasone dipropionate 0.05% (Diprolene®)	L,O	clobetasol propionate 0.05% (Olux®, Olux-E®, Tovet®)	F
clobetasol propionate 0.05% (Temovate®)	C,O, So	betamethasone dipropionate 0.05% (Diprosone®)	C,O	**clobetasol propionate 0.05% (Impeklo®)**	**L**
fluocinonide 0.05%	C,O,So	~~**clobetasol propionate 0.05% (Clobex®)**~~	~~**L**~~	desoximetasone 0.25% (Topicort®)	C,O,Spr
halobetasol propionate 0.05% (Ultravate®)	C	clobetasol propionate 0.05% (Temovate®)	G	diflorasone diacetate 0.05% (Apexicon®)	C,O
		desoximetasone 0.05% (Topicort®)	G	diflorasone diacetate/ emollient 0.05% (Apexicon E®)	C
		fluocinonide 0.05%	G	halobetasol propionate 0.01% (Bryhali®)	L
		fluocinonide 0.1% (Vanos®)	C	halobetasol propionate 0.05% (Lexette®)	F
		flurandrenolide tape 0.05% (Cordran®)	Tape		
		halcinonide 0.1% (Halog®)	C,O,So		
		halobetasol propionate 0.05% (Ultravate®)	L,O		
		halobetasol propionate/lactic acid 0.05%/10% (Ultravate X®)	C		
Medium-High to Medium Potency					
betamethasone dipropionate 0.05%	L	betamethasone dipropionate/ calcipotriene 0.064%/0.005% (Taclonex®)	O,Spr, Sus	hydrocortisone valerate 0.2% (Westcort®)	C,O
betamethasone valerate 0.1% (Beta-Val®)	C,L,O	betamethasone dipropionate/ calcipotriene 0.064%/0.005% (Enstilar® Foam)	F		

Topical Corticosteroids					
Tier-1		**Tier-2**		**Tier-3**	
fluticasone propionate 0.05% (Cutivate®)	C,O	betamethasone valerate 0.12% (Luxiq®)	F		
mometasone furoate 0.1% (Elocon®)	C,L,O, So	clocortolone pivalate 0.1% (Cloderm®)	C		
triamcinolone acetonide 0.025%	O	desoximetasone 0.05% (Topicort LP®)	C,O		
triamcinolone acetonide 0.1%	C,L,O	fluocinolone acetonide 0.025% (Synalar®)	C,O		
triamcinolone acetonide 0.5%	C,O	fluocinonide emollient 0.05% (Lidex E®)	C		
		flurandrenolide 0.05%	C,L,O		
		fluticasone propionate 0.05% (Cutivate®)	L		
		hydrocortisone butyrate 0.1%	C,L,O, So		
		hydrocortisone probutate 0.1% (Pandel®)	C		
		prednicarbate 0.1% (Dermatop®)	C,O		
		triamcinolone acetonide 0.147mg/g (Kenalog®)	Spr		
		triamcinolone acetonide 0.05% (Trianex®)	O		
Low Potency					
desonide 0.05% (Desonate®)	G	alclometasone dipropionate 0.05% (Aclovate®)	C,O	fluocinolone acetonide 0.01% (Derma-Smoothe®; Derma-Smoothe FS®)	Oil
fluocinolone acetonide 0.01% (Capex®)	Sh	fluocinolone acetonide 0.01% (Synalar®)	C,So	desonide 0.05%	L
hydrocortisone acetate 1%	C,O	hydrocortisone 2.5% (Texacort®)	So	desonide emollient 0.05%	C,O
hydrocortisone acetate 2.5%	C,L,O	hydrocortisone/ pramoxine 1%/1% (Pramosone®)	C,L		

Topical Corticosteroids					
Tier-1		**Tier-2**		**Tier-3**	
hydrocortisone/urea 1%/10% (U-Cort®)	C				
triamcinolone acetonide 0.025%	C,L				

Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
C = cream; F = foam; G = gel; L = lotion; O = ointment; Sh = shampoo; So = solution; Spr = spray; Sus = suspension

Topical Corticosteroids Tier-3 Approval Criteria:

1. Documented trials of all Tier-1 and Tier-2 topical corticosteroids of similar potency in the past 90 days that did not yield adequate relief; and
2. If Tier-1 and Tier-2 trials are completed and do not yield adequate relief, a patient-specific, clinically significant reason for requesting a Tier-3 medication in the same potency instead of trying a higher potency medication must be provided; and
3. When the same medication is available in Tier-1 or Tier-2, a patient-specific, clinically significant reason must be provided for using a special dosage formulation of that medication in Tier-3 (e.g., foams, shampoos, sprays, kits); and
4. Topical corticosteroid kits require tier trials and a patient-specific, clinically significant reason for use of the kit over other standard formulations.

Recommendation 6: Vote to Update the Approval Criteria for the Ophthalmic Anti-Inflammatory Products

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the ophthalmic corticosteroids and ophthalmic non-steroidal anti-inflammatory drugs (NSAIDs) Product Based Prior Authorization (PBPA) categories (changes noted in red in the following PBPA Tier charts):

1. Moving brand name Lotemax® (loteprednol) 0.5% gel and 0.5% ointment from Tier-2 to Tier-1 in the Ophthalmic Corticosteroids PBPA Tier chart based on net costs
2. Moving Ilevro® (nepafenac) 0.3% suspension from Tier-1 to Tier-2 in the Ophthalmic NSAIDs PBPA Tier chart based on net costs; current Tier-2 criteria will apply

Ophthalmic Corticosteroids	
Tier-1	**Tier-2**
dexamethasone 0.1% sus (Maxidex®)	fluorometholone 0.25% sus (FML Forte®)
dexamethasone sodium phosphate 0.1% sol	fluorometholone 0.1% oint (FML S.O.P®)
difluprednate 0.05% emu (Durezol®)	loteprednol 1% sus (Inveltys®)

fluorometholone 0.1% sus (Flarex®)	~~**loteprednol 0.5% gel (Lotemax®)**~~
fluorometholone 0.1% sus (FML Liquifilm®)	~~**loteprednol 0.5% oint (Lotemax®)**~~
loteprednol 0.5% **gel, oint,** sus (Lotemax®) – **Brand Preferred**	loteprednol 0.38% gel (Lotemax® SM)
prednisolone acetate 1% sus (Omnipred®)	prednisolone acetate 1% sus (Pred Forte®)
prednisolone acetate 0.12% sus (Pred Mild®)	
prednisolone sodium phosphate 1% sol	

emu = emulsion; oint = ointment; sol = solution; sus = suspension
Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC)

Ophthalmic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	
Tier-1	**Tier-2**
diclofenac 0.1% sol (Voltaren®)	bromfenac 0.09% sol (Bromday®)
flurbiprofen 0.03% sol$^{\Delta}$ (Ocufen®)	bromfenac 0.075% sol (BromSite®)
ketorolac 0.5% sol (Acular®)	bromfenac 0.07% sol (Prolensa®)
~~**nepafenac 0.3% sus (Ilevro®)**~~	ketorolac 0.4% sol (Acular LS®)
	ketorolac 0.45% sol (Acuvail®)
	nepafenac 0.1% sus (Nevanac®)
	nepafenac 0.3% sus (Ilevro®)

sol = solution; sus = suspension
$^{\Delta}$Not a required Tier-1 trial; does not have to be attempted for approval of a Tier-2 medication.
Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).

Ophthalmic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) Tier-2 Approval Criteria:

1. Documented trials of all Tier-1 ophthalmic NSAIDs (from different medication lines) in the last 30 days that did not yield adequate relief of symptoms or resulted in intolerable adverse effects; or
2. Contraindication(s) to all lower tiered medications; or
3. A unique indication for which the Tier-1 ophthalmic NSAIDs lack.

Recommendation 7: Vote to Prior Authorize Nulibry™ (Fosdenopterin)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Nulibry™ (fosdenopterin) with the following criteria:

Nulibry™ (Fosdenopterin) Approval Criteria:

1. An FDA approved indication to reduce the risk of mortality in members with molybdenum cofactor deficiency (MoCD) Type A; and
2. MoCD Type A must be confirmed by genetic testing; and
   a. If the member is presumed to have MoCD Type A, Nulibry™ can be approved for 1 month until genetic testing can be performed; and

b. Nulibry™ will be discontinued if genetic testing results do not confirm MoCD Type A; and
3. Nulibry™ must be administered by a health care provider or the prescriber must verify the member or member's caregiver has been trained by a health care professional on proper storage, preparation, and intravenous (IV) administration of Nulibry™; and
4. Member's weight (kg) must be provided and must have been taken within the last 4 weeks to ensure accurate weight-based dosing according to package labeling; and
5. Approval quantities will be dependent on the member's age, weight, and dosing based on the Nulibry™ *Prescribing Information*.

Recommendation 8: Vote to Prior Authorize Danyelza® (Naxitamab-gqgk) and Truseltiq™ (Infigratinib)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Danyelza® (naxitamab-gqgk) and Truseltiq™ (infigratinib) with the following criteria:

Danyelza® (Naxitamab-gqgk) Approval Criteria [Neuroblastoma Diagnosis]:

1. Diagnosis of relapsed or refractory high-risk neuroblastoma in adult and pediatric members 1 year of age and older; and
2. Disease in the bone or bone marrow demonstrating a partial response, minor response, or stable disease to prior therapy (i.e., no progressive disease following most recent therapy); and
3. Must be given in combination with a granulocyte-macrophage colony-stimulating factor (GM-CSF) according to package labeling (GM-CSF dosed at 250mcg/m^2/day daily starting 5 days prior to Danyelza® therapy and 500mcg/m^2/day daily on days 1 to 5 of Danyelza® therapy); and
4. Prescriber must agree to provide the member appropriate premedication for pain management and neuropathic pain (e.g., oral opioids, gabapentin); and
5. Prescriber must agree to provide the member appropriate premedication for infusion-related reactions and nausea/vomiting including an intravenous (IV) corticosteroid, a histamine 1 (H_1) antagonist, an H_2 antagonist, acetaminophen, and an antiemetic.

Truseltiq™ (Infigratinib) Approval Criteria [Cholangiocarcinoma Diagnosis]:

1. Diagnosis of unresectable, locally advanced or metastatic cholangiocarcinoma; and
2. Presence of fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement; and
3. Disease has progressed on at least 1 prior systemic therapy; and

4. As a single agent.

Recommendation 9: Vote to Prior Authorize Feraheme® (Ferumoxytol), Injectafer® (Ferric Carboxymaltose), and Monoferric® (Ferric Derisomaltose)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Feraheme® (ferumoxytol injection), Injectafer® (ferric carboxymaltose injection), and Monoferric® (ferric derisomaltose injection) with the following criteria:

Feraheme® (Ferumoxytol) Approval Criteria:

1. An FDA approved indication of 1 of the following:
   a. Iron deficiency anemia (IDA); or
   b. IDA with chronic kidney disease (CKD); and
2. Documented lab results verifying IDA; and
3. Documentation of intolerance or inadequate response to oral iron therapy after at least 3 months at recommended dosing; and
4. Prescriber must verify the member does not have a previous history of allergic reaction to any intravenous iron medications; and
5. A recent, failed trial of Infed® (iron dextran) or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Infed® and Venofer® must be provided.

Injectafer® (Ferric Carboxymaltose) Approval Criteria:

1. An FDA approved indication of 1 of the following:
   a. Iron deficiency anemia (IDA); or
   b. IDA in patients with non-dialysis dependent chronic kidney disease (CKD); and
2. Documented lab results verifying IDA; and
3. Documentation of intolerance or inadequate response to oral iron therapy after at least 3 months at recommended dosing; and
4. A recent, failed trial of Infed® (iron dextran) or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Infed® and Venofer® must be provided.

Monoferric® (Ferric Derisomaltose) Approval Criteria:

1. An FDA approved indication of 1 of the following:
   a. Iron deficiency anemia (IDA); or
   b. IDA in patients with non-dialysis dependent chronic kidney disease (CKD); and
2. Documented lab results verifying IDA; and
3. Documentation of intolerance or inadequate response to oral iron therapy after at least 3 months at recommended dosing; and

4. A recent, failed trial of Infed® (iron dextran) or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Infed® and Venofer® must be provided.

Recommendation 10: Annual Review of Synagis® (Palivizumab)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the current Synagis® (palivizumab) prior authorization criteria based on recent variations in the respiratory syncytial virus (RSV) season in Oklahoma (changes noted in red):

Synagis® (Palivizumab) Approval Criteria:

A. Member Selection:
   1. Infants younger than 12 months of age 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 ≥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 have moderate-to-severe pulmonary hypertension]; or
      d. May be considered for:
         i. Infants with neuromuscular disease or a congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough; or
         ii. Infants who undergo cardiac transplantation during RSV season; or
         iii. Infants who are profoundly immunocompromised during RSV season; or
         iv. Infants with cystic fibrosis with clinical evidence of CLD and/or are nutritionally compromised; or
   2. Infants 12 to 24 months of age at the start of RSV season:
      a. Born before 32 weeks, 0 days gestation and have CLD of prematurity (required ≥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; or
      b. May be considered for:
         i. Infants who undergo cardiac transplantation during RSV season; or
         ii. Infants who are profoundly immunocompromised during RSV season; or

iii. Infants with cystic fibrosis with manifestations of severe lung disease or weight for length less than the 10th percentile.

B. Length of Treatment: Palivizumab is approved for use only during RSV season in Oklahoma as determined by the Oklahoma State Department of Health (OSDH) Viral Respiratory Illness Sentinel Surveillance System or other credible statewide monitoring system. The threshold for determining RSV seasonality is 10% of positive tests. RSV is determined to be in season once the percentage of positive tests is >10%; however, due to a potential lag in reporting data, palivizumab coverage will begin when the percentage of positive tests is consistently increasing and approaching the 10% threshold. RSV season is determined to be at an end when the percentage of positive tests is consistently <10%. ~~Approval dates will be November 1st through March 31st.~~ Initial approvals will be for the duration of 3 months from the determined RSV season start date in Oklahoma. Subsequent approvals will be for the duration of 1 month until RSV season end. A separate prior authorization request will be required for consideration of initial approval and for each subsequent approval.

C. Units Authorized: The member's current weight (taken within the last 3 weeks) must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling. ~~The maximum duration of therapy is 5 doses, with a~~ Doses are 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 1 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.

Recommendation 11: Annual Review of Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) Modulators

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends updating the FDA approved indication and age restriction of Trikafta® (elexacaftor/tezacaftor/ivacaftor and ivacaftor) based on the new FDA approvals with the following criteria (changes and new criteria shown in red):

Trikafta® (Elexacaftor/Tezacaftor/Ivacaftor and Ivacaftor) Approval Criteria:

1. An FDA approved diagnosis of cystic fibrosis (CF) in members who have at least 1 *F508del* mutation in the CF transmembrane conductance regulator *(CFTR)* gene or a mutation in the CFTR gene that is responsive based on in vitro data; and
2. If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a *CFTR* mutation followed by verification with bi-directional sequencing when recommended by the mutation test's instructions for use; and
3. Member must be 6 ~~12~~ years of age or older; and
4. Members using Trikafta® must be supervised by a pulmonary specialist; and
5. If member is currently stabilized on Orkambi® (lumacaftor/ivacaftor) or Symdeko® (tezacaftor/ivacaftor and ivacaftor) and experiencing adverse effects associated with Orkambi® or Symdeko® use, the prescriber must indicate that information on the prior authorization request; and
6. Prescriber must verify that member has been counseled on proper administration of Trikafta® including taking with a fat-containing food; and
7. Prescriber must verify that ALT, AST, and bilirubin will be assessed prior to initiating Trikafta®, every 3 months during the first year of treatment, and annually thereafter; and
8. Prescriber must verify that the member does not have severe hepatic impairment; and
9. Prescriber must verify that pediatric members will receive baseline and follow-up ophthalmological examinations as recommended in the Trikafta® *Prescribing Information*; and
10. Member must not be taking any of the following medications concomitantly with Trikafta®: rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, and St. John's wort; and
11. For members 6 to 11 years of age, the member's recent weight must be provided on the prior authorization request in order to authorize the appropriate dose according to package labeling, as follows:
    a. Members 6 to 11 years of age weighing <30kg will be approved for Trikafta® (elexacaftor 50mg/tezacaftor 25mg/ivacaftor 37.5mg and ivacaftor 75mg) upon meeting approval criteria; or
    b. Members 6 to 11 years of age weighing ≥30kg and members 12 years of age and older will be approved for Trikafta® (elexacaftor 100mg/tezacaftor 50mg/ivacaftor 75mg and ivacaftor 150mg) upon meeting approval criteria; and
12. A quantity limit of 3 tablets per day or 84 tablets per 28 days will apply; and
13. Initial approval will be for the duration of 3 months, after which time compliance will be required for continued approval. After 6 months of utilization, compliance and information regarding efficacy, such as

improvement in forced expiratory volume in 1 second (FEV_1), will be required for continued approval. Additionally after 6 months of utilization, information regarding efficacy as previously mentioned or fewer adverse events than with a previous CFTR therapy must be provided for members who switched from Orkambi® (lumacaftor/ivacaftor) or Symdeko® (tezacaftor/ivacaftor and ivacaftor).

Recommendation 12: Annual Review of Breast Cancer Medications and 30-Day Notice to Prior Authorize Herceptin® (Trastuzumab) and Margenza® (Margetuximab-cmkb)

NO ACTION REQUIRED.

Recommendation 13: Annual Review of Prostate Cancer Medications and 30-Day Notice to Prior Authorize Orgovyx™ (Relugolix)

NO ACTION REQUIRED

Recommendation 14: Annual Review of Cystadrops® (Cysteamine 0.37% Ophthalmic Solution) and Cystaran® (Cysteamine 0.44% Ophthalmic Solution)

NO ACTION REQUIRED

Recommendation 15: U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates

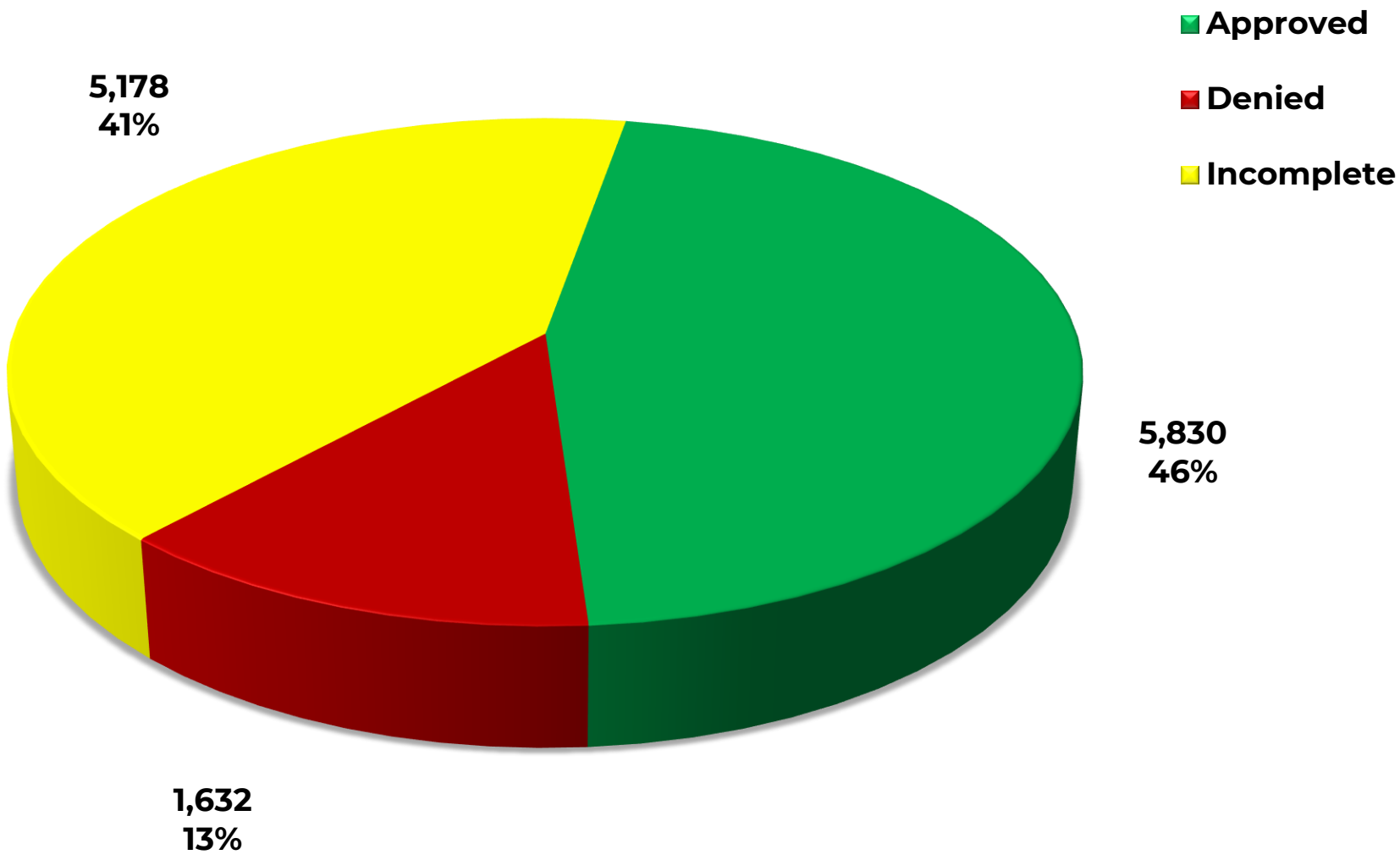
NO ACTION REQUIRED

Recommendation 16: Future Business

NO ACTION REQUIRED

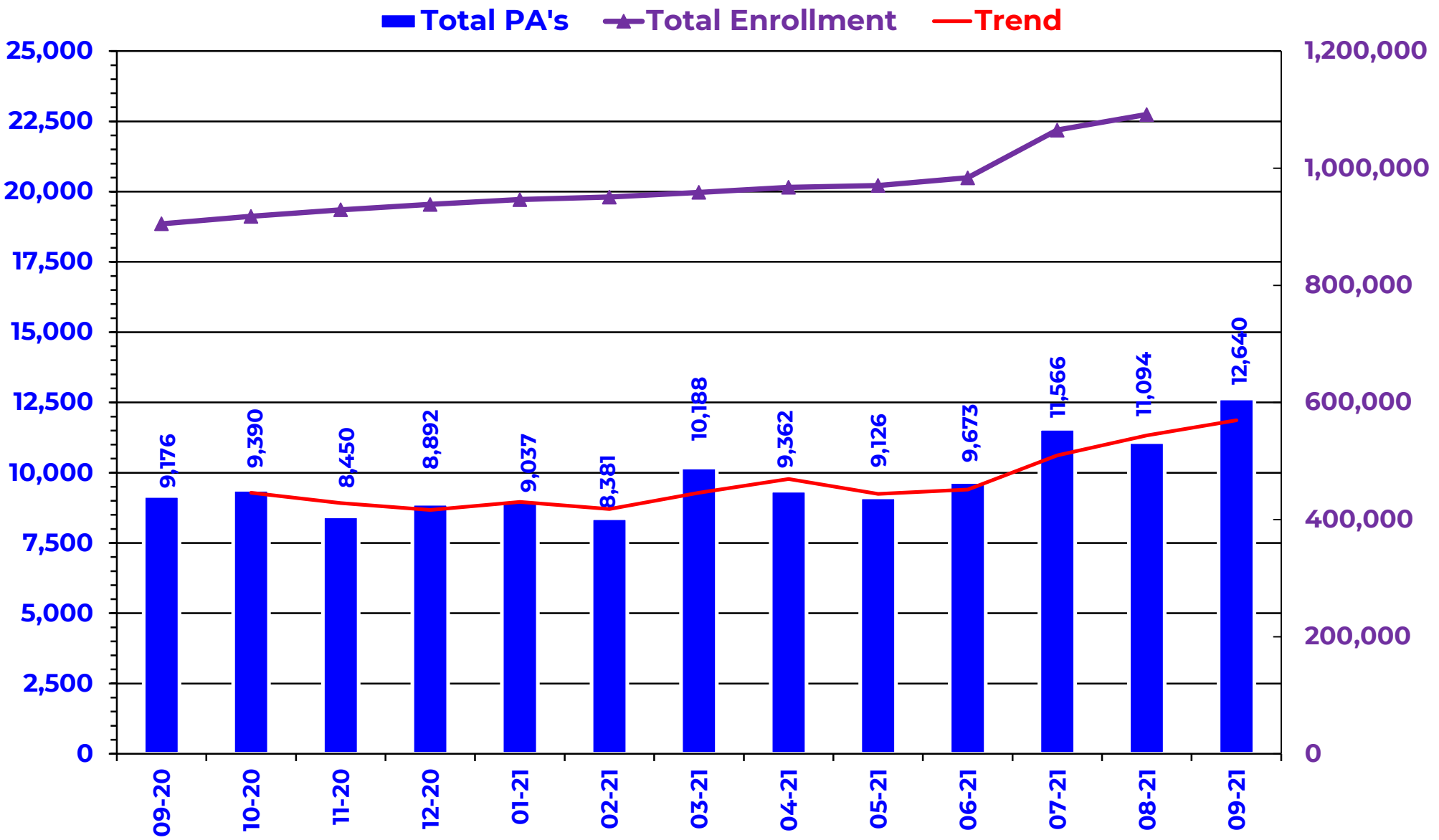
Appendix B

PRIOR AUTHORIZATION ACTIVITY REPORT: SEPTEMBER 2021



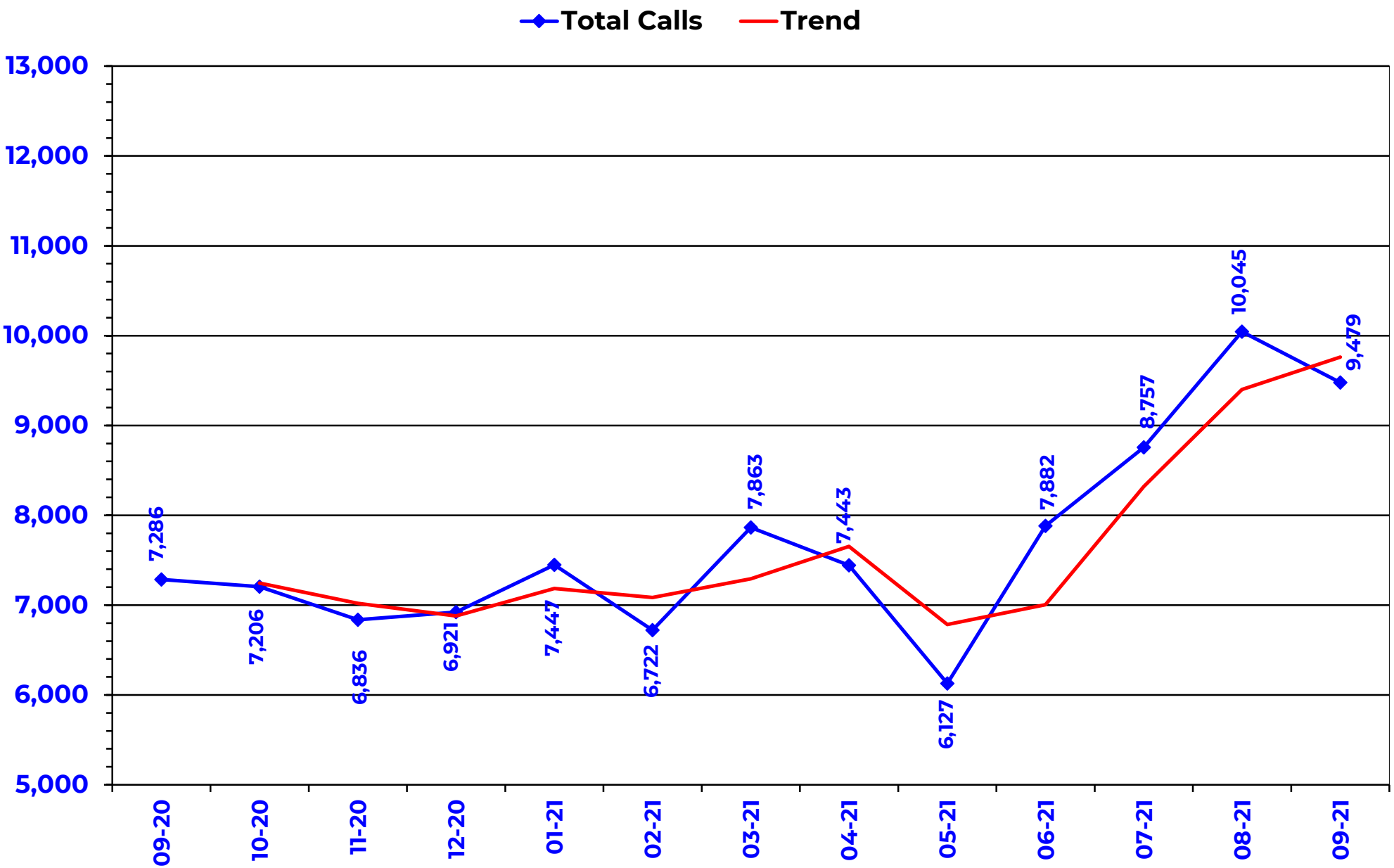
PA totals include approved/denied/incomplete/overrides

PRIOR AUTHORIZATION REPORT: SEPTEMBER 2020 – SEPTEMBER 2021



PA totals include approved/denied/incomplete/overrides

CALL VOLUME MONTHLY REPORT: SEPTEMBER 2020 – SEPTEMBER 2021



Prior Authorization Activity

9/1/2021 Through 9/30/2021

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort/Dulera	82	27	6	49	358
Analgesic - NonNarcotic	17	0	5	12	0
Analgesic, Narcotic	246	98	25	123	168
Angiotensin Receptor Antagonist	10	3	1	6	244
Antiasthma	54	18	10	26	248
Antibiotic	35	18	4	13	255
Anticonvulsant	182	91	12	79	320
Antidepressant	320	91	44	185	342
Antidiabetic	1,079	466	150	463	355
Antigout	11	7	1	3	222
Antihemophilic Factor	12	8	1	3	358
Antihistamine	42	14	11	17	291
Antimigraine	375	58	133	184	221
Antineoplastic	142	92	15	35	170
Antiparasitic	19	2	10	7	9
Antiulcers	57	15	8	34	158
Anxiolytic	24	4	4	16	224
Atypical Antipsychotics	492	257	39	196	352
Biologics	257	132	29	96	296
Bladder Control	61	8	16	37	255
Blood Thinners	656	363	28	265	340
Botox	60	35	15	10	327
Buprenorphine Medications	111	33	5	73	82
Calcium Channel Blockers	20	5	3	12	197
Cardiovascular	79	37	13	29	351
Chronic Obstructive Pulmonary Disease	260	62	63	135	337
Constipation/Diarrhea Medications	198	27	61	110	237
Contraceptive	33	12	3	18	301
Corticosteroid	14	2	6	6	18
Dermatological	348	114	92	142	188
Diabetic Supplies	1,106	477	137	492	271
Diuretic	14	7	0	7	279
Endocrine & Metabolic Drugs	83	41	6	36	215
Erythropoietin Stimulating Agents	24	5	7	12	109
Fibromyalgia	18	2	2	14	191
Fish Oils	26	4	7	15	359
Gastrointestinal Agents	151	32	17	102	190
Glaucoma	16	6	1	9	56
Growth Hormones	138	89	17	32	136
Hepatitis C	186	109	17	60	9
HFA Rescue Inhalers	14	0	1	13	0
Insomnia	86	11	27	48	167

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

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Insulin	267	91	34	142	346
Miscellaneous Antibiotics	26	4	4	18	21
Multiple Sclerosis	105	56	9	40	217
Muscle Relaxant	37	0	9	28	0
Nasal Allergy	105	14	31	60	163
Neurological Agents	109	31	21	57	194
Neuromuscular Agents	22	7	8	7	203
NSAIDs	39	5	9	25	304
Ocular Allergy	19	4	5	10	161
Ophthalmic	25	2	11	12	265
Ophthalmic Anti-infectives	15	3	1	11	36
Ophthalmic Corticosteroid	15	3	2	10	247
Osteoporosis	27	8	6	13	358
Other*	353	83	52	218	275
Otic Antibiotic	28	4	5	19	13
Pediculicide	12	7	1	4	7
Respiratory Agents	65	33	1	31	168
Smoking Cessation	70	8	54	8	99
Statins	21	0	6	15	0
Stimulant	1,365	828	91	446	348
Synagis	90	53	11	26	23
Testosterone	96	27	22	47	345
Thyroid	17	4	2	11	244
Topical Antifungal	28	0	10	18	0
Topical Corticosteroids	89	0	52	37	0
Vitamin	95	22	33	40	234
Pharmacotherapy	93	86	0	7	269
Emergency PAs	0	0	0	0	
Total	**10,391**	**4,265**	**1,542**	**4,584**	

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

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Overrides					
Acute vs. Chronic Narcotic Quantity Limit	1	1	0	0	176
Brand	42	26	0	16	295
Compound	14	10	0	4	81
Diabetic Supplies	18	15	0	3	128
Drug Quantity Limit Override	1	1	0	0	107
Dosage Change	349	316	5	28	13
High Dose	11	6	1	4	359
Ingredient Duplication	7	5	0	2	6
Lost/Broken Rx	104	94	4	6	16
MAT Override	266	194	6	66	67
NDC vs. Age	339	221	24	94	254
NDC vs. Sex	17	9	2	6	114
Nursing Home Issue	64	57	0	7	14
Opioid MME Limit	157	58	6	93	112
Opioid Quantity	53	39	3	11	159
Other*	70	57	1	12	15
Quantity vs. Days Supply	673	420	35	218	251
STBS/STBSM	16	9	2	5	93
Step Therapy Exception	4	1	1	2	358
Stolen	10	8	0	2	29
Third Brand Request	33	18	0	15	14
Overrides Total	**2,249**	**1,565**	**90**	**594**	
Total Regular PAs + Overrides	**12,640**	**5,830**	**1,632**	**5,178**	

Denial Reasons	
Unable to verify required trials.	4,268
Does not meet established criteria.	1,681
Lack required information to process request.	846
Other PA Activity	
Duplicate Requests	1,252
Letters	23,631
No Process	5
Changes to existing PAs	808
Helpdesk Initiated Prior Authorizations	875
PAs Missing Information	1

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

Fall 2021 Pipeline Update

Oklahoma Health Care Authority
October 2021

Introduction

The following report is a pipeline review compiled by the University of Oklahoma College of Pharmacy: Pharmacy Management Consultants. Information in this report is focused on medications not yet approved by the U.S. Food and Drug Administration (FDA). The pipeline report is not an all-inclusive list, and medications expected to be highly utilized or have a particular impact in the SoonerCare population have been included for review. Pipeline data is collected from a variety of sources and is subject to change; dates listed are projections and all data presented are for informational purposes only. Costs listed in the following report do not reflect rebated prices or net costs.

Somatrogon[1,2,3,4]

Anticipated Indication(s): Treatment of pediatric patients with growth hormone deficiency (GHD)

Clinical Trial(s): In January 2021, OPKO Health and Pfizer submitted a Biologics License Application (BLA) to the FDA for somatrogon for the treatment of pediatric GHD. Somatrogon is a glycosylated investigational biologic product that maintains the same amino acid sequence of human growth hormone, with the addition of 1 copy of the C-terminal peptide (CTP) from the beta chain of human chorionic gonadotropin (hCG) at the N-terminus and 2 copies of CTP at the C-terminus. The glycosylation and addition of the CTP domains extend the half-life of the molecule and allow for once-weekly administration. In October 2019, the results of a Phase 3 study of somatrogon in pediatric patients with GHD were announced. The study was a randomized, open-label, active-controlled study in 224 pre-pubertal treatment-naïve patients with GHD. Patients were randomized 1:1 to receive somatrogon once weekly or Genotropin® (somatropin) once daily for 12 months. The primary efficacy endpoint was height velocity at 12 months. The results of the study demonstrated that once-weekly somatrogon was non-inferior to once-daily Genotropin® for the primary efficacy endpoint. The least squares mean growth velocity was 10.12cm/year in the somatrogon group vs. 9.78cm/year in the Genotropin® group [treatment difference: 0.33cm/year; 95% confidence interval (CI): -0.39, 1.05]. Somatrogon was well tolerated in the study with an adverse event profile comparable to that of once-daily Genotropin®. In October 2020, top-line results of a second Phase 3 study of

somatrogon were announced. The C0311002 study was a Phase 3, randomized, multicenter, open-label, crossover study which assessed patient perception of treatment burden with the use of once-weekly somatrogon vs. once-daily Genotropin® in 87 pediatric patients 3 years of age to younger than 18 years of age with GHD. Patients were randomized 1:1 to (2) 12-week treatment periods, with half of the patients receiving somatrogon during the first 12 weeks and half receiving Genotropin®. After the first 12-week period, the patients then received 12 weeks of treatment with the other product. The primary endpoint of the study was an evaluation of treatment burden, as assessed by the Life Interference total score, after each 12-week treatment period, with higher scores reflecting higher treatment burden. The results of the study demonstrated statistically significantly lower treatment burden with weekly somatrogon relative to daily Genotropin®, with a treatment difference of -15.49 on the Life Interference total score (95% CI: -11.27, -19.71; P<0.0001). Pfizer and OPKO are also evaluating the use of somatrogon for the treatment of adult GHD.

Place in Therapy: GHD is a rare disease that affects approximately 1 in 4,000 to 1 in 10,000 people worldwide. The cause of GHD varies, but can be genetic or may be acquired after birth. Without treatment, patients with GHD experience very short adult height and are at risk for other health problems. In most cases, patients with GHD are treated with daily GH injections. If approved by the FDA, somatrogon would become only the second once-weekly treatment option for pediatric patients with GHD, as Skytrofa® (lonapegsomatropin-tcgd), the first once-weekly treatment for pediatric GHD, was recently approved by the FDA in August 2021.

Projected FDA Decision: October 2021

SoonerCare Impact: During fiscal year 2021 (07/01/2020 to 06/30/2021), there were 2,734 paid pharmacy claims for GH products for 353 unique members, which accounted for a total cost of $10,810,447.14 and an average cost per claim of $3,954.08. These costs do not reflect rebated prices or net costs.

Dextromethorphan/Bupropion[5,6,7]

Anticipated Indication(s): Treatment of adults with major depressive disorder (MDD)

Clinical Trial(s): In March 2021, Axsome Therapeutics submitted a New Drug Application (NDA) to the FDA for AXS-05, a novel combination of dextromethorphan and bupropion given orally for the treatment of MDD. Dextromethorphan is an N-methyl-D-aspartate (NMDA) glutamate receptor antagonist, and bupropion is a norepinephrine and dopamine reuptake inhibitor and also serves to increase the bioavailability of dextromethorphan. The Phase 3 GEMINI study of dextromethorphan/bupropion was a

randomized, double-blind, placebo-controlled, multicenter study in 327 adult patients with moderate-to-severe MDD. The study randomized patients 1:1 to receive either dextromethorphan/bupropion 45mg/105mg or placebo once daily for 3 days and then twice daily for the remainder of 6 weeks. The primary endpoint was the change from baseline in the Montgomery-Åsberg Depression Rating Scale (MADRS) total score at week 6. Results of the study demonstrated a statistically significant reduction in the MADRS total score in patients treated with dextromethorphan/bupropion relative to placebo (P=0.002). Additionally, reduction in the MADRS total score was statistically significant as early as 1 week after initiating treatment with dextromethorphan/bupropion, and remained statistically significant throughout the duration of the study, demonstrating a rapid, durable, and clinically meaningful effect on the symptoms of MDD. The FDA had initially set a Prescription Drug User Fee Act (PDUFA) date of August 22, 2021 for review of the dextromethorphan/ bupropion NDA; however, the FDA informed Axsome in August 2021 that it would not meet that deadline due to unspecified deficiencies in the NDA submission. Axsome is conducting additional studies of dextromethorphan/ bupropion, including in patients with treatment-resistant depression (TRD) in the Phase 3 STRIDE-1 study and in patients with agitation related to Alzheimer's disease in the Phase 3 ACCORD study.

Place in Therapy: An estimated 7.1% of adults in the United States, about 17 million people, experience MDD each year. MDD is associated with low mood, inability to feel pleasure, feelings of guilt and worthlessness, low energy, and other emotional and physical symptoms and can result in impaired social, occupational, and educational functioning or suicide. Despite treatment with currently available therapies, approximately 66% of patients diagnosed with and treated for MDD do not experience an adequate response to treatment with first- or second-line therapies. Patients who have TRD have failed to respond to 2 or more antidepressant therapies. If approved by the FDA, dextromethorphan/bupropion would become the only oral NMDA antagonist for the treatment of MDD.

Projected FDA Decision: 4th Quarter 2021

SoonerCare Impact: During fiscal year 2021, there were 423,080 paid pharmacy claims for antidepressant medications for 77,101 unique members, which accounted for a total cost of $7,187,959.43 and an average cost per claim of $16.99. These costs do not reflect rebated prices or net costs. This utilization data includes paid pharmacy claims for all covered indications and does not distinguish between utilization for MDD and utilization for other indications for which use may be appropriate.

Tezepelumab[8,9,10]

Anticipated Indication(s): Treatment of adolescents and adults with severe, uncontrolled asthma

Clinical Trial(s): In May 2021, AstraZeneca and Amgen submitted a BLA to the FDA for tezepelumab for the treatment of adolescents and adults with severe, uncontrolled asthma. Tezepelumab is a human monoclonal antibody that blocks thymic stromal lymphopoietin (TSLP). TSLP is an epithelial cytokine located at the top of multiple inflammatory cascades which are thought to be critical for the initiation and persistence of airway inflammation associated with severe asthma. The expression of TSLP is increased in the airways of asthma patients and has been shown to correlate with disease severity. By blocking TSLP, tezepelumab may prevent the release of pro-inflammatory cytokines resulting in fewer asthma exacerbations and improved asthma control. In May 2021, results from the Phase 3 NAVIGATOR study were published in *The New England Journal of Medicine*. NAVIGATOR was a randomized, double-blind, placebo-controlled study in adolescents (12 to 17 years of age) and adults (18 to 80 years of age) with severe, uncontrolled asthma. Patients included in the study were being treated with a medium-dose or high-dose inhaled corticosteroid (ICS) and at least 1 other controller medication, with or without the use of oral corticosteroids, and all patients continued to receive the previously prescribed ICS, additional controller medication, and/or oral corticosteroids throughout the study. Patients were randomized 1:1 to receive either tezepelumab 210mg subcutaneously or placebo every 4 weeks for 52 weeks. The study enrolled patients with both high (≥300 cells/mcL) and low (<300 cells/mcL) blood eosinophil counts. The primary efficacy endpoint was the annualized asthma exacerbation rate (AAER) over the 52-week treatment period. Secondary endpoints, including the effect of tezepelumab on lung function, asthma control, and health-related qualify of life, were also assessed. The results of the study showed a statistically significant 56% reduction in the AAER in patients treated with tezepelumab (AAER: 0.93; 95% CI: 0.8, 1.07) relative to patients who received placebo (AAER: 2.1; 95% CI: 1.84, 2.39) (P<0.001). In prespecified subgroup analyses, treatment with tezepelumab resulted in statistically significant reductions in the AAER regardless of baseline eosinophil count.

Place in Therapy: An estimated 339 million people worldwide have asthma, with approximately 10% having severe asthma. Many patients with severe asthma remain uncontrolled despite use of currently available therapies; these patients may experience frequent asthma exacerbations, limitations of lung function, and reduced quality of life. Patients with severe asthma account for approximately 50% of asthma-related health care costs, in addition to having a higher risk of asthma-related hospitalization and mortality. If approved by the FDA, tezepelumab would provide an additional

biologic treatment option for patients with severe asthma, regardless of baseline eosinophil counts.

Projected FDA Decision: January 2022

SoonerCare Impact: During fiscal year 2021, there were 89,551 paid pharmacy claims for inhaled corticosteroids (ICS), long-acting beta$_2$ agonists (LABA), and long-acting muscarinic antagonists (LAMA) indicated for the treatment of asthma for 27,723 unique members, which accounted for a total cost of $26,859,888.45 and an average cost per claim of $299.94. Additionally, during fiscal year 2021 there were 2,032 paid pharmacy claims for monoclonal antibodies indicated for the treatment of asthma for 282 unique members, which accounted for a total cost of $6,177,109.05 and an average cost per claim of $3,039.92, and there were 191 unduplicated paid medical claims for monoclonal antibodies indicated for the treatment of asthma for 16 unique members, which accounted for a total cost of $492,604.35 and an average cost per claim of $2,579.08. These costs do not reflect rebated prices or net costs. This utilization data includes paid pharmacy and medical claims for all covered indications and does not distinguish between utilization for asthma and utilization for other indications for which use may be appropriate.

Pipeline Table[11,12]

Medication Name*	Manufacturer	Therapeutic Use	Route of Admin	Approval Status	Anticipated FDA Response
Cantharidin	Verrica	Molluscum contagiosum	TOP	NDA	09/2021
Reltecimod	Atox Bio	NSTI-related organ dysfunction	IV	NDA; Fst Trk; OD	09/2021
Risperidone	Laboratorios Farmacéuticos Rovi	Schizophrenia	IM	NDA	09/2021
Ansofaxine	Luye	MDD	PO	NDA	3Q2021
Avacopan	ChemoCentryx	Antineutrophil cytoplasmic antibody-associated vasculitis	PO	NDA; OD	10/2021
Bimekizumab	UCB	Plaque psoriasis	SC	BLA	10/2021
Ranibizumab	Genentech	Wet AMD	INVT	BLA	10/2021
RVT-802	Enzyvant/Roivant	Congenital athymia	Implant	BLA; OD	10/2021
Sodium Oxybate Extended-Release	Avadel	Narcolepsy	PO	NDA; OD	10/2021

Medication Name*	Manufacturer	Therapeutic Use	Route of Admin	Approval Status	Anticipated FDA Response
Somatrogon	Pfizer/OPKO	GHD (pediatrics)	SC	BLA; OD	10/2021
Testosterone Undecanoate	Marius Pharmaceuticals	Hypogonadism	PO	NDA	10/2021
Treprostinil DPI	United Therapeutics	PAH	INH	NDA	10/2021
Triamcinolone Acetonide	Clearside	Macular edema	IO/SR	NDA	10/2021
Varenicline	Oyster Point Pharma	Dry eye disease	IN	NDA	10/2021
Episalvan	Amryt	Epidermolysis bullosa	TOP	NDA; Fst Trk; OD	11/2021
Naloxone (High Dose)	US Worldmeds	Opioid overdose	IM	NDA	11/2021
Omidenepag Isopropyl	Santen Pharmaceutical	Glaucoma	OP	NDA	11/2021
Pacritinib	CTI BioPharma	Myelofibrosis	PO	NDA; Fst Trk; OD	11/2021
Palovarotene	Ipsen	Fibrodysplasia ossificans progressiva	PO	NDA; Brk Thru; Fst Trk; OD	11/2021
Ropeginterferon Alfa-2b	PharmaEssentia	Polycythemia vera	SC	BLA; OD	11/2021
Sodium Thiosulfate	Fennec	Ototoxicity	IV	NDA; OD	11/2021
Topiramate Oral Solution	Eton	Seizure disorders	PO	NDA	11/2021
Treprostinil	Liquidia Technologies	PAH	INH	NDA	11/2021
Trivalent Hepatitis B Vaccine	VBI Vaccines	HBV infection prevention	IM	BLA	11/2021
Vosoritide	BioMarin	Achondroplasia	SC	NDA; OD	11/2021
Buprenorphine	Braeburn	OUD	SC	NDA	12/2021
Budesonide	Calliditas	Nephropathy	PO	NDA; OD	12/2021
Clindamycin	Dare Bioscience	Bacterial vaginosis	INV	NDA	12/2021
Dextroamphetamine Transdermal System	Noven Pharmaceuticals	ADHD	TOP	NDA	12/2021
Diazepam	Aquestive Therapeutics	Seizures	PO	NDA	12/2021
Efgartigimod	Argenx	Myasthenia gravis	IV	BLA; Fst Trk; OD	12/2021
Pilocarpine	Allergan	Presbyopia	OPH	NDA	12/2021
Tadalafil/Finasteride	Veru	BPH	PO	NDA	12/2021
Celecoxib/Tramadol	Esteve	Acute pain	PO	NDA	2021
Abrocitinib	Pfizer	AD	PO	NDA; Brk Thru	4Q2021

Medication Name*	Manufacturer	Therapeutic Use	Route of Admin	Approval Status	Anticipated FDA Response
Dextromethorphan/ Bupropion	Axsome	TRD	PO	NDA; Brk Thru; Fst Trk	4Q2021
Daridorexant	Idorsia Pharmaceuticals	Insomnia	PO	NDA	01/2022
Dexmedetomidine	Bioxcel	Acute agitation related to bipolar disorder or schizophrenia	SL	NDA; Fst Trk	01/2022
Faricimab	Roche/Chugai	Diabetic macular edema/AMD	INVT	BLA	01/2022
Inclisiran	Novartis	Hyperlipidemia	SC	NDA; OD	01/2021
Levoketoconazole	Strongbridge Biopharma	Cushing's syndrome	PO	NDA; OD	01/2022
Maribavir	Takeda	CMV	PO	NDA; Brk Thru; Fst Trk; OD	01/2022
Mavacamten	MyoKardia	Cardiomyo-pathy	PO	NDA; Brk Thru; Fst Trk; OD	01/2022
Oteseconazole	Mycovia	Vulvovaginal candidiasis (recurrent)	PO	NDA; Fst Trk	01/2022
Tezepelumab	AstraZeneca/ Amgen	Asthma	IV/SC	BLA	01/2022
Bardoxolone Methyl	Reata Pharmaceuticals/ AbbVie	Alport syndrome	PO	NDA; OD	02/2022
Human Immunoglobulin	GC Pharma	Primary immunodefic-iency	IV	BLA	02/2022
Lenacapavir	Gilead	HIV-1	SC	NDA	02/2022
Mitapivat	Agios	Pyruvate kinase deficiency	PO	NDA; Fst Trk; OD	02/2022
Benegrastim	Evive Biotech	Chemotherapy -induced neutropenia	SC	BLA	03/2022
Cipaglucosidase Alfa	Amicus	Pompe disease	IV	BLA; OD	03/2022
Gefapixant	Merck/Roche	Chronic cough	PO	NDA	03/2022
Testosterone	Lipocine	Hypogonadism	PO	NDA	03/2022
Udenafil	Mezzion Pharma	Congenital single ventricle heart disease	PO	NDA; OD	03/2022

Medication Name*	Manufacturer	Therapeutic Use	Route of Admin	Approval Status	Anticipated FDA Response
Vadadustat	Otsuka Pharma	CKD-related anemia	PO	NDA	03/2022
Ganaxolone	Marinus Pharmaceuticals	Seizures	PO	NDA; OD	04/2022
Vutrisiran	Alnylam	Transthyretin-mediated amyloidosis	SC	BLA; Fst Trk; OD	04/2022
Dihydroergotamine Autoinjector	Amneal	Migraine and cluster headache treatment	SC	NDA	04/2022 – 09/2022
Tapinarof	Roivant	Plaque psoriasis	TOP	NDA	05/2022
Sodium Phenylbutyrate	Acer Therapeutics	Urea cycle disorders	PO	NDA	08/2022

3Q = 2rd quarter; 4Q = 4th quarter; AD = atopic dermatitis; ADHD = attention-deficit hyperactivity disorder; Admin = administration; AMD = age-related macular degeneration; BLA = Biologic License Application; BPH = benign prostatic hyperplasia; Brk Thru = breakthrough; CKD = chronic kidney disease; CMV = cytomegalovirus; DM = diabetes mellitus; Fst Trk = fast track; GHD = growth hormone deficiency; HBV = hepatitis B virus; HIV = human immunodeficiency virus; HSCT = Hematopoietic stem cell transplantation; IN = intranasal; INH = inhaled; INV = intravaginal; INVT = intravitreal; IO/SR = intraocular/subretinal; IV = intravenous; MDD = major depressive disorder; MS = multiple sclerosis; NDA = New Drug Application; NSCLC = non-small cell lung cancer; NSTI = necrotizing soft tissue infection; OD = orphan drug; OP = ophthalmic; OUD = opioid use disorder; PAH = pulmonary hypertension; PNH = paroxysmal nocturnal hemoglobinuria; PO = by mouth; SC = subcutaneous; SL = sublingual; SLE = systemic lupus erythematosus; TOP = topical; TRD = treatment-resistant depression; VKC = Vernal keratoconjunctivitis
*Most biosimilars and oncology medications are excluded from the table. Medications known to have received a Complete Response Letter (CRL) from the FDA that have not resubmitted were also excluded.

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Appendix C

Vote to Prior Authorize Herceptin® (Trastuzumab) and Margenza® (Margetuximab-cmkb) and Update the Approval Criteria for the Breast Cancer Medications

Oklahoma Health Care Authority
October 2021

Market News and Updates[1,2,3]

New U.S. Food and Drug Administration (FDA) Approval(s):

- **December 2020:** The FDA approved Margenza® (margetuximab-cmkb) in combination with chemotherapy for the treatment of adult patients with metastatic human epidermal growth factor receptor 2 (HER2)-positive breast cancer who have received 2 or more prior anti-HER2 regimens, at least 1 of which was for metastatic disease.
- **January 2021:** The FDA approved Enhertu® (fam-trastuzumab deruxtecan-nxki) for the treatment of adult patients with locally advanced or metastatic HER2-positive gastric or gastroesophageal junction (GEJ) adenocarcinoma who have received a prior trastuzumab-based regimen.
- **April 2021:** The FDA approved Trodelvy® (sacituzumab govitecan-hziy) for the treatment of adult patients with unresectable, locally advanced or metastatic triple-negative breast cancer (mTNBC) who have received 2 or more prior systemic therapies, at least 1 of which was for metastatic disease.
- **April 2021:** The FDA granted accelerated approval to Trodelvy® (sacituzumab govitecan-hziy) for the treatment of adult patients with locally advanced or metastatic urothelial cancer who previously received a platinum-containing chemotherapy and either a programmed death receptor-1 (PD-1) or a programmed death-ligand 1 (PD-L1) inhibitor.
- **July 2021:** The FDA approved Keytruda® (pembrolizumab) for the treatment of adult patients with high-risk, early-stage, triple-negative breast cancer in combination with chemotherapy as neoadjuvant treatment and then continued as a single agent as adjuvant treatment after surgery.

News:

- **August 2021:** Genentech announced the voluntary withdrawal of the FDA's accelerated approval for Tecentriq® (atezolizumab) in combination with chemotherapy (Abraxane®, nab-paclitaxel) for the treatment of adults with unresectable, locally advanced or mTNBC whose tumors express PD-L1. This decision was made in consultation

with the FDA and was based on the agency's assessment of the current mTNBC treatment landscape and in accordance with the requirements of the accelerated approval program. This withdrawal does not impact other FDA approved Tecentriq® indications.

Guideline Update(s):

- The National Comprehensive Cancer Network (NCCN) Compendium guideline recommendations were updated to include the use of Ibrance® (palbociclib) with letrozole or any aromatase inhibitor. The combination therapy showed a benefit in progression-free survival in both younger and older women with breast cancer.

Margenza® (Margetuximab-cmkb) Product Summary[4]

- **Therapeutic Class:** HER2/neu receptor antagonist
- **Indication(s):** In combination with chemotherapy for the treatment of adult patients with metastatic HER2-positive breast cancer who have received 2 or more prior anti-HER2 regimens, at least 1 of which was for metastatic disease
- **How Supplied:** 250mg/10mL (25mg/mL) solution in single-dose vials (SDVs)
- **Dose:** 15mg/kg, via intravenous (IV) infusion every 3 weeks (21-day cycle) until disease progression or unacceptable toxicity
- **Cost:** The Wholesale Acquisition Cost (WAC) is $2,077 per SDV, resulting in a cost of $10,385 every 3 weeks based on the recommended dosing for an adult patient weighing 80kg.

Recommendations

The College of Pharmacy recommends the prior authorization of Margenza® (margetuximab-cmkb) with the following criteria:

Margenza® (Margetuximab-cmkb) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of metastatic breast cancer; and
2. Human epidermal growth factor receptor 2 (HER2)-positive; and
3. Member has received 2 or more prior anti-HER2 regimens, at least 1 of which was for metastatic disease; and
4. Used in combination with chemotherapy (capecitabine, eribulin, gemcitabine, or vinorelbine).

Additionally, the College of Pharmacy recommends the prior authorization of Herceptin® (trastuzumab) and updating the prior authorization criteria for Herzuma® (trastuzumab-pkrb), Kanjinti® (trastuzumab-anns), Ogivri® (trastuzumab-dkst), Ontruzant® (trastuzumab-dttb), and Trazimera™ (trastuzumab-qyyp) based on net costs (changes noted in red):

Herceptin® (Trastuzumab), Herzuma® (Trastuzumab-pkrb), Kanjinti® (Trastuzumab-anns), Ogivri® (Trastuzumab-dkst), Ontruzant® (Trastuzumab-dttb), and Trazimera™ (Trastuzumab-qyyp) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive breast cancer; and
2. Authorization of Herceptin® (trastuzumab), Herzuma® (trastuzumab-pkrb), or Kanjinti® (trastuzumab-anns) will also require a patient-specific, clinically significant reason why the member cannot use ~~Herceptin® (trastuzumab)~~ Ogivri® (trastuzumab-dkst), Ontruzant® (trastuzumab-dttb), or Trazimera™ (trastuzumab-qyyp). Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Herceptin® (Trastuzumab), Herzuma® (Trastuzumab-pkrb), Kanjinti® (Trastuzumab-anns), Ogivri® (Trastuzumab-dkst), Ontruzant® (Trastuzumab-dttb), and Trazimera™ (Trastuzumab-qyyp) Approval Criteria [Metastatic Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic gastric or GEJ adenocarcinoma; and
2. Authorization of Herceptin® (trastuzumab), Herzuma® (trastuzumab-pkrb), or Kanjinti® (trastuzumab-anns) will also require a patient-specific, clinically significant reason why the member cannot use ~~Herceptin® (trastuzumab)~~ Ogivri® (trastuzumab-dkst), Ontruzant® (trastuzumab-dttb), or Trazimera™ (trastuzumab-qyyp). Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

The College of Pharmacy also recommends updating the approval criteria for Enhertu® (fam-trastuzumab deruxtecan-nxki), Keytruda® (pembrolizumab), and Trodelvy® (sacituzumab govitecan-hziy) based on recent FDA approvals (changes and new criteria noted in red; only criteria with updates are listed):

Enhertu® (Fam-Trastuzumab Deruxtecan-nxki) Approval Criteria [Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of locally advanced or metastatic gastric or GEJ adenocarcinoma; and
2. Human epidermal growth factor receptor 2 (HER2)-positive disease; and
3. Member has received at least 1 prior trastuzumab-based regimen.

Keytruda® (Pembrolizumab) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of locally recurrent, unresectable or metastatic triple-negative breast cancer; and
   a. Tumors express programmed death ligand 1 (PD-L1) with a combined positive score (CPS) ≥10; and
   b. Used in combination with chemotherapy; or
2. Diagnosis of early stage triple-negative breast cancer; and
   a. Disease is considered high-risk; and
   b. Used in combination with chemotherapy as neoadjuvant therapy.

Trodelvy® (Sacituzumab Govitecan-hziy) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of triple-negative breast cancer; and
2. Locally advanced or metastatic disease; and
3. Member must have received ≥2 prior therapies, at least 1 of which was for metastatic disease.

Trodelvy® (Sacituzumab Govitecan-hziy) Approval Criteria [Urothelial Cancer Diagnosis]:

1. Diagnosis of unresectable, locally advanced, or metastatic disease; and
2. Member must have previously received a platinum-containing chemotherapy; and
3. Member must have previously received either a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor.

Further, the College of Pharmacy recommends updating the prior authorization criteria for Ibrance® (palbociclib) based on NCCN Compendium approval (changes noted in red):

Ibrance® (Palbociclib) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of advanced, metastatic, hormone receptor positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer; and
2. In combination with:
   a. ~~Letrozole as initial endocrine-based therapy~~ An aromatase inhibitor in postmenopausal women; or
   b. Fulvestrant in women with disease progression following endocrine therapy; or
   c. An aromatase inhibitor or fulvestrant in male patients.

Finally, the College of Pharmacy recommends the removal of the Tecentriq® (atezolizumab) approval criteria for the indication of unresectable locally advanced or mTNBC based on FDA-guided voluntary withdrawal of this indication by the manufacturer (changes noted in red):

~~**Tecentriq® (Atezolizumab) Approval Criteria [Breast Cancer Diagnosis]:**~~

~~1. Unresectable locally advanced or metastatic triple-negative breast cancer; and~~
~~2. Used in combination with nab-paclitaxel (Abraxane®); and~~
~~3. Positive expression of programmed death ligand-1 (PD-L1); and~~
~~4. Member has not failed other immunotherapy(ies).~~

[1] U.S. Food and Drug Administration (FDA). Hematology/Oncology (Cancer) Approvals & Safety Notifications. Available online at: https://www.fda.gov/drugs/resources-information-approved-drugs/hematologyoncology-cancer-approvals-safety-notifications. Last revised 09/01/2021. Last accessed 09/14/2021.
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Appendix D

Vote to Prior Authorize Orgovyx™ (Relugolix)

Oklahoma Health Care Authority
October 2021

Market News and Updates[1]

New U.S. Food and Drug Administration (FDA) Approval(s):

- **December 2020:** The FDA approved the first oral gonadotropin-releasing hormone (GnRH) receptor antagonist, Orgovyx™ (relugolix), for the treatment of adult patients with advanced prostate cancer.

Orgovyx™ (Relugolix) Product Summary[2]

- **Therapeutic Class:** GnRH receptor antagonist
- **Indication(s):** Treatment of adult patients with advanced prostate cancer
- **How Supplied:** 120mg oral tablets
- **Dose:** Loading dose of 360mg [(3) 120mg tablets] on the first day of treatment followed by 120mg taken once daily
- **Cost:** The Wholesale Acquisition Cost (WAC) is $77.10 per tablet resulting in an initial monthly cost of $2,467.20 at the recommended dosing of 360mg on the first day followed by 120mg once daily and a subsequent monthly cost of $2,313 at 120mg once daily.

Recommendations

The College of Pharmacy recommends the prior authorization of Orgovyx™ (relugolix) with the following criteria listed in red:

Orgovyx™ (Relugolix) Approval Criteria [Prostate Cancer Diagnosis]:

1. Diagnosis of advanced prostate cancer; and
2. A patient-specific, clinically significant reason why the member cannot use Eligard® (leuprolide acetate), Firmagon® (degarelix), and Lupron Depot® (leuprolide acetate) must be provided [reason(s) must address each medication]; and
3. A quantity limit of 30 tablets per 30 days will apply. Upon meeting approval criteria, a quantity limit override will be approved for the day 1 loading dose of 360mg.

[1] U.S. Food and Drug Administration (FDA). Hematology/Oncology (Cancer) Approvals & Safety Notifications. Available online at: https://www.fda.gov/drugs/resources-information-approved-drugs/hematologyoncology-cancer-approvals-safety-notifications. Last revised 09/01/2021. Last accessed 09/14/2021.

[2] Orgovyx™ Prescribing Information. Myovant Sciences, Inc. Available online at: https://www.myovant.com/wp-content/uploads/2020/12/NDA-214621-Final-USPIandPI.pdf. Last revised 12/2020. Last accessed 09/14/2021.

Appendix E

Fiscal Year 2021 Annual Review of Spinal Muscular Atrophy (SMA) Medications

Oklahoma Health Care Authority
October 2021

Current Prior Authorization Criteria

Evrysdi® (Risdiplam) Approval Criteria:

1. An FDA approved diagnosis of spinal muscular atrophy (SMA) in members 2 months of age and older; and
2. Molecular genetic testing to confirm bi-allelic pathogenic variants in the *survival motor neuron 1* (*SMN1*) gene; and
3. Member is not currently dependent on permanent invasive ventilation (defined as ≥16 hours of respiratory assistance per day continuously for >21 days in the absence of an acute, reversible illness or a perioperative state); and
4. Evrysdi® must be prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA); and
5. Prescriber must agree to monitor member's liver function prior to initiating Evrysdi® and periodically while receiving Evrysdi® treatment; and
6. Pharmacy must confirm Evrysdi® will be constituted to an oral solution by a pharmacist prior to dispensing and must confirm Evrysdi® will be shipped via cold chain supply to adhere to the storage and handling requirements in the Evrysdi® *Prescribing Information*; and
7. Prescriber must confirm the member or caregiver has been counseled on the proper storage of Evrysdi® and has been instructed on how to prepare the prescribed daily dose of Evrysdi® prior to administration of the first dose; and
8. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
9. Female members of reproductive potential must be willing to use effective contraception during treatment with Evrysdi® and for at least 1 month after the last dose; and
10. Prescriber must verify male members of reproductive potential have been counseled on the potential effects on fertility and the potential of compromised male fertility is acceptable; and
11. Member will not be approved for concomitant treatment with Spinraza® (nusinersen); and

12. Member must not have previously received treatment with Zolgensma® (onasemnogene abeparvovec-xioi); and
13. A baseline assessment must be provided using a functionally appropriate exam [e.g., Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), Hammersmith Functional Motor Scale Expanded (HFMSE), Hammersmith Infant Neurological Exam (HINE), Upper Limb Module (ULM) Test]; and
14. Initial authorizations will be for the duration of 6 months, at which time the prescriber must verify the member is compliant with Evrysdi® and responding to the medication as demonstrated by clinically significant improvement or maintenance of function from pre-treatment baseline status using the same exam as performed at baseline assessment; and
15. Member's recent weight must be provided to ensure accurate dosing in accordance with Evrysdi® *Prescribing Information*; and
16. A quantity limit of 240mL per 36 days will apply.

Spinraza® (Nusinersen) Approval Criteria:

1. A diagnosis of spinal muscular atrophy (SMA):
    a. Type 1; or
    b. Type 2; or
    c. Type 3 with symptoms; and
2. Molecular genetic testing to confirm bi-allelic pathogenic variants in the *survival motor neuron 1* (*SMN1*) gene; and
3. Member is not currently dependent on permanent invasive ventilation (defined as ≥16 hours of respiratory assistance per day continuously for >21 days in the absence of an acute, reversible illness or a perioperative state); and
4. Spinraza® must be prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA); and
5. Member must not have previously received treatment with Zolgensma® (onasemnogene abeparvovec-xioi); and
6. Member will not be approved for concomitant treatment with Evrysdi® (risdiplam); and
7. Prescriber must verify platelet count, coagulation laboratory testing, and quantitative spot urine protein testing have been assessed at baseline, levels are acceptable to the prescriber, and levels will be monitored prior to each dose; and
8. Spinraza® must be administered in a health care facility by a specialist experienced in performing lumbar punctures; and
    a. Spinraza® must be shipped to the facility where the member is scheduled to receive treatment; and

9. A baseline assessment must be provided using at least 1 of the following exams as functionally appropriate:
    a. Hammersmith Infant Neurological Exam (HINE); or
    b. Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND); or
    c. Upper Limb Module (ULM) Test; or
    d. Hammersmith Functional Motor Scale Expanded (HFMSE); and
10. Initial authorizations will be for the duration of 6 months, at which time the prescriber must verify the member is responding to the medication as demonstrated by clinically-significant improvement or maintenance of function from pretreatment baseline status using the same exam as performed at baseline assessment:
    a. HINE; or
    b. CHOP-INTEND; or
    c. ULM Test; or
    d. HFMSE; and
11. Approval quantity will be based on Spinraza® *Prescribing Information* and FDA approved dosing regimen(s).
    a. Only (1) 5mL vial of Spinraza® is to be dispensed prior to each scheduled procedure for administration.

Zolgensma® (Onasemnogene Abeparvovec-xioi) Approval Criteria:

1. An FDA approved diagnosis of spinal muscular atrophy (SMA) in pediatric members younger than 2 years of age; and
2. Member must have reached full-term gestational age prior to Zolgensma® infusion; and
3. Molecular genetic testing to confirm bi-allelic mutations in the *survival motor neuron 1* (*SMN1*) gene; and
4. Member is not currently dependent on permanent invasive ventilation (defined as ≥16 hours of respiratory assistance per day continuously for >21 days in the absence of an acute, reversible illness or a perioperative state); and
5. Zolgensma® must be prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA); and
6. Member must have baseline anti-AAV9 antibody titers ≤1:50; and
7. Prescriber must agree to monitor liver function tests, platelet counts, and troponin-I at baseline and as directed by the Zolgensma® *Prescribing Information*; and
8. Prescriber must agree to administer systemic corticosteroids starting 1 day prior to the Zolgensma® infusion and continuing as recommended in the Zolgensma® *Prescribing Information* based on member's liver function; and

9. Zolgensma® must be shipped to the facility where the member is scheduled to receive treatment and must adhere to the storage and handling requirements in the Zolgensma® *Prescribing Information*; and
10. Member will not be approved for concomitant treatment with Evrysdi® (risdiplam) or Spinraza® (nusinersen) following Zolgensma® infusion (current authorizations for risdiplam or nusinersen will be discontinued upon Zolgensma® approval); and
11. Member's recent weight must be provided to ensure accurate dosing in accordance with Zolgensma® *Prescribing Information*; and
12. Only 1 Zolgensma® infusion will be approved per member per lifetime.

Utilization of SMA Medications: Fiscal Year 2021

Fiscal Year Comparison

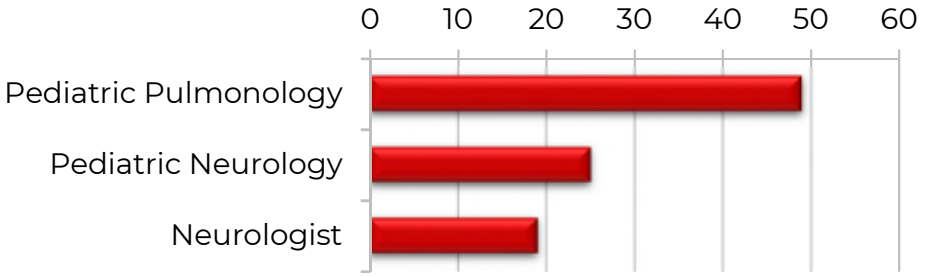
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2020	17	36	$12,299,577.75	$341,654.94	$3,858.09	169	3,188
2021	25	93	$10,610,458.19	$114,090.95	$2,448.76	9,588	4,333
% Change	**47.10%**	**158.30%**	**-13.73%**	**-66.61%**	**-36.53%**	**5,573.40%**	**35.90%**
Change	**8**	**57**	**-$1,689,119.56**	**-$227,563.99**	**-$1,409.33**	**9,419**	**1,145**

*Total number of unduplicated utilizing members.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2020 = 07/01/2019 to 06/30/2020; Fiscal Year 2021 = 07/01/2020 to 06/30/2021

Demographics of Members Utilizing SMA Medications

- Due to the limited number of members utilizing SMA medications during fiscal year 2021, detailed demographic information could not be provided.

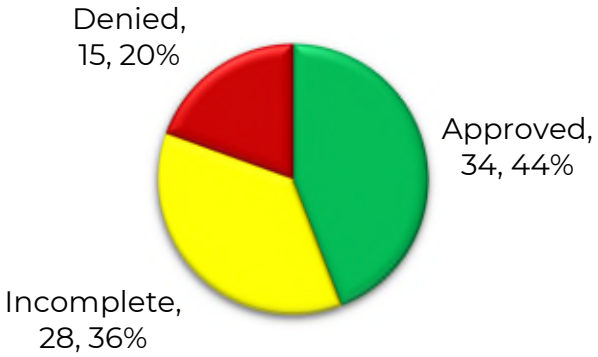
Top Prescriber Specialties of SMA Medications by Number of Claims



Prior Authorization of SMA Medications

There were 77 prior authorization requests submitted for SMA medications during fiscal year 2021. The following chart shows the status of the submitted petitions for fiscal year 2021.

Status of Petitions



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

Anticipated Patent Expiration(s):

- Evrysdi® (risdiplam): May 2035
- Spinraza® (nusinersen): September 2035

News:

- **January 2021:** Biogen announced the treatment of the first patient in the global clinical study, RESPOND. The Phase 4 study will examine the clinical benefit and assess the safety of Spinraza® (nusinersen) in infants and children with SMA who still have unmet clinical needs following treatment with gene therapy Zolgensma® (onasemnogene abeparvovec-xioi). RESPOND will be conducted at approximately 20 sites worldwide and aims to enroll up to 60 children with SMA.
- **March 2021:** Genentech announced new exploratory 2-year longer-term data from part 2 of SUNFISH, a global placebo-controlled study evaluating Evrysdi® (risdiplam) in patients 2 to 25 years of age with type 2 or non-ambulant type 3 SMA. The study suggested that gains in motor function observed with risdiplam treatment at month 12 continued to improve or were maintained at month 24 across primary and secondary endpoint measures. The findings included the following:
  - Maintained motor function improvements between months 12 and 24 as measured by Motor Function Measure (MFM-32).
  - Increased motor function as measured by Revised Upper Limb Module (RULM) and the Hammersmith Functional Motor Scale-Expanded (HFMSE) between months 12 and 24.
  - Stabilized motor function for patients who began treatment with risdiplam after 12 months of placebo as measured by MFM-32, RULM, and HFMSE.
  - Increased total score change from baseline, as measured by the caregiver-reported SMA Independence Scale (SMAIS) upper limb

module, and the patient-reported SMAIS score stabilized between months 12 and 24.

Additional risdiplam studies that are currently recruiting patients or have completed recruitment include JEWELFISH and RAINBOWFISH. JEWELFISH is an open-label exploratory study designed to assess the safety, tolerability, pharmacokinetics (PK), and pharmacodynamics (PD) in patients with SMA who are 6 months to 60 years of age who received other investigational or approved SMA therapies for ≥90 days prior to receiving risdiplam. This study has completed recruitment (N=174). RAINBOWFISH is an open-label, single-arm, multicenter study, investigating the efficacy, safety, PK, and PD of risdiplam in patients (N≈25), from birth to 6 weeks of age (at first dose) with genetically diagnosed SMA who are not yet presenting with symptoms. This study is currently recruiting.

- **April 2021:** Based on results from the completed clinical study entitled "An Open-Label, Single-Dose, Parallel-Group, Two-Part Study to Evaluate the Pharmacokinetics And Safety Of Risdiplam In Subjects With Mild Or Moderate Hepatic Impairment Compared To Subjects With Normal Hepatic Function," the U.S. Food and Drug Administration (FDA) approved updates to section 8 (Use in Specific Populations) and subsection 12.3 (Pharmacokinetics) of the Evrysdi® *Prescribing Information*. This included removing *Hepatic Impairment* from section 8 and adding *Hepatic Impairment* to section 12.3 with information from the study. Section 12.3 now includes the following:
  - The pharmacokinetics and safety of risdiplam have been studied in subjects with mild or moderate hepatic impairment (as defined by Child-Pugh class A and B, respectively, N=8 each) compared to subjects with normal hepatic function (N=10). Following the administration of 5mg Evrysdi®, the area under the plasma concentration-time curve from time 0 to infinity (AUC_{inf}) and peak plasma concentrations (C_{max}) of risdiplam were approximately 20% and 5% lower, respectively, in subjects with mild hepatic impairment and were approximately 8% and 20% higher, respectively, in subjects with moderate hepatic impairment, versus matched healthy control subjects. The magnitude of these changes is not considered to be clinically meaningful. The pharmacokinetics and safety in patients with severe hepatic impairment (Child-Pugh C) have not been studied.
- **May 2021:** An ongoing, long-term follow-up safety study of 13 infants with symptomatic SMA type 1 treated with a single low or therapeutic dose of onasemnogene abeparvovec-xioi in the START Phase 1 clinical study showed a favorable safety profile for up to 6.2 years after dosing. For patients who received the therapeutic dose (N=10), which subsequently became the FDA approved dose, onasemnogene

abeparvovec-xioi provided sustained, durable efficacy. All 10 patients remained alive and without the need for permanent ventilation. Additionally, all 10 patients treated with the therapeutic dose maintained previously acquired motor milestones. Two patients attained the new milestone of "standing with assistance."

- **June 2021:** An analysis of data from the Phase 2 CS3A and Phase 3 ENDEAR studies in children with infantile-onset SMA suggests that a higher dose of nusinersen may lead to a clinically meaningful increase in the Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND) score beyond that already observed with the 12mg approved dose. These findings further reinforce the scientific rationale for the evaluation of a higher dose of nusinersen in the ongoing DEVOTE study. DEVOTE is a Phase 2/3 study evaluating the safety, tolerability, and potential for increased efficacy of nusinersen when administered at a higher dose than currently approved. DEVOTE is a 3-part study that includes an open-label safety evaluation cohort (part A), a pivotal, double-blind, randomized, active-controlled treatment cohort (part B), and an open-label cohort of patients transitioning from the approved 12mg dosing regimen of nusinersen to the higher dose regimen (part C). Safety data from part A (N=6) support continued development of a higher dose (28mg). Enrollment in the pivotal part B of DEVOTE is ongoing and will evaluate a higher dose regimen (2 loading doses of 50mg 14 days apart followed by 28mg maintenance doses every 4 months) compared to the currently approved dosing regimen for nusinersen.
- **June 2021:** An analysis of data from the NURTURE study (N=25) showed 92% of patients who initiated nusinersen treatment as pre-symptomatic infants maintained the ability to swallow after a median of 3.8 years. This is in contrast with the natural history of SMA where impaired swallowing is expected for patients with 2 or 3 SMN2 copies and can lead to an increased risk of aspiration pneumonia, choking, and failure to thrive. In this analysis, NURTURE study patients were consistently rated by their caregiver as, on average, never to rarely experiencing difficulty for the majority of measures related to general feeding, drinking liquids, and eating solid foods. In addition, post-hoc data from the open-label CS2-CS12 and SHINE extension studies indicate children and teens with later-onset SMA (N=14) showed improvement in walking distance over 5 years of nusinersen treatment and stabilization in fatigue.

Pipeline:

- **Apitegromab:** In April 2021, Scholar Rock announced positive top-line data from the TOPAZ Phase 2 clinical study evaluating apitegromab (previously known as SRK-015) in patients with type 2 and type 3 SMA.

Apitegromab is a selective inhibitor of the activation of latent myostatin. Myostatin is expressed primarily by skeletal muscle cells and the absence of its gene is associated with an increase in muscle mass and strength. The TOPAZ Phase 2 proof-of-concept study enrolled 58 patients with type 2 and type 3 SMA across 16 study sites in the United States and Europe. The study evaluated the safety and efficacy of intravenous apitegromab dosed every 4 weeks (Q4W) over a 12-month treatment period in 3 patient cohorts. The following are key findings from the 12-month top-line analysis:

- Cohort 1: This cohort included patients 5 to 21 years of age with ambulatory type 3 SMA who received 20mg/kg apitegromab Q4W monotherapy and in conjunction with nusinersen. The majority of patients (pooled population) in cohort 1 (57%, 13/23 patients) maintained or improved their motor function, as reflected by a ≥0-point change from baseline in Revised Hammersmith Scale (RHS) score, and 22% of patients (5/23) attained a ≥3-point increase from baseline.
- Cohort 2: This cohort included patients 5 to 21 years of age with type 2 and non-ambulatory type 3 SMA who initiated nusinersen at 5 years of age or older and who received 20mg/kg Q4W of apitegromab. The majority of patients in cohort 2 (64%, 9/14 patients) attained a >1-point increase from baseline on the HFMSE and 29% of patients (4/14) attained a >3-point increase from baseline.
- Cohort 3: This cohort included patients 2 years of age and older with type 2 SMA who initiated nusinersen at younger than 5 years of age and received either 2mg/kg Q4W or 20mg/kg Q4W of apitegromab. A mean change from baseline was observed on the HFMSE of 5.3-point and 7.1-point improvement in the 2mg/kg dose and the 20mg/kg dose arms, respectively. Across the full cohort, 59% of patients (10/17) attained a >5-point increase and 35% of patients (6/17) attained a >10-point increase from baseline.

The FDA granted apitegromab Orphan Drug Designation (ODD) and Rare Pediatric Disease (RPD) designation. A Phase 3 registrational study is expected to be initiated by the end of 2021.

- **AVXS-101 IT:** In September 2020, Novartis Gene Therapies received feedback from the FDA following their review of data from the STRONG study of the intrathecal (IT) formulation of AVXS-101 in patients with SMA. AVXS-101 IT is a 1-time, IT administered gene therapy. In the Phase 1/2 STRONG study, AVXS-101 IT substantially improved HFMSE scores and offered a clinically meaningful response in SMA type 2 patients 2 to 5 years of age. The FDA acknowledged the potential of AVXS-101 IT in this patient population and recommended a pivotal confirmatory study to supplement the existing STRONG data and further support the

regulatory submission for AVXS-101 IT. Study design and other details are being evaluated. This request for a study is unrelated to the partial clinical hold that was placed on AVXS-101 IT by the FDA in October 2019 following findings from a small, AveXis-initiated pre-clinical study in which animals treated with AVXS-101 IT showed dorsal root ganglia mononuclear cell inflammation. In September 2020, Novartis indicated the new study would not be initiated in the United States until the hold has been lifted by the FDA. On August 4, 2021, the FDA lifted the partial study hold after analyzing data from the company's nonclinical toxicology study in non-human primates that addressed all detected issues.

- **BIIB110:** Biogen is currently evaluating BIIB110 for SMA in a Phase 1 study. BIIB110 is a hybrid activin II receptor (ACTIIR) ligand trap that sequesters both myostatin and activins while sparing the related ligand bone morphogen protein 9 (BMP9). Inhibition of the myostatin pathway is a genetically validated target for muscle enhancement. This targeted mechanism of action may result in greater muscle mass, function, and improved safety compared to other myostatin inhibition approaches.
- **Reldesemtiv:** In 2017, the FDA granted reldesemtiv ODD and in July 2019, the European Medical Agency (EMA) did the same. Reldesemtiv is a fast skeletal muscle troponin activator designed to improve muscle contraction by slowing calcium release from regulatory proteins (troponins) in skeletal muscle fibers. It is currently being studied as a potential add-on therapy for patients with SMA and as a treatment for amyotrophic lateral sclerosis (ALS). Results from a Phase 2 clinical study of reldesemtiv in patients with SMA showed that reldesemtiv met its primary objective to determine potential PD effects after multiple oral doses in patients with SMA, and secondary objectives to evaluate the safety, tolerability, and PK of reldesemtiv. The study enrolled 70 patients 12 years of age and older who were given reldesemtiv 150mg or 450mg twice daily or placebo. Dose-dependent increases in Six Minute Walk Distance (6MWD) in ambulatory patients was noted at both post-baseline time points, week 4 and week 8. The study also showed increases vs. placebo in Maximal Expiratory Pressure (MEP) in both treatment groups. Adverse events were similar between groups receiving reldesemtiv and placebo.

Recommendations

The College of Pharmacy recommends updating the approval criteria for Evrysdi® (risdiplam) based on the recent FDA update to the *Prescribing Information* (changes noted in red):

Evrysdi® (Risdiplam) Approval Criteria:

1. An FDA approved diagnosis of spinal muscular atrophy (SMA) in members 2 months of age and older; and
2. Molecular genetic testing to confirm bi-allelic pathogenic variants in the *survival motor neuron 1* (*SMN1*) gene; and
3. Member is not currently dependent on permanent invasive ventilation (defined as ≥16 hours of respiratory assistance per day continuously for >21 days in the absence of an acute, reversible illness or a perioperative state); and
4. Evrysdi® must be prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA); and
5. Prescriber must agree ~~to monitor member's liver function prior to initiating Evrysdi® and periodically while receiving Evrysdi® treatment~~ to evaluate member's liver function prior to initiating Evrysdi® and must verify the member does not have severe hepatic impairment (Child-Pugh C); and
6. Pharmacy must confirm Evrysdi® will be constituted to an oral solution by a pharmacist prior to dispensing and must confirm Evrysdi® will be shipped via cold chain supply to adhere to the storage and handling requirements in the Evrysdi® *Prescribing Information*; and
7. Prescriber must confirm the member or caregiver has been counseled on the proper storage of Evrysdi® and has been instructed on how to prepare the prescribed daily dose of Evrysdi® prior to administration of the first dose; and
8. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
9. Female members of reproductive potential must be willing to use effective contraception during treatment with Evrysdi® and for at least 1 month after the last dose; and
10. Prescriber must verify male members of reproductive potential have been counseled on the potential effects on fertility and the potential of compromised male fertility is acceptable; and
11. Member will not be approved for concomitant treatment with Spinraza® (nusinersen); and
12. Member must not have previously received treatment with Zolgensma® (onasemnogene abeparvovec-xioi); and
13. A baseline assessment must be provided using a functionally appropriate exam [e.g., Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), Hammersmith Functional Motor Scale Expanded (HFMSE), Hammersmith Infant Neurological Exam (HINE), Upper Limb Module (ULM) Test]; and

14. Initial authorizations will be for the duration of 6 months, at which time the prescriber must verify the member is compliant with Evrysdi® and responding to the medication as demonstrated by clinically significant improvement or maintenance of function from pre-treatment baseline status using the same exam as performed at baseline assessment; and
15. Member's recent weight must be provided to ensure accurate dosing in accordance with Evrysdi® *Prescribing Information*; and
16. A quantity limit of 240mL per 36 days will apply.

Utilization Details of SMA Medications: Fiscal Year 2021

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM
RISDIPLAM PRODUCTS					
EVRYSDI SOL 0.75MG/ML	61	8	$1,162,275.86	7.63	$19,053.70
SUBTOTAL	**61**	**8***	**$1,162,275.86**	**7.63**	**$19,053.70**
NUSINERSEN PRODUCTS					
SPINRAZA INJ 12MG/5ML	29	14	$3,073,148.10	2.07	$105,970.62
SUBTOTAL	**29**	**14***	**$3,073,148.10**	**2.07**	**$105,970.62**
ONASEMNOGENE ABEPARVOVEC-XIOI PRODUCTS					
ZOLGENSMA INJ 3x8.3ML KIT	1	1	$2,125,011.41	1	$2,125,011.41
ZOLGENSMA INJ 7x8.3ML KIT	1	1	$2,125,011.41	1	$2,125,011.41
ZOLGENSMA INJ 1x5.5ML/4x8.3ML KIT	1	1	$2,125,011.41	1	$2,125,011.41
SUBTOTAL	**3**	**3***	**$6,375,034.23**	**1**	**$2,125,011.41**
TOTAL	**93**	**25***	**$10,610,458.19**	**3.72**	**$114,090.95**

INJ = injection; SOL = solution
*Total number of unduplicated utilizing members.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021

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Appendix F

Fiscal Year 2021 Annual Review of Hepatitis C Medications and 30-Day Notice to Prior Authorize Epclusa® (Sofosbuvir/Velpatasvir) Pellets and Mavyret® (Glecaprevir/Pibrentasvir) Pellets

Oklahoma Health Care Authority
October 2021

Introduction

Sovaldi® (sofosbuvir) and Olysio™ (simeprevir), the first direct-acting antivirals (DAAs) approved by the U.S. Food and Drug Administration (FDA) for the treatment of chronic hepatitis C virus (HCV), were FDA approved in the fourth quarter of 2013, but were previously restricted under Oklahoma law, preventing prior authorization management by the Oklahoma Health Care Authority. The state law was changed in May 2014 allowing for prior authorization implementation of the HCV medications effective July 1, 2014.

As new DAAs were FDA approved, they were subsequently reviewed and recommended to be prior authorized by the Drug Utilization Review (DUR) Board in the following order:

- November 2014: Harvoni® (ledipasvir/sofosbuvir)
- January 2015: Viekira Pak™ (ombitasvir/paritaprevir/ritonavir and dasabuvir)
- December 2015: Daklinza® (daclatasvir) and Technivie™ (ombitasvir/paritaprevir/ritonavir)
- April 2016: Zepatier® (elbasvir/grazoprevir)
- December 2016: Epclusa® (sofosbuvir/velpatasvir) and Viekira XR™ [dasabuvir/ombitasvir/paritaprevir/ritonavir extended-release (ER)]
- December 2017: Mavyret® (glecaprevir/pibrentasvir) and Vosevi® (sofosbuvir/velpatasvir/voxilaprevir)
- October 2019: Harvoni® (ledipasvir/sofosbuvir) oral pellets and Sovaldi® (sofosbuvir) oral pellets
- October 2020: Epclusa® (sofosbuvir/velpatasvir) 200mg/50mg tablets

In February 2017, the DUR Board voted to remove the minimum METAVIR equivalent fibrosis score requirement with a full implementation date of January 1, 2018. The minimum fibrosis score was lowered from F2 to F1 effective July 1, 2017 and from F1 to F0 effective January 1, 2018. In April 2018, the DUR Board voted to update the viral load requirements to ensure treated members have chronic HCV; the viral load requirements were implemented in May 2018 and are reflected in the current prior authorization criteria section of this report.

Current Prior Authorization Criteria

Generic Epclusa® (sofosbuvir/velpatasvir) and Mavyret® (glecaprevir/pibrentasvir) are SoonerCare's preferred DAAs for the treatment of chronic HCV based on net cost after supplemental rebate participation. Harvoni® (ledipasvir/sofosbuvir) pellets are covered for pediatric patients requiring that dosage form. DAAs for the treatment of chronic HCV are preferred based on the lowest net cost product(s) and may be moved to non-preferred if the net cost changes in comparison to the other available DAAs. Use of an alternative DAA for the treatment of HCV including Vosevi® (sofosbuvir/velpatasvir/voxilaprevir) requires a patient-specific, clinically significant reasoning why the preferred DAAs are not appropriate for the member. The following is a template for standard prior authorization criteria for the preferred HCV medications. The criteria for each medication is based on FDA approved regimens and American Association for the Study of Liver Diseases (AASLD) and Infectious Diseases Society of America (IDSA) guidance-recommended regimens. Specific HCV medication criteria will vary based on product labeling, FDA approved indications, guidance recommendations, drug interaction potential, and use in specific populations.

Hepatitis C Medication Approval Criteria:

1. An FDA approved age appropriate to the requested medication; and
2. An FDA approved diagnosis of chronic hepatitis C (CHC) and an FDA-indicated genotype (GT) appropriate to the requested medication; and
3. Requested hepatitis C medication must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated for hepatitis C treatment by a gastroenterologist, infectious disease specialist, or transplant specialist within the last 3 months; and
4. Hepatitis C virus (HCV) GT testing must be confirmed and indicated on the prior authorization request; and
5. Member has chronic HCV infection defined by:
    a. If the member has a liver fibrosis score ≥F1 (METAVIR equivalent), then only 1 detectable and quantifiable HCV RNA (>15 IU/mL) test within the last 12 months is required; or
    b. If the member has a liver fibrosis score <F1 (METAVIR equivalent), then the following must be met:
        i. Positive (i.e., reactive) HCV antibody test that is at least 6 months old and has a detectable and quantifiable HCV RNA (>15 IU/mL) test 6 months after date of positive HCV antibody test; or
        ii. Two detectable and quantifiable HCV RNA (>15 IU/mL) tests at least 6 months apart; and
6. FDA approved regimens and requirements based on cirrhosis status, viral GT, treatment history, and viral load thresholds will apply; and

7. Member must sign and submit the Hepatitis C Intent to Treat Contract; and
8. Member's pharmacy must submit the Hepatitis C Therapy Pharmacy Agreement for each member on therapy; and
9. Prescriber must verify that they will provide SoonerCare with all necessary labs to evaluate hepatitis C therapy efficacy including sustained virologic response (SVR-12); and
10. Prescriber must agree to counsel members on the potential harms of illicit intravenous (IV) drug use or alcohol use and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and
11. Documentation of initiation of immunization with the hepatitis A and B vaccines must be provided; and
12. Decompensated cirrhosis or moderate or severe hepatic impairment (Child-Pugh B or C) restrictions based on FDA approvals and safety recommendations will apply; and
13. Member must not have a limited life expectancy (<12 months) that cannot be remediated by treating HCV, liver transplantation, or another directed therapy; and
14. Female members must not be pregnant and must have a negative pregnancy test immediately prior to therapy initiation. Male and female members must be willing to use 2 forms of non-hormonal birth control while on therapy; and
15. Member must not be taking any medications not recommended for use with the requested hepatitis C medication; and
16. All other clinically significant issues must be addressed prior to starting therapy including but not limited to the following: neutropenia, anemia, thrombocytopenia, surgery, depression, psychosis, epilepsy, obesity, weight-management, severe concurrent medical diseases, such as but not limited to, retinal disease, or autoimmune thyroid disease; and
17. Prescriber must verify that they will work with the member to ensure the member remains adherent to hepatitis C therapies; and
18. Member must be adherent for continued approval. Treatment gaps of therapy longer than 3 days/month will result in denial of subsequent requests for continued therapy; and
19. Approvals for treatment regimen initiation for 8 or 12 weeks of therapy will not be granted prior to the 10th of a month, and for 16 weeks of therapy prior to the 15th of a month in order to prevent prescription limit issues from affecting the member's compliance.

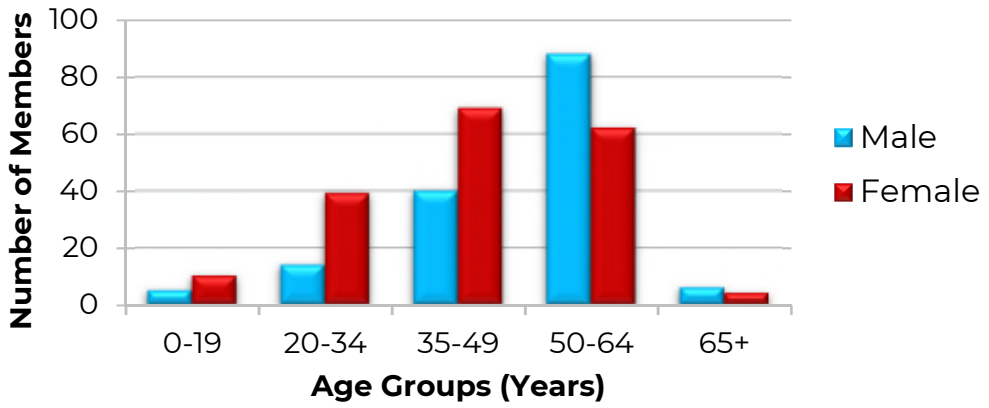
Utilization of Hepatitis C Medications: Fiscal Year 2021

Comparison of Fiscal Years

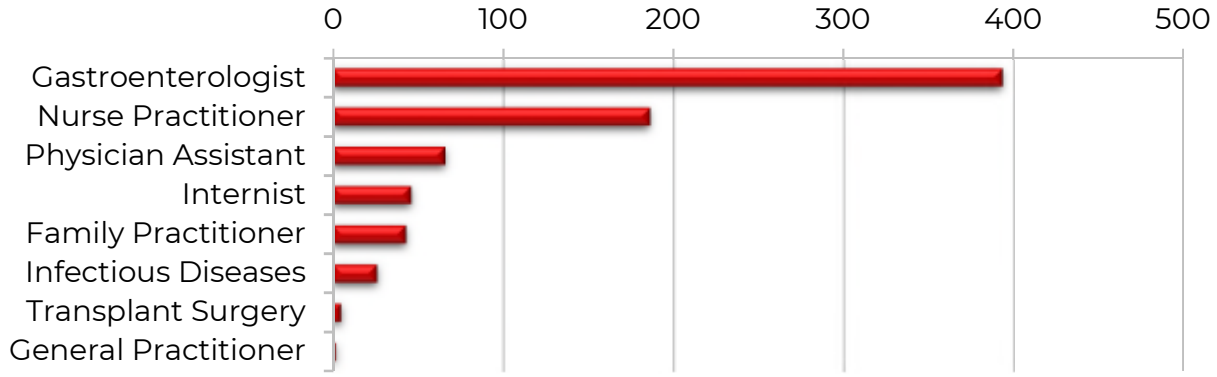
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2020	398	897	$19,716,822.77	$21,980.85	$786.69	38,085	25,063
2021	337	767	$14,865,542.63	$19,381.41	$692.00	33,070	21,482
% Change	**-15.30%**	**-14.50%**	**-24.60%**	**-11.80%**	**-12.00%**	**-13.20%**	**-14.30%**
Change	**-61**	**-130**	**-$4,851,280.14**	**-$2,599.44**	**-$94.69**	**-5,015**	**-3,581**

*Total number of unduplicated utilizing members.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2020 = 07/01/2019 to 06/30/2020; Fiscal Year 2021 = 07/01/2020 to 06/30/2021

Demographics of Members Utilizing Hepatitis C Medications



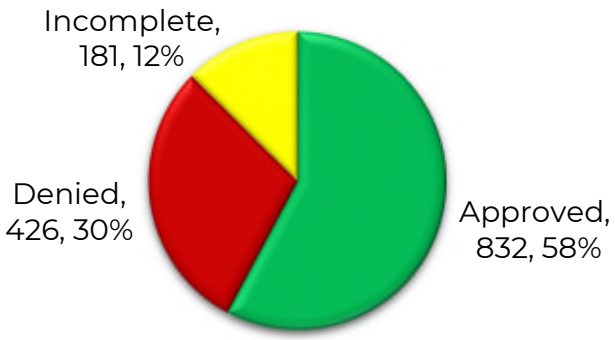
Top Prescriber Specialties of Hepatitis C Medications by Number of Claims



Prior Authorization of Hepatitis C Medications

There were 1,439 prior authorization requests submitted for 415 unique members for hepatitis C medications during fiscal year 2021. Approvals are granted for 28 days of therapy each time, so members will have a prior authorization request for each refill of therapy. The following chart shows the status of the submitted petitions for fiscal year 2021.

Status of Petitions



Market News and Updates[1,2,3,4,5,6]

Anticipated Patent Expiration(s):

- Zepatier® (elbasvir/grazoprevir): May 2031
- Harvoni® (ledipasvir/sofosbuvir) pellets: March 2033
- Epclusa® (sofosbuvir/velpatasvir) pellets: May 2033
- Epclusa® (sofosbuvir/velpatasvir) tablets: July 2034
- Harvoni® (ledipasvir/sofosbuvir) tablets: July 2034
- Mavyret® (glecaprevir/pibrentasvir) pellets and tablets: December 2035
- Vosevi® (sofosbuvir/velpatasvir/voxilaprevir): June 2037

New U.S. FDA Approval(s) and Label Update(s):

- **June 2021:** In June 2021, the FDA approved Epclusa® (sofosbuvir/velpatasvir) oral pellets for the treatment of chronic HCV in pediatric patients 3 years of age and older with Genotype (GT)-1, -2, -3, -4, -5, or -6.
- **June 2021:** In June 2021, the FDA approved Mavyret® (glecaprevir/pibrentasvir) oral pellets for the treatment of chronic HCV in pediatric patients 3 years to younger than 12 years of age weighing ≤45kg with GT-1, -2, -3, -4, -5, or -6 without cirrhosis or with compensated cirrhosis.

Guideline Update(s):

- **March 2021:** The AASLD/ISDA released updated guidance for retreatment of persons in whom prior treatment therapy failed which included an approach to retreatment based on prior regimen failure and retreatment of multiple DAA regimen failures.

News:

- **March 2021:** A single arm phase 4 clinical study evaluated a minimal monitoring (MINMON) approach in treatment-naive individuals who had no evidence of decompensated cirrhosis. The MINMON approach comprised four key elements: no pretreatment genotyping, all tablets dispensed at study entry, no scheduled on-treatment clinic visits/labs, and two remote contacts at weeks 4 (adherence evaluation) and 22 (scheduled SVR visit). Unplanned visits for patients' concerns were

permitted. Of the 400 participants, SVR-12 data was available for 396 participants and 379 (95.0%) achieved SVR.

- **May 2021:** A collaborative study between the Centers for Disease Control and Prevention (CDC) and Quest Diagnostics indicates sharp declines in routine HCV testing and treatments in the early months of the COVID-19 pandemic. Continued results beyond the study period found a strong rebound in testing had occurred by the end of 2020, although testing has not yet recovered to pre-pandemic levels.

Recommendations

The College of Pharmacy recommends the prior authorization of Epclusa® (sofosbuvir/velpatasvir) pellets with criteria similar to Epclusa® tablets and the prior authorization of Mavyret® (glecaprevir/pibrentasvir) pellets with criteria similar to Mavyret® tablets. Additionally, the College of Pharmacy recommends updating the Epclusa® (sofosbuvir/velpatasvir) and Mavyret® (glecaprevir/pibrentasvir) prior authorization criteria based on new FDA label updates. The following criteria will apply (changes and additions noted in red):

Epclusa® (Sofosbuvir/Velpatasvir Tablets and Pellets) Approval Criteria:

1. Member must be ~~6~~ 3 years of age or older ~~or weighing at least 17kg~~; and
2. An FDA approved diagnosis of Chronic Hepatitis C (CHC) genotype (GT)-1, GT-2, GT-3, GT-4, GT-5, or GT-6; and
3. Epclusa® must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated for hepatitis C treatment by a gastroenterologist, infectious disease specialist, or transplant specialist within the last 3 months; and
4. Hepatitis C Virus (HCV) GT testing must be confirmed and indicated on prior authorization request; and
5. Member has chronic HCV infection defined by:
    a. If the member has a liver fibrosis score ≥F1 (METAVIR equivalent), then only 1 detectable and quantifiable HCV RNA (>15 IU/mL) test within the last 12 months is required (must be within last 3 months if requesting 8-week regimen); or
    b. If the member has a liver fibrosis score <F1 (METAVIR equivalent), then the following must be met:
        i. Positive (i.e., reactive) HCV antibody test that is at least 6 months old and has a detectable and quantifiable HCV RNA (>15 IU/mL) test 6 months after date of positive HCV antibody test; or
        ii. Two detectable and quantifiable HCV RNA (>15 IU/mL) tests at least 6 months apart; and
7. The following regimens and requirements based on prior treatment experience, baseline viral load, and cirrhosis will apply:
    a. **GT-1, -2, -3, -4, -5, -6:**

i. Treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A): Epclusa® for 12 weeks; or
ii. Treatment-naïve or treatment-experienced with decompensated cirrhosis (Child-Pugh B and C): Epclusa® + weight based ribavirin for 12 weeks; or

b. New regimens will apply as approved by the FDA; and

8. Member must sign and submit the Hepatitis C Intent to Treat contract; and
9. Member's pharmacy must submit the Hepatitis C Therapy Pharmacy Agreement for each member on therapy; and
10. Prescriber must verify that they will provide SoonerCare with all necessary labs to evaluate hepatitis C therapy efficacy including Sustained Virologic Response (SVR-12); and
11. Prescriber must agree to counsel members on potential harms of illicit intravenous (IV) drug use or alcohol use and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and
12. Documentation of initiation of immunization with the hepatitis A and B vaccines must be provided; and
13. Female members must not be pregnant and must have a negative pregnancy test immediately prior to therapy initiation. Male and female members must be willing to use 2 forms of non-hormonal birth control while on therapy (and for 6 months after therapy completion for ribavirin users); and
14. Member must not be taking the following medications: H_2-receptor antagonists at doses >40mg famotidine equivalent, amiodarone, omeprazole or other proton pump inhibitors, topotecan, rifampin, rifabutin, rifapentine, carbamazepine, eslicarbazepine, phenytoin, phenobarbital, oxcarbazepine, efavirenz, tenofovir disoproxil fumarate, tipranavir/ritonavir, St. John's wort, and rosuvastatin doses >10mg; and
15. If member is using antacids they must agree to separate antacid and Epclusa® administration by 4 hours; and
16. All other clinically significant issues must be addressed prior to starting therapy including but not limited to the following: neutropenia, anemia, thrombocytopenia, surgery, depression, psychosis, epilepsy, obesity, weight-management, severe concurrent medical diseases, such as but not limited to, retinal disease, or autoimmune thyroid disease; and
17. Member must not have a limited life expectancy (<12 months) that cannot be remediated by treating HCV, liver transplantation, or another directed therapy; and
18. Prescriber must verify that they will work with the member to ensure the member remains adherent to hepatitis C therapies; and

19. Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days/month will result in denial of subsequent requests for continued therapy; and
20. Approvals for treatment regimen initiation for 12 weeks of therapy will not be granted prior to the 10th of a month in order to prevent prescription limit issues from affecting the member's compliance.

Mavyret® (Glecaprevir/Pibrentasvir Tablets and Pellets) Approval Criteria:

1. Member must be ~~12~~ 3 years of age or older ~~or weigh at least 45kg~~; and
2. An FDA approved diagnosis of Chronic Hepatitis C (CHC) genotype (GT)-1, GT-2, GT-3, GT-4, GT-5, or GT-6; and
3. Mavyret® must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated for hepatitis C treatment by a gastroenterologist, infectious disease specialist, or transplant specialist within the last 3 months; and
4. Hepatitis C Virus (HCV) genotype testing must be confirmed and indicated on the prior authorization request; and
5. Member has chronic HCV infection defined by:
    a. If the member has a liver fibrosis score ≥F1 (METAVIR equivalent), then only 1 detectable and quantifiable HCV RNA (>15 IU/mL) test within the last 12 months is required; or
    b. If the member has a liver fibrosis score <F1 (METAVIR equivalent), then the following must be met:
        i. Positive (i.e., reactive) HCV antibody test that is at least 6 months old and has a detectable and quantifiable HCV RNA (>15 IU/mL) test 6 months after date of positive HCV antibody test; or
        ii. Two detectable and quantifiable HCV RNA (>15 IU/mL) tests at least 6 months apart; and
6. The following regimens and requirements based on cirrhosis status, viral genotype, and treatment history will apply (new regimens will apply as approved by the FDA):

Genotype	Prior Treatment Experience	No Cirrhosis	Compensated Cirrhosis
1, 2, 3, 4, 5, or 6	Treatment-Naïve	8 weeks	8 weeks
1	NS5A w/o NS3/4A PI	16 weeks	16 weeks
1	NS3/4A PI w/o NS5A	12 weeks	12 weeks
1, 2, 4, 5, or 6	PRS	8 weeks	12 weeks
3	PRS	16 weeks	16 weeks

PRS = pegylated interferon, ribavirin, and/or sofosbuvir; w/o = without; PI = protease inhibitor
Examples of NS5A inhibitors include: daclatasvir, elbasvir, ledipasvir, ombitasvir, pibrentasvir, velpatasvir
Examples of NS3/4A PIs include: boceprevir, glecaprevir, grazoprevir, paritaprevir, simeprevir, telaprevir, voxilaprevir
HCV/HIV-1 co-infection and patients with any degree of renal impairment follow the same dosage recommendations in the table above. For liver or kidney transplant recipients, Mavyret® is recommended for 12 weeks in adult and pediatric patients 12 years and older or weighing at least 45kg.
A 16-week treatment duration is recommended in genotype (GT) 1-infected patients who are NS5A

inhibitor-experienced without prior treatment with an NS3/4A PI or in GT 3-infected patients who are PRS treatment-experienced.

7. Member must sign and submit the Hepatitis C Intent to Treat contract; and
8. Member's pharmacy must submit the Hepatitis C Therapy Pharmacy Agreement for each member on therapy; and
9. Prescriber must verify that they will provide SoonerCare with all necessary labs to evaluate hepatitis C therapy efficacy including Sustained Virologic Response (SVR-12); and
10. Prescriber must agree to counsel members on the potential harms of illicit intravenous (IV) drug use or alcohol use and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and
11. Documentation of initiation of immunization with the hepatitis A and B vaccines must be provided; and
12. Member must not have decompensated cirrhosis or moderate or severe hepatic impairment (Child-Pugh B or C); and
13. Member must not have a limited life expectancy (<12 months) that cannot be remediated by treating HCV, liver transplantation, or another directed therapy; and
14. Female members must not be pregnant and must have a pregnancy test immediately prior to therapy initiation. Male and female members must be willing to use 2 forms of non-hormonal birth control while on therapy; and
15. Member must not be taking the following medications: carbamazepine, rifampin, ethinyl estradiol-containing medications, St. John's wort, atazanavir, darunavir, lopinavir, ritonavir, efavirenz, atorvastatin, lovastatin, simvastatin, rosuvastatin doses greater than 10mg per day, or cyclosporine doses greater than 100mg per day; and
16. All other clinically significant issues must be addressed prior to starting therapy including but not limited to the following: neutropenia, anemia, thrombocytopenia, surgery, depression, psychosis, epilepsy, obesity, weight-management, severe concurrent medical diseases, such as but not limited to, retinal disease, or autoimmune thyroid disease; and
17. Prescriber must verify that they will work with the member to ensure the member remains adherent to hepatitis C therapies; and
18. Approval of the 8-week carton (in place of the 4-week carton) requires a patient-specific, clinically significant reason why the member requires the 8-week carton in place of the 4-week carton; and
19. Member must be adherent for continued approval. Treatment gaps of therapy longer than 3 days/month will result in denial of subsequent requests for continued therapy; and
20. Approvals for treatment regimen initiation for 8 or 12 weeks of therapy will not be granted prior to the 10th of a month, and for 16 weeks of

therapy prior to the 15th of a month in order to prevent prescription limit issues from affecting the member's compliance.

Utilization Details of Hepatitis C Medications: Fiscal Year 2021

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	% COST	COST/ CLAIM
SOFOSBUVIR/VELPATASVIR PRODUCTS						
EPCLUSA TAB 400-100MG	420	163	$10,182,914.01	2.58	68.50%	$24,245.03
SOF/VEL TAB 400-100MG	116	58	$919,715.06	2	6.19%	$7,928.58
EPCLUSA TAB 200-50MG	1	1	$49,851.41	1	0.34%	$49,851.41
SUBTOTAL	**537**	**222**	**$11,152,480.48**	**2.42**	**75.03%**	**$20,768.12**
GLECAPREVIR/PIBRENTASVIR PRODUCTS						
MAVYRET TAB 100-40MG	179	102	$2,304,869.70	1.75	15.50%	$12,876.37
SUBTOTAL	**179**	**102**	**$2,304,869.70**	**1.75**	**15.50%**	**$12,876.37**
SOFOSBUVIR/LEDIPASVIR PRODUCTS						
HARVONI PEL 45-200MG	16	6	$693,182.56	2.67	4.66%	$43,323.91
HARVONI PEL 33.75-150MG	8	4	$252,091.28	2	1.70%	$31,511.41
HARVONI TAB 45-200MG	3	1	$94,534.23	3	0.64%	$31,511.41
SUBTOTAL	**27**	**11**	**$1,039,808.07**	**2.45**	**7.00%**	**$38,522.52**
RIBAVIRIN PRODUCTS						
RIBAVIRIN CAP 200MG	10	3	$908.64	3.33	0.01%	$90.86
SUBTOTAL	**10**	**3**	**$908.64**	**3.33**	**0.01%**	**$90.86**
SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR PRODUCTS						
VOSEVI TAB 400-100-100MG	8	3	$199,407.28	2.67	1.34%	$24,925.91
SUBTOTAL	**8**	**3**	**$199,407.28**	**2.67**	**1.34%**	**$24,925.91**
SOFOSBUVIR PRODUCTS						
SOVALDI PEL 150MG	6	1	$168,068.46	6	1.13%	$28,011.41
SUBTOTAL	**6**	**1**	**$168,068.46**	**6**	**1.13%**	**$28,011.41**
TOTAL	**767**	**337***	**$14,865,542.63**	**2.28**	**100%**	**$19,381.41**

CAP = capsule; PEL = pellet; SOF/VEL = sofosbuvir/velpatasvir; TAB = tablet
*Total number of unduplicated members.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021

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[2] Drugs@FDA: FDA-Approved Drugs. Epclusa® Supplemental New Drug Application (sNDA) 208341 Approval. Available online at: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm. Issued 06/10/2021. Last accessed 09/20/2021.
[3] Drugs@FDA: FDA-Approved Drugs. Mavyret® Supplemental New Drug Application (sNDA) 209394 Approval. Available online at: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm. Issued 06/10/2021. Last accessed 09/20/2021.
[4] American Association for the Study of Liver Diseases (AASLD)/Infectious Diseases Society of America (IDSA). Retreatment of Persons in Whom Prior Therapy Failed. Available online at: http://www.hcvguidelines.org. Last revised 03/12/2021. Last accessed 09/29/2021.
[5] Caleb Rans, PharmD. New 'Minimal Monitoring' Approach to HCV Treatment May Simplify Care. *Medscape*. Available online at: https://www.medscape.com/viewarticle/947455. Issued 03/15/2021. Last accessed 09/29/2021.
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Appendix G

Fiscal Year 2021 Annual Review of Ovarian Cancer Medications

Oklahoma Health Care Authority
October 2021

Introduction[1,2]

According to the National Cancer Institute, in 2021 there will be an estimated 21,410 new cases of ovarian cancer, with an estimated 13,770 deaths attributed to the disease. Ovarian malignancies consist of multiple histopathologic forms. The most common form is epithelial ovarian cancer, which accounts for approximately 90% of all ovarian neoplasms. The remaining 10% of ovarian cancer cases are comprised of germ cell, sex-cord stromal, carcinosarcomas, clear-cell, mucinous, and serous tumors. To date, there are no effective large-scale population-based screening options to detect early ovarian cancers. Most ovarian neoplasms are diagnosed in later stages, making the disease more difficult to cure. The current 5-year overall survival is approximately 46.5%, with only 40% of women ever obtaining cure. There are several different types of treatments available for patients with ovarian cancer, including surgery, radiation, hormone therapy, monoclonal antibodies, targeted therapy, and immunotherapy. However, traditional chemotherapy, especially platinum and taxane oncolytics, remain the backbone of both adjuvant and metastatic treatment regimens. Anti-angiogenesis agents such as bevacizumab also play a large role in the treatment of these cancers. Newer targeted agents, including poly [adenosine diphosphate (ADP)-ribose] polymerase (PARP) inhibitors, and immunotherapy have recently become therapeutic options in upfront, relapsed/refractory, and maintenance settings.

Current Prior Authorization Criteria

Lynparza® (Olaparib) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of metastatic breast cancer; and
2. Member must have shown progression on previous chemotherapy in any setting; and
3. Positive test for a germline BRCA-mutation (*gBRCAm*); and
4. Members with hormone receptor (HR) positive disease must have failed prior endocrine therapy or are not considered to be a candidate for endocrine therapy.

Lynparza® (Olaparib) Approval Criteria [Castration-Resistant Prostate Cancer (CRPC) Diagnosis]:

1. Diagnosis of metastatic CRPC; and
2. Member must have failed previous first-line therapy; and
3. Used as a single agent except for the following:
    a. Concomitant treatment with a gonadotropin-releasing hormone (GnRH) analog or prior history of bilateral orchiectomy; and
4. Disease must be positive for a mutation in a homologous recombination gene.

Lynparza® (Olaparib) Approval Criteria [Ovarian, Fallopian Tube, or Primary Peritoneal Cancer Diagnosis]:

1. **Treatment of Advanced Recurrent/Refractory Disease:**
    a. Diagnosis of deleterious or suspected deleterious germline BRCA-mutated (*gBRCAm*), advanced disease; and
    b. Previous treatment with ≥2 prior lines of chemotherapy (prior chemotherapy regimens should be documented on the prior authorization request); and
    c. A quantity limit based on FDA approved dosing will apply; or
2. **Maintenance Treatment of Advanced Disease:**
    a. Disease must be in a complete or partial response to primary chemotherapy; and
        i. Used as a single-agent in members with a diagnosis of deleterious or suspected deleterious *gBRCAm* or somatic BRCA-mutated (*sBRCAm*), advanced ovarian cancer; or
        ii. Used in combination with bevacizumab following a primary therapy regimen that included bevacizumab; or
    b. Complete or partial response to second-line or greater platinum-based chemotherapy (no mutation required); and
    c. A quantity limit based on FDA approved dosing will apply.

Lynparza® (Olaparib) Approval Criteria [Pancreatic Cancer Diagnosis]:

1. Diagnosis of metastatic pancreatic adenocarcinoma with known germline BRCA1/BRCA2 mutation; and
2. Maintenance therapy as a single-agent; and
3. In members who have not progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen.

Mekinist® (Trametinib) Approval Criteria [Serous Ovarian Cancer Diagnosis]:

1. Diagnosis of persistent disease or recurrent low-grade serous carcinoma; and
2. Meets 1 of the following:
    a. Immediate treatment for serially rising CA-125 in members who previously received chemotherapy; or

b. Progression on primary, maintenance, or recurrence therapy; or
c. Stable or persistent disease (if not on maintenance therapy); or
d. Complete remission and relapse after receiving prior chemotherapy.

Rubraca® (Rucaparib) Approval Criteria [Castration-Resistant Prostate Cancer (CRPC) Diagnosis]:

1. Diagnosis of metastatic CRPC; and
2. Member must have failed previous first-line therapy; and
3. Used as a single agent except for the following:
   a. Concomitant treatment with a gonadotropin-releasing hormone (GnRH) analog or prior history of bilateral orchiectomy; and
4. Disease must be positive for a mutation in BRCA1 or BRCA2.

Rubraca® (Rucaparib) Approval Criteria [Ovarian, Fallopian Tube, or Primary Peritoneal Cancer Diagnosis]:

1. **Treatment of Advanced Recurrent/Refractory Disease:**
   a. Diagnosis of recurrent or refractory disease; and
   b. Previous treatment with ≥2 prior lines of chemotherapy (prior chemotherapy regimens should be documented on the prior authorization request); and
   c. Disease is associated with a deleterious or suspected deleterious BRCA mutation; and
   d. Used as a single agent; or
2. **Maintenance Treatment of Advanced Disease:**
   a. Diagnosis of advanced or recurrent disease; and
   b. Disease must be in a complete or partial response to platinum-based chemotherapy; and
   c. Used as a single agent.

Zejula® (Niraparib) Approval Criteria [Ovarian, Fallopian Tube, or Primary Peritoneal Cancer Diagnosis]:

1. **Treatment of Advanced Recurrent/Refractory Disease as a Single Agent:**
   a. Diagnosis of recurrent or refractory disease; and
   b. Previous treatment with ≥3 prior lines of chemotherapy (prior chemotherapy regimens should be documented on the prior authorization request); and
   c. Diagnosis is associated with homologous recombination deficiency (HRD) positive status defined by either:
      i. A deleterious or suspected deleterious BRCA mutation; or
      ii. Genomic instability and progression >6 months after response to last platinum-based chemotherapy; and
   d. Used as a single agent; or

2. **Treatment of Advanced Recurrent/Refractory Disease in Combination with Bevacizumab:**
    a. Used in combination with bevacizumab for platinum-sensitive persistent disease or recurrence; and
    b. Meets 1 of the following:
        i. As immediate treatment for serially rising CA-125 in members who previously received chemotherapy, or
        ii. Evidence of radiographic and/or clinical relapse in members with previous complete remission and relapse ≥6 months after completing prior chemotherapy; or
3. **Maintenance Treatment of Advanced Disease:**
    a. Diagnosis of advanced or recurrent disease; and
    b. Disease must be in a complete or partial response to platinum chemotherapy; and
    c. Used as a single agent.

Utilization of Ovarian Cancer Medications: Fiscal Year 2021

Fiscal Year Comparison

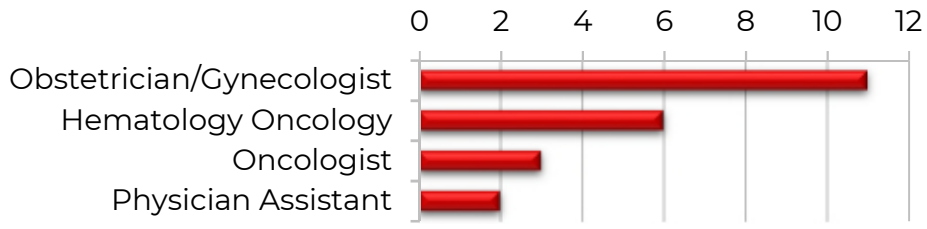
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2020	7	27	$216,334.15	$8,012.38	$267.08	1,230	810
2021	7	22	$261,703.18	$11,895.60	$396.52	1,860	660
% Change	**0.00%**	**-18.50%**	**21.00%**	**48.50%**	**48.50%**	**51.20%**	**-18.50%**
Change	**0**	**-5**	**$45,369.03**	**$3,883.22**	**$129.44**	**630**	**-150**

*Total number of unduplicated utilizing members.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2020 = 07/01/2019 to 06/30/2020; Fiscal Year 2021 = 07/01/2020 to 06/30/2021

Demographics of Members Utilizing Ovarian Cancer Medications

- Due to the limited number of members utilizing ovarian cancer medications during fiscal year 2021, detailed demographic information could not be provided.

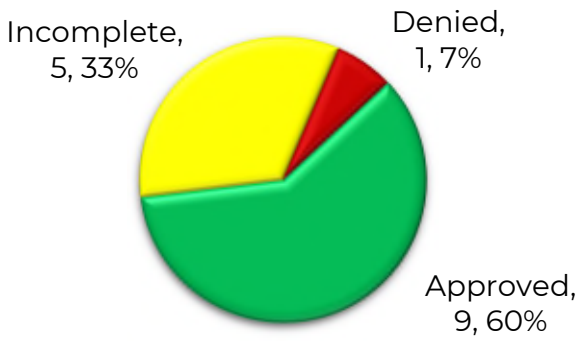
Top Prescriber Specialties of Ovarian Cancer Medications by Number of Claims



Prior Authorization of Ovarian Cancer Medications

There were 15 prior authorization requests submitted for ovarian cancer medications during fiscal year 2021. The following chart shows the status of the submitted petitions for fiscal year 2021.

Status of Petitions



Recommendations

The College of Pharmacy does not recommend any changes to the current ovarian cancer medications prior authorization criteria at this time.

Utilization Details of Ovarian Cancer Medications: Fiscal Year 2021

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM
OLAPARIB PRODUCTS					
LYNPARZA TAB 150MG	9	2	$130,130.70	4.5	$14,458.97
LYNPARZA TAB 100MG	3	1	$43,380.90	3	$14,460.30
SUBTOTAL	**12**	**3**	**$173,511.60**	**4**	**$14,459.30**
NIRAPARIB PRODUCTS					
ZEJULA CAP 100MG	8	2	$74,131.64	4	$9,266.46
SUBTOTAL	**8**	**2**	**$74,131.64**	**4**	**$9,266.46**
TRAMETINIB PRODUCTS					
MEKINIST TAB 0.5MG	2	2	$14,059.94	1	$7,029.97
SUBTOTAL	**2**	**2**	**$14,059.94**	**1**	**$7,029.97**
TOTAL	**22**	**7***	**$261,703.18**	**3.14**	**$11,895.60**

CAP = capsule; TAB = tablet
*Total number of unduplicated utilizing members.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021

[1] National Institutes of Health (NIH). Surveillance, Epidemiology, and End Results (SEER) Program Populations. Cancer Stat Facts: Ovarian Cancer. *National Cancer Institute, DCCPS, Surveillance Research Program*. Available online at: https://seer.cancer.gov/statfacts/html/ovary.html. Last accessed 09/15/2021.

[2] National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Ovarian Cancer Version 3.2021. *National Comprehensive Cancer Network*. Available online at: https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf. Issued 09/09/2021. Last accessed 09/15/2021.

Appendix H

30-Day Notice to Prior Authorize Jakafi® (Ruxolitinib) and Rezurock™ (Belumosudil)

Oklahoma Health Care Authority
October 2021

Introduction[1]

Chronic graft-versus-host disease (cGVHD) is a major cause of morbidity and mortality following allogeneic hematopoietic stem cell transplants. Severe cGVHD, requiring systemic treatment, occurs in up to one-third of allogeneic transplant patients. Corticosteroids are currently used as first-line systemic therapy for cGVHD; however, half of patients are refractory to initial therapy and require alternative treatments. Current treatment options for refractory cGVHD are limited primarily to calcineurin inhibitors, ruxolitinib, and ibrutinib. Novel agents with distinct mechanisms of action from available treatment options, such as belumosudil, are currently being investigated with great interest due to a lack of treatment options in refractory patients.

Market News and Updates[2,3]

New U.S. Food and Drug Administration (FDA) Approval(s):

- **July 2021:** The FDA approved Rezurock™ (belumosudil), a kinase inhibitor, for adult and pediatric patients 12 years of age and older with cGVHD after failure of at least 2 prior lines of systemic therapy.
- **September 2021:** The FDA approved Jakafi® (ruxolitinib) for cGVHD after failure of 1 or 2 lines of systemic therapy in adult and pediatric patients 12 years of age and older. Jakafi® was originally FDA approved in 2011 for intermediate or high-risk myelofibrosis. Since that time, Jakafi has also received FDA approval for polycythemia vera in 2014 and acute GVHD (aGVHD) in 2019.

Jakafi® (Ruxolitinib) Product Summary[4]

- **Therapeutic Class:** Kinase inhibitor
- **Indication(s):**
  - Intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis in adults
  - Polycythemia vera in adults who have had an inadequate response to or are intolerant of hydroxyurea
  - Steroid-refractory aGVHD in adult and pediatric patients 12 years of age and older

- cGVHD after failure of 1 or 2 lines of systemic therapy in adult and pediatric patients 12 years of age and older
- **How Supplied:** 5mg, 10mg, 15mg, 20mg, and 25mg oral tablets
- **Dose:**
  - Myelofibrosis: Starting dose is based on the patient's baseline platelet count:

Baseline Platelet Count	Recommended Starting Dose
>200 × 10^9/L	20mg twice daily
100 to 200 × 10^9/L	15mg twice daily
50 to <100 × 10^9/L	5mg twice daily

  - Polycythemia vera: Starting dose is 10mg twice daily; dose may be titrated based on safety and efficacy
  - aGVHD: Starting dose is 5mg twice daily; dose may be increased to 10mg twice daily after 3 days of treatment if the absolute neutrophil count (ANC) and platelet counts are not decreased by 50% or more
  - cGVHD: Starting dose is 10mg twice daily; dose may be adjusted based on safety and efficacy
- **Cost:** The Wholesale Acquisition Cost (WAC) is $245.90 per tablet for all available strengths. This results in a cost of $14,754 per 30 days based on the recommended starting dose for cGVHD of 10mg twice daily. Cost will vary based on diagnosis and treatment regimen.

Rezurock™ (Belumosudil) Product Summary[5]

- **Therapeutic Class:** Kinase inhibitor
- **Indication(s):** Treatment of adult and pediatric patients 12 years of age and older with cGVHD after failure of at least 2 prior lines of systemic therapy
- **How Supplied:** 200mg oral tablets
- **Dose:** 200mg once daily with food
- **Cost:** The WAC is $516.67 per 200mg tablet, resulting in a cost of $15,500.10 per 30 days based on the recommended dose of 200mg daily.

Recommendations

The College of Pharmacy recommends the prior authorization of Jakafi® (ruxolitinib) and Rezurock™ (belumosudil) with the following criteria listed in red:

Jakafi® (Ruxolitinib) Approval Criteria [Graft-Versus-Host Disease (GVHD) Diagnosis]:

1. Diagnosis of acute or chronic GVHD; and

2. Failure of at least 1 prior line of systemic therapy; and
3. Member must be 12 years of age or older.

Jakafi® (Ruxolitinib) Approval Criteria [Myelofibrosis (MF) Diagnosis]:

1. Diagnosis of MF; and
2. Symptomatic lower-risk MF with no response or loss of response to peginterferon alfa-2a or hydroxyurea; or
3. Intermediate to high-risk MF; and
4. Member must be 18 years of age or older.

Jakafi® (Ruxolitinib) Approval Criteria [Polycythemia Vera Diagnosis]:

1. Diagnosis of polycythemia vera; and
2. Inadequate response or loss of response to hydroxyurea or peginterferon alfa-2a therapy; and
3. Member must be 18 years of age or older.

Rezurock™ (Belumosudil) Approval Criteria [Graft-Versus-Host Disease (GVHD) Diagnosis]:

1. Diagnosis of chronic GVHD; and
2. Failure of at least 2 prior lines of systemic therapy.

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[1] Saidu NE, Bonini C, Dickinson AM, et al. New Approaches for the Treatment of Chronic Graft-Versus-Host Disease: Current Status and Future Directions. *Frontiers in Immunology* 2020; 11:2625.
[2] U.S. Food and Drug Administration (FDA). Hematology/Oncology (Cancer) Approvals & Safety Notifications. Available online at: https://www.fda.gov/drugs/resources-information-approved-drugs/hematologyoncology-cancer-approvals-safety-notifications. Last revised 09/22/2021. Last accessed 09/29/2021.
[3] U.S. FDA. Drugs@FDA: FDA-Approved Drugs. Available online at: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=BasicSearch.process. Last revised 09/2021. Last accessed 09/29/2021.
[4] Jakafi® Prescribing Information. Incyte Corporation. Available online at: https://www.jakafi.com/pdf/prescribing-information.pdf. Last revised 09/2021. Last accessed 09/29/2021.
[5] Rezurock™ Prescribing Information. Kadmon Pharmaceuticals, LLC. Available online at: https://www.rezurock.com/full-prescribing-information.pdf. Last revised 07/2021. Last accessed 09/02/2021.

Appendix I

Fiscal Year 2021 Annual Review of Targeted Immunomodulator Agents and 30-Day Notice to Prior Authorize Lupkynis™ (Voclosporin) and Saphnelo™ (Anifrolumab-fnia)

Oklahoma Health Care Authority
October 2021

Current Prior Authorization Criteria

The current product based prior authorization (PBPA) Tier chart and specific prior authorization criteria for the Targeted Immunomodulator Agents can be found in the *Recommendations* section at the end of this report.

Utilization of Targeted Immunomodulator Agents: Fiscal Year 2021

Comparison of Fiscal Years: Pharmacy Claims

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2020	1,066	6,991	$43,288,515.81	$6,192.03	$209.58	41,349	206,549
2021	1,251	8,549	$56,932,489.33	$6,659.55	$223.52	53,486	254,714
% Change	**17.4%**	**22.3%**	**31.5%**	**7.6%**	**6.7%**	**29.4%**	**23.3%**
Change	**185**	**1,558**	**$13,643,973.52**	**$467.52**	**$13.94**	**12,137**	**48,165**

*Total number of unduplicated utilizing members.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2020 = 07/01/2019 to 06/30/2020; Fiscal Year 2021 = 07/01/2020 to 06/30/2021

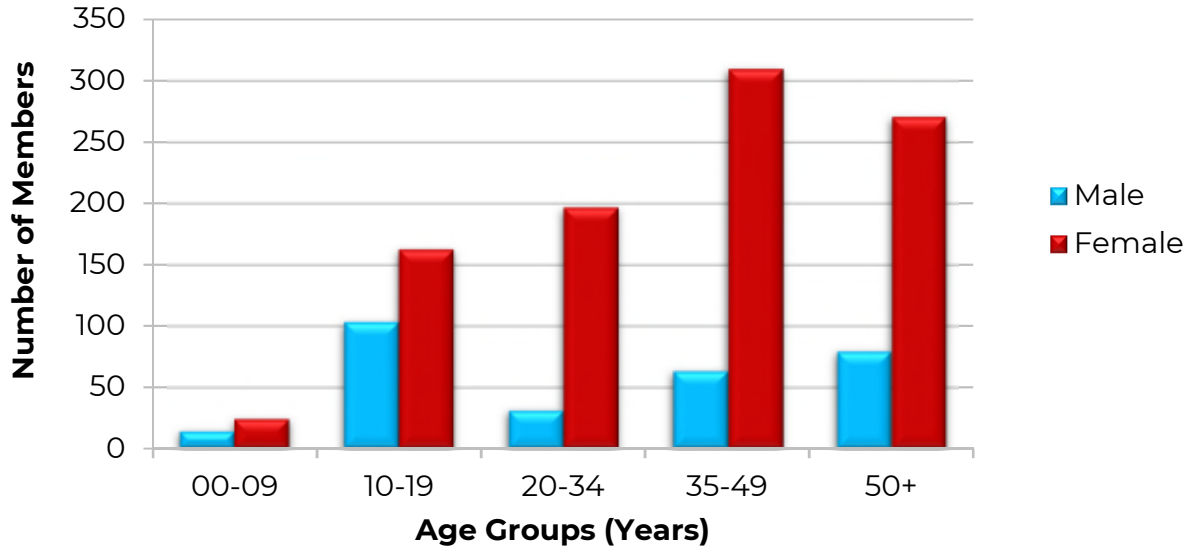
- The increase in cost can be accounted for by price increases for some medications in this class, in addition to increased utilization. However, the consumer price index (CPI) penalty of the federal rebate is designed to keep Medicaid net cost relatively flat despite manufacturer price increases. Additionally, the majority of pharmacy utilization was seen in Tier-2 medications which are supplementally rebated medications. The costs included in this report do not reflect rebated prices or net costs.

Fiscal Year 2021 Utilization: Medical Claims

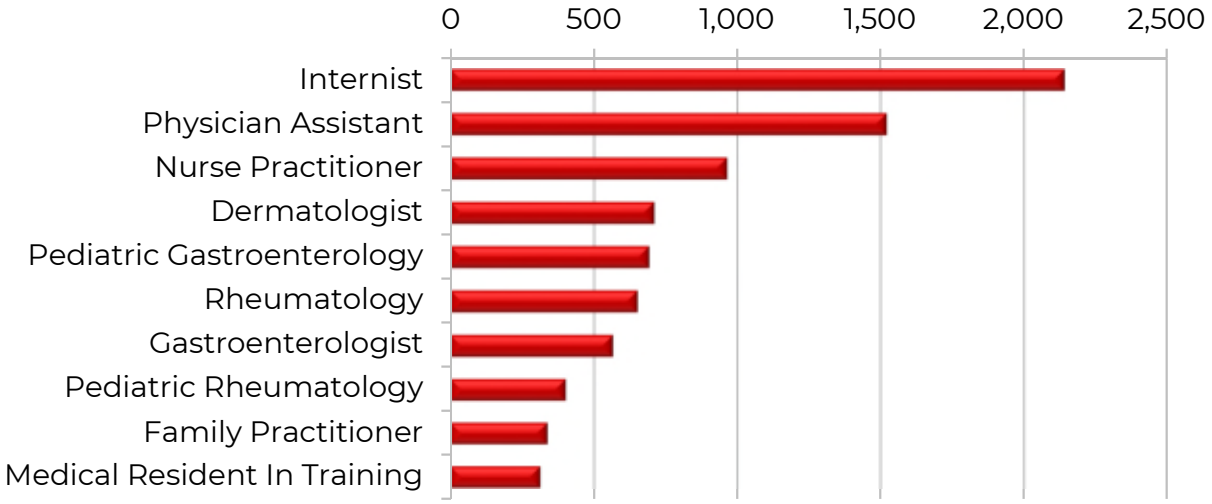
Fiscal Year	*Total Members	†Total Claims	Total Cost	Cost/ Claim	Total Units
2021	310	1,243	$5,986,111.72	$4,815.86	190,613

*Total number of unduplicated utilizing members.
†Total number of unduplicated claims.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021

Demographics of Members Utilizing Targeted Immunomodulator Agents: Pharmacy Claims



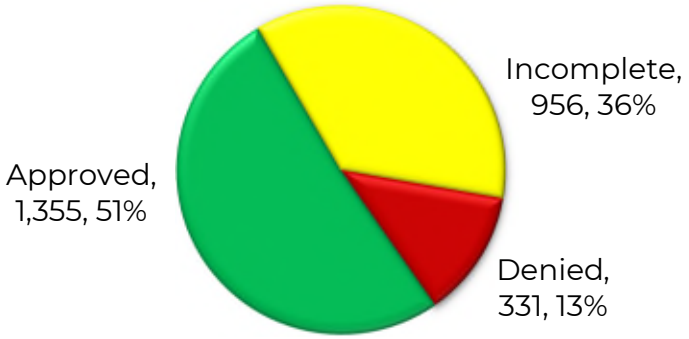
Top Prescriber Specialties of Targeted Immunomodulator Agents by Number of Claims: Pharmacy Claims



Prior Authorization of Targeted Immunomodulator Agents

There were 2,642 prior authorization requests submitted for targeted immunomodulator agents during fiscal year 2021. Computer edits are in place to detect lower tiered medications in a member's claims history and generate automated prior authorizations where possible. The following chart shows the status of the submitted petitions for fiscal year 2021.

Status of Petitions



Market News and Updates[1,2,3,4,5]

New U.S. Food and Drug Administration (FDA) Approval(s):

- **January 2021:** The FDA approved Lupkynis™ (voclosporin) as the first oral therapy in combination with mycophenolate mofetil (MMF) and low dose oral corticosteroids (OCS) for the treatment of lupus nephritis (LN), a condition that can cause irreversible kidney damage. In the pivotal Phase 3 study, AURORA, patients who were on Lupkynis™ plus MMF and low dose OCS were more than 2 times as likely to achieve a complete renal response than those taking placebo plus MMF and low dose OCS. Also, patients in the Lupkynis™ group achieved a 50% reduction in urine protein-to-creatinine ratio (UPCR) twice as fast as those in the placebo arm. UPCR is a standard measurement used to monitor protein levels in the kidney. The most common side effects reported were glomerular filtration rate (GFR) decrease, hypertension, and diarrhea.
- **February 2021:** The FDA expanded the indication for Humira® (adalimumab) to include pediatric patients 5 years of age and older with moderate-to-severe ulcerative colitis (UC). The approval was based on results of the Phase 3 ENVISION I study that evaluated the safety and efficacy of Humira® in pediatric patients 4 to 17 years of age who had moderate-to-severe UC, which was defined as a Full Mayo Score (FMS) of 6 to 12 with an endoscopy sub-score of 2 to 3 points. Clinical remission was defined as a Partial Mayo Score (PMS) or as a FMS ≤2 with no individual sub-score >1. The study results demonstrated that at the higher dosage of Humira®, 60% of patients had clinical remission at week 8 and 45% of patients, who responded at week 8, were in remission at week 52. Patients in the higher dosage group received Humira® at 2.4mg/kg (maximum of 160mg) at weeks 0 and 1, 1.2mg/kg at week 2, and 0.6mg/kg at weeks 4 and 6.
- **August 2021:** The FDA approved Saphnelo™ (anifrolumab) as the first-in-class type I interferon (IFN) receptor antibody for the treatment of

moderate-to-severe systemic lupus erythematosus (SLE) in patients receiving standard therapy. The approval of Saphnelo™ was based on 2 Phase 3 studies (TULIP-1 and TULIP-2) and 1 Phase 2 study (MUSE) that compared the safety and efficacy of Saphnelo™ versus placebo in which both groups received standard therapy which included OCS, antimalarials, and immunosuppressants. In these studies, more patients treated with Saphnelo™ experienced a reduction in overall disease activity across organ systems, including skin and joints, and achieved a sustained reduction in OCS use when compared to placebo. The most common side effects reported were nasopharyngitis, upper respiratory tract infection, and bronchitis.

News:

- **September 2021:** The FDA recently completed a review of safety data from a safety study comparing Xeljanz® (tofacitinib) and Xeljanz® XR [tofacitinib extended-release (ER)] to tumor necrosis factor (TNF) blockers in patients with rheumatoid arthritis (RA) also on methotrexate (MTX). The FDA concluded there is an increased risk of serious events which include myocardial infarction (MI), stroke, cancer, blood clots, and death with tofacitinib. The FDA is now requiring a warning for tofacitinib and 2 other medications in the same class as tofacitinib, known as the Janus kinase (JAK) inhibitors, Olumiant® (baricitinib) and Rinvoq™ (upadacitinib). Two other JAK inhibitors, Jakafi® (ruxolitinib) and Inrebic® (fedratinib), are not indicated for the treatment of arthritis and other inflammatory conditions and are not a part of the warning at this time.

Guideline Update(s):

- **2021 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis:** The recently released guideline contains 44 recommendations (7 strong and 37 conditional) and addresses treatment with disease-modifying antirheumatic drugs (DMARDs), corticosteroids, and use of DMARDs in certain high-risk populations. Below is a list of important takeaways form the current guidelines:
    - MTX monotherapy is recommended as first-line in DMARD-naïve patients with moderate-to-high disease activity as it is preferred over hydroxychloroquine, sulfasalazine, biologic DMARDs (bDMARDs), and targeted synthetic DMARDs (tsDMARDs).
    - For DMARD-naïve patients with low disease activity, hydroxychloroquine is recommended over sulfasalazine, MTX, and leflunomide; sulfasalazine is recommended over MTX and MTX is recommended over leflunomide in patients with low disease activity.

- When initiating MTX, oral MTX is recommend over subcutaneous MTX.
- Long term corticosteroid therapy (≥3 months) is not recommended due to significant toxicities, but short-term use may be necessary to alleviate symptoms prior to the onset of action of DMARDs.
- Addition of a bDMARD or tsDMARD is conditionally recommended over triple therapy (addition of sulfasalazine and hydroxychloroquine) for patients taking maximally tolerated doses of MTX who are not at target.
- Addition of a non-TNF inhibitor bDMARD or tsDMARD is conditionally recommended over addition of a TNF inhibitor for patients with New York Heart Association (NYHA) class III or IV heart failure and an inadequate response to conventional synthetic DMARDs (csDMARDs).

Lupkynis™ (Voclosporin) Product Summary[6]

Indication(s): Voclosporin is a calcineurin-inhibitor immunosuppressant indicated in combination with a background immunosuppressive therapy regimen for the treatment of adult patients with LN.

How Supplied: 7.9mg oral capsule

Dosing:
- Prior to initiating voclosporin, a baseline estimated GFR (eGFR) and blood pressure (BP) needs to be established
- Voclosporin is not recommended in patients with a baseline eGFR ≤45 mL/min/1.73 m^2 unless the benefit exceeds the risk
- Voclosporin should not be initiated in patients with a baseline BP of >165/105mmHg or with a hypertensive emergency
- The recommended starting dose is 23.7mg [(3) 7.9mg capsules] twice daily
- Voclosporin should be swallowed whole on an empty stomach and administered consistently as close to a 12-hour schedule as possible, and with at least 8 hours between doses
- Discontinuation of voclosporin should be considered in patients who do not experience a therapeutic benefit by 24 weeks
- For patients with severe renal impairment or mild-to-moderate hepatic impairment, the recommended dose is 15.8mg [(2) 7.9mg capsules] twice daily

Contraindications:
- Concomitant use of strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin) due to significantly increased exposure to

voclosporin which may increase the risk of acute and/or chronic nephropathy
- Known serious or severe hypersensitivity reaction to voclosporin or any of its excipients

Warnings and Precautions:
- Lymphoma and Other Malignancies: Immunosuppressants, including voclosporin, increase the risk of developing lymphomas and other malignancies, particularly of the skin. Patients should be examined for skin changes and advised to avoid or limit sun exposure and avoid artificial ultraviolet (UV) light by wearing protective clothing and using a broad spectrum sunscreen.
- Serious Infections: Serious infections, including voclosporin, increase the risk of developing bacterial, viral, fungal, and protozoal infections, including opportunistic infections, which may lead to serious, including fatal, outcomes. Patients should be monitored for the development of infection, and the benefits and risks for the individual patient should be considered. The lowest effective dose to maintain response should be used.
- Nephrotoxicity: Like other calcineurin inhibitors, voclosporin may cause acute and/or chronic nephrotoxicity. Renal function should be monitored closely and dosage reduction or discontinuation considered in patients with decreases in eGFR from baseline. Patients with persistent decrease of eGFR should be evaluated for chronic calcineurin inhibitor nephrotoxicity.
- Hypertension (HTN): HTN is a common adverse reaction of voclosporin and may require antihypertensive therapy. BP should be monitored regularly during treatment, and new-onset HTN and exacerbations of pre-existing HTN should be treated.
- Neurotoxicity: Voclosporin, like other calcineurin inhibitors, may cause a spectrum of neurotoxicities, including posterior reversible encephalopathy syndrome (PRES), delirium, seizure, coma, tremors, paresthesias, headache, mental status changes, and changes in motor and sensory functions. Patients should be monitored for neurologic symptoms and dosage reduction or discontinuation considered if neurotoxicity occurs.
- Hyperkalemia: Hyperkalemia, which may be serious and require treatment, has been reported with calcineurin inhibitors, including voclosporin. Concomitant use with agents known to cause hyperkalemia [e.g., potassium-sparing diuretics, angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs)] may increase this risk for hyperkalemia. Serum potassium levels should be monitored periodically during treatment.

- QTc Prolongation: Prolongation of the QTc interval in a dose-dependent manner after single dose administration can occur at doses higher than the recommended LN therapeutic dose. The use of this medication with other medications known to prolong QTc may result in clinically significant QT prolongation.
- Immunizations: Live attenuated vaccines should be avoided during treatment with voclosporin, and inactivated vaccines may not be sufficiently immunogenic during treatment with voclosporin.
- Pure Red Cell Aplasia (PRCA): Cases of PRCA have been reported in patients treated with another calcineurin-inhibitor immunosuppressant. A mechanism for calcineurin-inhibitor-induced PRCA has not been elucidated. If PRCA is diagnosed, discontinuation of voclosporin should be considered.
- Pregnancy: Voclosporin should be avoided in pregnant women due to the alcohol content of the drug formulation; since Lupkynis™ may be used in combination with MMF, caution is advised as MMF use in pregnant women and men whose female partners are pregnant can cause fetal harm.

Mechanism of Action: Voclosporin is a calcineurin-inhibitor immunosuppressant that inhibits lymphocyte proliferation, T-cell cytokine production, and expression of T-cell activation surface antigens. Voclosporin also has a non-immunological role in providing stability to the podocytes found in the kidneys.

Adverse Reactions: The most commonly reported adverse reactions in clinical studies (≥3% and >placebo) include eGFR decrease, HTN, diarrhea, headache, anemia, cough, urinary tract infection, dyspepsia, alopecia, renal impairment, abdominal pain, mouth ulceration, fatigue, tremor, acute kidney injury, and decreased appetite.

Efficacy: The safety and efficacy of voclosporin was established in a 52-week, randomized, double-blind, placebo-controlled study in 357 patients with a diagnosis of SLE and with a kidney biopsy within the past 6 months (or up to 2 years if the patient had a recent LN flare) showing active nephritis. Patients in both arms received background treatment with MMF and low dose OCS.

- Primary Endpoint: The proportion of patients achieving a complete renal response at week 52, which was defined as achieving all of the following: UPCR ≤0.5mg/mg, eGFR ≥60mL/min/1.73 m^2 or no confirmed decrease from baseline in eGFR of >20%, received no rescue medications for LN, and did not receive >10mg prednisone equivalent for ≥3 days or for ≥7 days in total within 8 weeks of the primary endpoint measurement.
- Results: A significantly higher proportion of patients in the voclosporin arm achieved a complete renal response when compared to placebo at

week 24 (32.4% vs. 19.7%; P=0.002) and at week 52 (40.8% vs. 22.5%; P<0.001).

Cost: The Wholesale Acquisition Cost (WAC) of Lupkynis™ is $65.83 per 7.9mg capsule. The estimated annual cost based on the recommended dose of 23.7mg twice daily would be $142,192.80.

Saphnelo™ (Anifrolumab-fnia) Product Summary[7]

Indication(s): Anifrolumab is a type I IFN receptor antagonist indicated for the treatment of adult patients with moderate to severe SLE, who are receiving standard therapy. The efficacy of anifrolumab has not been evaluated in patients with severe active LN or severe active central nervous system (CNS) lupus.

How Supplied: 300mg/2mL (150mg/mL) in a single-dose vial (SDV)

Dosing: The recommended dose is 300mg via intravenous (IV) infusion over 30 minutes every 4 weeks

Warnings and Precautions:

- Serious Infections: Serious and sometimes fatal infections have occurred in patients receiving immunosuppressive agents, including anifrolumab. The risks and benefits of administering anifrolumab should be considered in patients with a chronic infection, history of recurrent infections, or known risk factors for infection. Initiating treatment with anifrolumab should be avoided in patients with any clinically significant active infection until the infection resolves or is adequately treated. Patients should be instructed to seek medical advice if signs or symptoms of clinically significant infection occur.
- Hypersensitivity Reactions: Serious hypersensitivity reactions, including anaphylaxis, have been reported following anifrolumab administration. Angioedema has also been reported. Pre-medication before infusion of anifrolumab should be considered for patients with a history of hypersensitivity or infusion-related reactions. Anifrolumab should be administered by health care providers prepared to manage hypersensitivity reactions, including anaphylaxis, and infusion-related reactions.
- Malignancy: There is an increased risk of malignancies with the use of immunosuppressants. The impact of anifrolumab treatment on the potential development of malignancies is unknown. The individual benefit-risk should be considered in patients with known risk factors for the development or reoccurrence of malignancy prior to prescribing anifrolumab, and the benefit-risk of continued treatment with anifrolumab could be considered in patients who develop malignancies.

- Immunizations: Immunizations should be updated prior to initiating therapy with anifrolumab. Concurrent use of live or live-attenuated vaccines should be avoided in patients treated with anifrolumab.
- Other Biologic Therapies: Anifrolumab has not been studied in combination with other biologic therapies and therefore is not recommended to be used in combination with other biologic therapies

Mechanism of Action: Anifrolumab is a monoclonal antibody that binds to subunit 1 of the type I IFN receptor with a high affinity and blocks plasma cell differentiation and normalizes peripheral T-cell subsets. Type I IFN plays a major role in the pathogenesis of SLE, with approximately 60-80% of adult patients with active SLE expressing elevated levels of type I IFN inducible genes.

Adverse Reactions: The most commonly reported adverse reactions in clinical studies (incidence ≥5% and >placebo) include nasopharyngitis, upper respiratory tract infections, bronchitis, infusion related reactions, herpes zoster, and cough.

Efficacy: The safety and efficacy of anifrolumab were assessed in 2 pivotal Phase 3 studies (TULIP-1 and TULIP-2) and 1 Phase 2b study (MUSE). All 3 studies were multicenter, randomized, double-blind, placebo-controlled and included patients 18 years of age and older with moderate-to-severe SLE with a SLE Disease Activity Index 2000 (SLEDAI-2K) score ≥6 points, organ level involvement based on British Isles Lupus Assessment Group (BILAG) assessment, and a Physician's Global Assessment (PGA) score ≥1, despite receiving standard SLE therapy. Standard SLE therapy included either 1 or any combination of OCS, antimalarials, and/or immunosuppressants at baseline (e.g., prednisone, hydroxychloroquine, MTX). Patients with severe active LN and severe active CNS lupus were excluded from the studies. Patients using biologic agents and cyclophosphamide were also excluded.

- TULIP-1: 457 patients were randomized (1:2:2) to receive anifrolumab 150mg, anifrolumab 300mg, or placebo every 4 weeks. The primary efficacy endpoint evaluated was SLE Responder Index (SRI-4) response. SRI-4 response was defined as meeting each of the following criteria at week 52 compared with baseline: reduction from baseline of ≥4 points in the SLEDAI-2K, no new organ system affected as defined by 1 or more BILAG A or ≥2 BILAG B items compared to baseline, no worsening from baseline in the patients' lupus disease activity defined by an increase ≥0.3 points on a 3-point PGA visual analogue scale (VAS), no discontinuation of treatment, and no use of restricted medications (e.g., cyclosporine, tacrolimus) beyond the protocol-allowed threshold. The study did not meet its primary endpoint based on SRI-4 response, but it did suggest efficacy with respect to the secondary endpoint of British Isles Lupus Assessment Group-based Composite Lupus Assessment

(BICLA) response. BICLA response was defined as meeting each of the following criteria at week 52 compared with baseline: a reduction of all baseline BILAG A to B/C/D and baseline BILAG B to C/D, and no BILAG worsening in other organ systems, as defined by ≥1 new BILAG A or ≥2 new BILAG B, no worsening from baseline in SLEDAI-2K, where worsening is defined as an increase from baseline of >0 points in SLEDAI-2K, no worsening from baseline in patients' lupus disease activity, where worsening is defined by an increase ≥0.3 points on a 3-point PGA VAS, no discontinuation of treatment, and no use of restricted medications beyond the protocol-allowed threshold.

- TULIP-2: 362 patients were randomized (1:1) to receive either anifrolumab 300mg or placebo every 4 weeks. The primary efficacy endpoint evaluated was BICLA response. The study met its primary endpoint, with a higher proportion of patients on anifrolumab having a BICLA response at week 52 when compared to placebo.
- MUSE: 305 patients were randomized (1:1:1) to anifrolumab 300mg, anifrolumab 1,000mg, or placebo every 4 weeks. The primary efficacy endpoint evaluated was the proportion of patients achieving a SRI-4 response at week 24 with sustained OCS reduction from week 12 through week 24. The study met its primary endpoint with more patients treated with anifrolumab 300mg achieving a SRI-4 response when compared to the placebo group.

Cost: The WAC of Saphnelo™ is $4,600.54 per 300mg/2mL SDV. The estimated annual cost based on the recommended dose of 300mg every 4 weeks would be $59,807.02.

Recommendations

The College of Pharmacy recommends the prior authorization of Lupkynis™ (voclosporin) and Saphnelo™ (anifrolumab-fnia) with the following criteria:

Lupkynis™ (Voclosporin) Approval Criteria:

1. An FDA approved indication for the treatment of adults with active lupus nephritis (LN) in combination with a background immunosuppressive therapy regimen; and
    a. Lupkynis™ must be used in combination with mycophenolate mofetil and oral corticosteroids; and
2. Member must be 18 years of age or older; and
3. Lupkynis™ must be prescribed by a nephrologist, rheumatologist, or other specialist with expertise in the treatment of LN; and
4. Member's current urine protein-to-creatinine ratio (UPCR) must be provided and must be ≥1.5mg/mg; and

5. Member's current estimated glomerular filtration rate (eGFR) must be provided and must be >45mL/min/1.73m^2 prior to initiating treatment with Lupkynis™; and
    a. Prescriber must agree to monitor renal function regularly during treatment with Lupkynis™ and modify the dose as needed in accordance with the Lupkynis™ *Prescribing Information*; and
6. Member's current blood pressure (BP) must be ≤165/105mmHg prior to initiating treatment with Lupkynis™; and
    a. Prescriber must agree to monitor BP regularly during treatment with Lupkynis™ and agree to discontinue treatment if BP is >165/105mmHg or member experiences a hypertensive emergency; and
7. Member must not be taking strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin) concomitantly with Lupkynis™; and
8. Prescriber must verify member has been counseled on proper administration of Lupkynis™ including taking on an empty stomach every 12 hours; and
9. Lupkynis™ will not be approved in combination with biologic therapies or cyclophosphamide; and
10. A quantity limit of 180 capsules per 30 days will apply; and
11. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment as indicated by a reduction in the member's UPCR. If the member does not experience therapeutic benefit by 6 months, discontinuation of Lupkynis™ should be considered; and
12. The safety and efficacy of Lupkynis™ have not been established beyond 1 year of treatment. For continued authorization consideration after 1 year of treatment, a patient-specific, clinically significant reason why a longer treatment duration is appropriate for the member must be provided.

Saphnelo™ (Anifrolumab-fnia) Approval Criteria:

1. An FDA approved indication for the treatment of adult patients with moderate-to-severe systemic lupus erythematosus (SLE), who are receiving standard therapy; and
2. Member must be 18 years of age or older; and
3. Documented inadequate response to at least 1 of the following medications appropriate to member's specific disease state:
    a. High-dose oral corticosteroids; or
    b. Methotrexate; or
    c. Azathioprine; or
    d. Mycophenolate; or

e. Cyclophosphamide; or
f. Hydroxychloroquine/chloroquine; and

4. Member must not have severe active lupus nephritis (LN) or severe active central nervous system lupus; and
5. Saphnelo™ will not be approved for combination use with biologic therapies or cyclophosphamide; and
6. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment.

Additionally, the College of Pharmacy recommends the following changes to the Targeted Immunomodulator Agents Product Based Prior Authorization (PBPA) Tier chart based on net costs:

1. Updating the prior authorization criteria for Tier-3 Targeted Immunomodulator Agents; and
2. Moving Kineret® (anakinra), Otezla® (apremilast), Rituxan® (rituximab), Xeljanz® (tofacitinib), Xeljanz® XR (tofacitinib ER), and Xeljanz® oral solution (tofacitinib) from Tier-3 to Tier-2 of the Targeted Immunomodulator Agents PBPA Tier chart (changes noted in red):

Targeted Immunomodulator Agents*±		
Tier-1 (DMARDs appropriate to disease state)	**Tier-2***	**Tier-3**
6-mercaptopurine	adalimumab (Humira®)+	abatacept (Orencia®, Orencia® ClickJect™)≠
azathioprine	**anakinra (Kineret®)**	adalimumab-afzb (Abrilada™)±
hydroxychloroquine	**apremilast (Otezla®)ß**	adalimumab-atto (Amjevita™)±
leflunomide	etanercept (Enbrel®)	adalimumab-adbm (Cyltezo™)±
mesalamine	**rituximab (Rituxan®)~**	adalimumab-bwwd (Hadlima™)±
methotrexate	**tofacitinib (Xeljanz®, Xeljanz® XR, Xeljanz® oral solution)**	adalimumab-fkjp (Hulio®)±
minocycline		adalimumab-adaz (Hyrimoz™)±
NSAIDs		~~**anakinra (Kineret®)**~~
oral corticosteroids		~~**apremilast (Otezla®)ß**~~
sulfasalazine		baricitinib (Olumiant®)
		brodalumab (Siliq™)**
		canakinumab (Ilaris®)¥
		certolizumab pegol (Cimzia®)
		etanercept-szzs (Erelzi®)±
		etanercept-ykro (Eticovo™)±
		golimumab (Simponi®, Simponi® Aria™)
		guselkumab (Tremfya™)
		infliximab (Remicade®)±
		infliximab-axxq (Avsola™)±

Targeted Immunomodulator Agents*±		
Tier-1 (DMARDs appropriate to disease state)	**Tier-2***	**Tier-3**
		infliximab-dyyb (Inflectra™)±
		infliximab-abda (Renflexis™)±
		ixekizumab (Taltz®)
		risankizumab-rzza (Skyrizi™)
		~~rituximab (Rituxan®)~~
		rituximab-abbs (Truxima®)±
		rituximab-arrx (Riabni™)±
		rituximab-pvvr (Ruxience®)±
		sarilumab (Kevzara®)
		secukinumab (Cosentyx®) Ω
		tildrakizumab-asmn (Ilumya™)
		tocilizumab (Actemra®)π
		~~tofacitinib (Xeljanz®, Xeljanz® XR)~~**
		upadacitinib (Rinvoq™)
		ustekinumab (Stelara®)
		vedolizumab (Entyvio®)**

DMARDs = disease modifying anti-rheumatic drugs; NSAIDs = nonsteroidal anti-inflammatory drugs
*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), or Wholesale Acquisition Costs (WAC) if NADAC unavailable. Products may be moved to a higher tier based on net cost if the manufacturer chooses not to participate in supplemental rebates. Appropriate laboratory monitoring must be verified by the prescriber prior to approval.
±Biosimilars or reference products preferred based on lowest net cost product. Authorization of higher net cost biosimilars or reference products requires a patient-specific, clinically significant reason why the member could not use the preferred formulation.
+Unique criteria applies for a diagnosis of hidradenitis suppurativa (HS) and noninfectious intermediate and posterior uveitis and panuveitis.
ß Unique criteria applies for a diagnosis of Behçet's disease (BD).
¥Unique criteria applies for a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), Tumor Necrosis Factor Receptor-Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), Familial Mediterranean Fever (FMF), Systemic Juvenile Idiopathic Arthritis (SJIA), or Adult-Onset Still's Disease (AOSD).
~Unique criteria applies for a diagnosis of pemphigus vulgaris (PV). Unique criteria applies for a diagnosis of granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA).
ΩFor Cosentyx® (secukinumab), only a trial of Humira® from the available Tier-2 medications will be required (based on supplemental rebate participation).
πUnique criteria applies for a diagnosis of giant cell arteritis (GCA) and chimeric antigen receptor (CAR) T-cell-induced cytokine release syndrome (CRS).
≠Orencia® ClickJect™ requires a patient-specific, clinically significant reason why the member cannot use the typical pre-filled syringe formulation.
** Unique criteria applies to this medication for approval.

Targeted Immunomodulator Agents Tier-2 Approval Criteria:

1. An FDA approved diagnosis; and
2. A trial of at least 1 Tier-1 medication in the last 90 days that did not yield adequate relief of symptoms or resulted in intolerable adverse effects; or
3. Prior stabilization on the Tier-2 medication documented within the last 100 days.

Targeted Immunomodulator Agents Tier-3 Approval Criteria:

1. An FDA approved diagnosis; and
2. Recent trials (within the last 360 days) of 1 Tier-1 medication and ~~all available~~ at least 2 Tier-2 medications that did not yield adequate relief of symptoms or resulted in intolerable adverse effects; or
3. Prior stabilization on the Tier-3 medication documented within the last 100 days; or
4. A unique FDA-approved indication not covered by Tier-2 medications.

Actemra® (Tocilizumab) Approval Criteria [Chimeric Antigen Receptor (CAR) T-Cell-Induced Cytokine Release Syndrome (CRS) Diagnosis]:

1. An FDA approved diagnosis of CAR T cell-induced CRS.

Actemra® (Tocilizumab) Approval Criteria [Giant Cell Arteritis (GCA) Diagnosis]:

1. An FDA approved diagnosis of GCA; and
2. Member must be 50 years of age or older; and
3. A history of erythrocyte sedimentation rate (ESR) of ≥30mm/hr or a history of C-reactive protein (CRP) ≥1mg/dL; and
4. Member should have a trial of corticosteroids for a minimum of 4 weeks or a reason why this is not appropriate must be provided; and
5. Actemra® must be taken in combination with tapering course of a corticosteroids upon initiation; and
6. Member must have baseline liver enzymes, absolute neutrophil count (ANC), lipid panel, and platelet count and verification that they are acceptable to prescriber; and
7. Member must not have severe hepatic impairment; and
8. Actemra® should not be initiated in members with active or chronic infection including hepatitis B, hepatitis C, human immunodeficiency virus, or tuberculosis; and
9. Approval quantity will be based on Actemra® *Prescribing Information* and FDA approved dosing regimen(s).

Benlysta® (Belimumab) Approval Criteria:

1. The intravenous (IV) formulation will be covered as a medical only benefit while the subcutaneous (sub-Q) formulation will be covered as a pharmacy only benefit; and
2. An FDA approved indication of 1 of the following:
   a. The treatment of members 5 years of age and older with active, autoantibody-positive, systemic lupus erythematosus (SLE) already receiving standard therapy; or
   b. The treatment of members 18 years of age and older with active lupus nephritis (LN) who are receiving standard therapy; and

3. Documented inadequate response to at least 2 of the following medications appropriate to member's specific disease state:
    a. High-dose oral corticosteroids; or
    b. Methotrexate; or
    c. Azathioprine; or
    d. Mycophenolate; or
    e. Cyclophosphamide; or
    f. Hydroxychloroquine/chloroquine; and
4. Member must not have severe active central nervous system lupus; and
5. Benlysta® will not be approved for combination use with biologic therapies; and
6. Benlysta® will not be approved for combination use with IV cyclophosphamide (exception for induction treatment with IV cyclophosphamide for members with a diagnosis of LN).

Entyvio® (Vedolizumab) Approval Criteria:

1. Member must be 18 years of age or older; and
2. An FDA approved diagnosis of moderate-to-severely active Crohn's disease (CD) or moderate-to-severely active ulcerative colitis (UC); and
3. A minimum of a 4 week trial of a Tier-2 tumor necrosis factor (TNF) blocker indicated for the treatment of CD or UC that did not yield adequate relief of symptoms or resulted in intolerable adverse effects. Current Tier-2 medications include the following:
    a. UC: Humira® (adalimumab); or
    b. CD: Humira® (adalimumab); or
4. Prior stabilization on the medication documented within the last 100 days; and
5. A quantity limit of 300mg every 8 weeks will apply. Approvals will be granted for titration quantities required for initial dosing; and
6. Initial approvals will be for the duration of 14 weeks as Entyvio® should be discontinued in patients who do not show evidence of therapeutic benefit by week 14.

Humira® (Adalimumab) Approval Criteria [Hidradenitis Suppurativa (HS) Diagnosis]:

1. A diagnosis of moderate-to-severe HS; and
2. Hurley Stage II or III disease; and
3. Member must have at least 3 abscesses or inflammatory nodules; and
4. Previous failure of at least 2 of the following: topical or systemic antibiotics, oral or intralesional corticosteroids, dapsone, cyclosporine, antiandrogens (spironolactone or oral contraceptives), finasteride, or surgery.

Humira® (Adalimumab) Approval Criteria [Noninfectious Intermediate and Posterior Uveitis or Panuveitis Diagnosis]:

1. A diagnosis of noninfectious intermediate uveitis, posterior uveitis, or panuveitis in members 2 years of age and older; and
2. A failed trial with a corticosteroid injection or systemic corticosteroid in which member has had an inadequate response; or
3. A patient-specific, clinically significant reason a trial of corticosteroid treatment is inappropriate for the member must be provided.

Ilaris® (Canakinumab) Approval Criteria [Active Systemic Juvenile Idiopathic Arthritis (SJIA) or Adult-Onset Still's Disease (AOSD) Diagnosis]:

1. An FDA approved indication of SJIA or AOSD; and
2. The member should not be using a tumor necrosis factor (TNF) blocking agent (e.g., adalimumab, etanercept, infliximab) or anakinra; and
3. Ilaris® should not be initiated in members with active or chronic infection including hepatitis B, hepatitis C, human immunodeficiency virus, or tuberculosis; and
4. Dosing should not be more often than once every 4 weeks; and
    a. Weight-based dosing in members 2 years of age and older (the member's recent weight must be provided):
        i. Body weight ≥7.5kg: 4mg/kg subcutaneous injection every 4 weeks (maximum 300mg/dose); and
5. Recent trials of 1 Tier-1 medication and all appropriate Tier-2 medications that did not yield adequate relief of symptoms or resulted in intolerable adverse effects; or
6. Prior stabilization on the Tier-3 medication documented within the last 100 days; and
7. Approvals will be for the duration of 1 year.

Ilaris® (Canakinumab) Approval Criteria [Cryopyrin-Associated Periodic Syndromes (CAPS) Diagnosis]:

1. An FDA approved indication of CAPS verified by genetic testing [which includes Familial Cold Auto-Inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)] in adults and children 4 years of age and older; and
2. Member must not be using a tumor necrosis factor (TNF) blocking agent (e.g., adalimumab, etanercept, infliximab) or anakinra; and
3. Ilaris® should not be initiated in members with active or chronic infection including hepatitis B, hepatitis C, human immunodeficiency virus, or tuberculosis; and
4. The following dosing requirements must be met:
    a. Dosing should not be more often than once every 8 weeks; and

b. Weight-based dosing (the member's recent weight must be provided):
    i. Body weight >40kg: 150mg; or
    ii. Body weight 15kg to 40kg: 2mg/kg. If inadequate response, dose may be increased to 3mg/kg; and
5. Approvals will be for the duration of 1 year.

Ilaris® (Canakinumab) Approval Criteria [Tumor Necrosis Factor Receptor-Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), or Familial Mediterranean Fever (FMF) Diagnosis]:

1. A diagnosis of TRAPS with chronic or recurrent disease activity defined as 6 flares per year; or
2. A diagnosis of HIDS/MKD; or
3. A diagnosis of FMF with documented active disease despite colchicine therapy or documented intolerance to effective doses of colchicine; and
4. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

Orencia® ClickJect™ (Abatacept) Approval Criteria:

1. Member must meet Tier-3 trial requirements; and
2. A patient-specific, clinically significant reason why the member cannot use the typical pre-filled syringe formulation must be provided.

Otezla® (Apremilast) Approval Criteria [Behçet's Disease (BD) Diagnosis]:

1. An FDA approved indication for the treatment of oral ulcers associated with BD; and
2. Member must have had oral ulcers at least 3 times in the last 12 month period; and
3. Member must have had a 2 week trial of the following that resulted in inadequate efficacy or intolerable adverse effects (or be contraindicated for the member):
    a. Topical corticosteroids (applied topically to the mouth); and
    b. Colchicine; and
4. Quantity limits according to package labeling will apply.

Rituxan® (Rituximab) Approval Criteria [Granulomatosis with Polyangiitis (GPA, Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA) Diagnosis]:

1. An FDA approved diagnosis of GPA or MPA in adult and pediatric members 2 years of age and older; and
2. Rituxan® must be used in combination with corticosteroids; and
3. Approval quantity will be based on Rituxan® *Prescribing Information* and FDA approved dosing regimen(s).

Rituxan® (Rituximab) Approval Criteria [Pemphigus Vulgaris (PV) Diagnosis]:

1. A diagnosis of moderate-to-severe PV; and
2. Rituxan® must be used in combination with a tapering course of corticosteroids; and
3. Initial approvals will be for (2) 1,000mg intravenous (IV) infusions separated by 2 weeks and a 500mg IV infusion at month 12. Subsequent approvals may be authorized based on 6 month evaluations or upon relapse no sooner than 16 weeks after the previous infusion.

Siliq® (Brodalumab) Approval Criteria:

1. Member must meet Tier-3 approval criteria; and
2. Members must also be enrolled in the Siliq® REMS Program for approval; and
3. Members with a concomitant diagnosis of Crohn's disease will not be approved; and
4. Initial authorizations of Siliq® (brodalumab) will be for the duration of 12 weeks at which time the prescriber must verify the member is responding to treatment. If an adequate response has not been achieved after 12 to 16 weeks of treatment with brodalumab, consideration should be given to discontinuing therapy.

Xeljanz® (Tofacitinib Oral Solution) Approval Criteria:

1. Member must meet Tier-2 approval criteria; and
2. An age restriction of 2 years of age to 10 years of age will apply. Members older than 10 years of age require a patient-specific, clinically significant reason why the oral tablet formulation cannot be used.

~~**Xeljanz® (Tofacitinib) Approval Criteria:**~~

~~1. Member must meet Tier-3 approval criteria; and~~
~~2. Member must have a negative tuberculosis test, successful treatment of active tuberculosis, or close evaluation and appropriate treatment of latent tuberculosis; and~~
~~3. Severe hepatic impairment has been ruled out; and~~
~~4. Approval will be for 12 weeks, after which time, prescriber must confirm performance of the following tests (and verification that the results are acceptable to prescriber) for further approval:~~
~~a. Lymphocytes; and~~
~~b. Neutrophils; and~~
~~c. Hemoglobin; and~~
~~d. Liver enzymes; and~~
~~e. Lipid panel; and~~

~~5. Subsequent approvals will be for the duration of 1 year. Yearly approvals require performance of repeat tuberculosis test.~~

~~**Xeljanz® XR [Tofacitinib Extended-Release (ER)] Approval Criteria:**~~

~~1. Member must meet Tier-3 approval criteria and all Xeljanz® approval criteria; and~~
~~2. A patient-specific, clinically significant reason why the member cannot take the twice daily formulation of Xeljanz® must be provided.~~

Lastly, the College of Pharmacy recommends the following changes to the criteria for the Targeted Immunomodulator Agents that have biosimilar product(s) (changes noted in red):

Abrilada™ (Adalimumab-afzb), Amjevita™ (Adalimumab-atto), Cyltezo™ (Adalimumab-adbm), Hadlima™ (Adalimumab-bwwd), Hulio® (Adalimumab-fkjp), and Hyrimoz™ (Adalimumab-adaz) Approval Criteria:

1. Member must meet Tier-3 trial requirements; and
2. A patient-specific, clinically significant reason why the member cannot use Humira® (adalimumab) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Erelzi® (Etanercept-szza) and Eticovo™ (Etanercept-ykro) Approval Criteria:

1. Member must meet Tier-3 trial requirements; and
2. A patient-specific, clinically significant reason why the member cannot use Enbrel® (etanercept) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

~~**Avsola® (Infliximab-axxq),**~~ **Inflectra® (Infliximab-dyyb) and Remicade® (Infliximab), ~~and Renflexis® (Infliximab-abda)~~ Approval Criteria:**

1. Member must meet Tier-3 trial requirements; and
2. A patient-specific, clinically significant reason why the member cannot use ~~Remicade® (infliximab)~~ Avsola® (infliximab-axxq) and Renflexis® (infliximab-abda) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Riabni™ (Rituximab-arrx), Ruxience® (Rituximab-pvvr), and Truxima® (Rituximab-abbs) Approval Criteria:

1. Member must meet Tier-3 trial requirements; and
2. A patient-specific, clinically significant reason why the member cannot use Rituxan® (rituximab) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Utilization Details of Targeted Immunomodulator Agents: Fiscal Year 2021

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM
TIER-2 PRODUCTS					
ADALIMUMAB PRODUCTS					
HUMIRA PEN INJ 40MG/0.4ML	2,862	480	$19,472,601.83	5.96	$6,803.84
HUMIRA INJ 40MG/0.4ML	538	98	$3,388,531.11	5.49	$6,298.38
HUMIRA PEN INJ 40MG/0.8ML	473	81	$3,386,042.45	5.84	$7,158.65
HUMIRA INJ 20MG/0.2ML	192	30	$1,254,704.66	6.4	$6,534.92
HUMIRA KIT 40MG/0.8ML	141	31	$921,419.92	4.55	$6,534.89
HUMIRA PEN KIT CD/UC/HS	86	84	$1,463,283.33	1.02	$17,014.92
HUMIRA PEN KIT PS/UV	40	39	$452,952.60	1.03	$11,323.82
HUMIRA INJ 10MG/0.1ML	21	3	$121,459.29	7	$5,783.78
HUMIRA PEN INJ 80MG/0.8ML	17	9	$203,073.27	1.89	$11,945.49
HUMIRA PED INJ CROHNS	11	11	$94,279.11	1	$8,570.83
HUMIRA PEN INJ CD/UC/HS	5	4	$84,660.92	1.25	$16,932.18
HUMIRA PEN KIT PED UC	4	4	$95,534.44	1	$23,883.61
HUMIRA PED INJ CROHNS	2	2	$35,832.06	1	$17,916.03
HUMIRA PEN INJ PS/UV	1	1	$11,614.03	1	$11,614.03
SUBTOTAL	**4,393**	**877**	**$30,985,989.02**	**5.01**	**$7,053.49**
ETANERCEPT PRODUCTS					
ENBREL SRCLK INJ 50MG/ML	1,216	209	$7,021,322.84	5.82	$5,774.11
ENBREL INJ 50MG/ML	231	47	$1,340,380.01	4.91	$5,802.51
ENBREL MINI INJ 50MG/ML	100	21	$520,540.40	4.76	$5,205.40
ENBREL INJ 25MG/0.5ML	71	12	$216,718.16	5.92	$3,052.37
ENBREL INJ 25MG/0.5ML PFS	55	8	$155,003.18	6.88	$2,818.24
ENBREL INJ 25MG/0.5ML	4	3	$14,966.04	1.33	$3,741.51
SUBTOTAL	**1,677**	**300**	**$9,268,930.63**	**5.59**	**$5,527.09**
TIER-2 SUBTOTAL	**6,070**	**1,177**	**$40,254,919.65**	**5.16**	**$6,631.78**
TIER-3 PRODUCTS					
ABATACEPT PRODUCTS					
ORENCIA INJ 125MG/ML	191	31	$880,013.00	6.16	$4,607.40
ORENCIA CLICKJET INJ 125MG/ML	77	17	$355,943.08	4.53	$4,622.64
ORENCIA INJ 250MG	36	5	$95,925.79	7.2	$2,664.61
ORENCIA INJ 50MG/0.4ML	9	1	$10,419.07	9	$1,157.67

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM
ORENCIA INJ 87.5MG/0.7ML	5	1	$23,265.15	5	$4,653.03
SUBTOTAL	**318**	**55**	**$1,365,566.09**	**5.78**	**$4,294.23**
SECUKINUMAB PRODUCTS					
COSENTYX PEN INJ 300MG	238	35	$1,455,098.24	6.8	$6,113.86
COSENTYX PEN INJ 150MG/ML	28	8	$208,648.66	3.5	$ 7,451.74
COSENTYX INJ 300MG	24	4	$158,085.18	6	$6,586.88
SUBTOTAL	**290**	**47**	**$1,821,832.08**	**6.17**	**$ 6,282.18**
TOFACITINIB PRODUCTS					
XELJANZ TAB 5MG	208	48	$944,017.50	4.33	$4,538.55
XELJANZ XR TAB 11MG	56	9	$260,549.51	6.22	$4,652.67
XELJANZ TAB 10MG	12	5	$47,303.00	2.4	$3,941.92
SUBTOTAL	**276**	**62**	**$1,251,870.01**	**4.45**	**$4,535.76**
USTEKINUMAB PRODUCTS					
STELARA INJ 90MG/ML	155	34	$3,535,730.77	4.56	$22,811.17
STELARA INJ 45MG/0.5ML	41	14	$479,254.06	2.93	$11,689.12
STELARA INJ 45MG/0.5ML	15	5	$177,170.3	3	$11,811.36
STELARA INJ 5MG/ML	7	7	$34,035.15	1	$4,862.16
SUBTOTAL	**218**	**60**	**$4,226,190.36**	**3.63**	**$19,386.19**
APREMILAST PRODUCTS					
OTEZLA TAB 30MG	197	33	$679,020.03	5.97	$3,446.80
OTEZLA TAB 10/20/30MG	19	18	$70,271.58	1.06	$3,698.50
SUBTOTAL	**216**	**51**	**$749,291.61**	**4.24**	**$3,468.94**
IXEKIZUMAB PRODUCTS					
TALTZ INJ 80MG/ML	142	19	$993,134.62	7.47	$6,993.91
TALTZ INJ 80MG/ML	35	4	$229,110.95	8.75	$6,546.03
SUBTOTAL	**177**	**23**	**$1,222,245.57**	**7.70**	**$6,905.34**
INFLIXIMAB PRODUCTS					
REMICADE INJ 100MG	165	36	$964,744.03	4.58	$5,846.93
SUBTOTAL	**165**	**36**	**$964,744.03**	**4.58**	**$5,846.93**
TOCILIZUMAB PRODUCTS					
ACTEMRA INJ 162MG/0.9ML	69	10	$239,603.97	6.9	$3,472.52
ACTEMRA INJ ACTPEN 162MG/0.9ML	53	9	$210,770.45	5.89	$3,976.80
ACTEMRA INJ 400MG/20ML	18	3	$41,709.78	6	$2,317.21
ACTEMRA INJ 200MG/10ML	6	2	$10,444.56	3	$1,740.76
ACTEMRA INJ 80MG/4ML	1	1	$472.57	1	$472.57
SUBTOTAL	**147**	**25**	**$503,001.33**	**5.88**	**$3,421.78**
CERTOLIZUMAB PRODUCTS					
CIMZIA PREFL KIT 200MG/ML	101	20	$513,817.76	5.05	$5,087.30
CIMZIA START KIT 200MG/ML	13	13	$181,555.37	1	$13,965.80
SUBTOTAL	**114**	**33**	**$695,373.13**	**3.45**	**$6,099.76**
UPADACITINIB PRODUCTS					
RINVOQ TAB 15MG ER	86	20	$430,169.57	4.30	$5,001.97
SUBTOTAL	**86**	**20**	**$430,169.57**	**4.30**	**$5,001.97**
CANAKINUMAB PRODUCTS					
ILARIS INJ 150MG/ML	66	11	$1,141,598.40	6.00	$17,296.95
SUBTOTAL	**66**	**11**	**$1,141,598.40**	**6.00**	**$17,296.95**

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM
VEDOLIZUMAB PRODUCTS					
ENTYVIO INJ 300MG	50	12	$295,152.08	4.17	$5,903.04
SUBTOTAL	**50**	**12**	**$295,152.08**	**4.17**	**$5,903.04**
GOLIMUMAB PRODUCTS					
SIMPONI INJ 50MG/0.5ML	42	7	$209,326.08	6	$4,983.95
SIMPONI INJ 100MG/ML	5	1	$30,300.35	5	$6,060.07
SUBTOTAL	**47**	**8**	**$239,626.43**	**5.88**	**$5,098.43**
GUSELKUMAB PRODUCTS					
TREMFYA INJ 100MG/ML	19	5	$232,362.59	3.8	$12,229.61
TREMFYA INJ 100MG/ML	16	6	$179,913.72	2.67	$11,244.61
SUBTOTAL	**35**	**11**	**$412,276.31**	**3.18**	**$11,779.32**
RISANKIZUMAB PRODUCTS					
SKYRIZI INJ 150MG	25	9	$414,971.07	2.78	$16,598.84
SUBTOTAL	**25**	**9**	**$414,971.07**	**2.78**	**$16,598.84**
SARILUMAB PRODUCTS					
KEVZARA INJ 200MG/1.14ML	25	5	$87,426.82	5.00	$3,497.07
SUBTOTAL	**25**	**5**	**$87,426.82**	**5.00**	**$3,497.07**
ANAKINRA PRODUCTS					
KINERET INJ 100MG/0.67ML	17	3	$80,274.69	5.67	$4,722.04
SUBTOTAL	**17**	**3**	**$80,274.69**	**5.67**	**$4,722.04**
BARICITINIB PRODUCTS					
OLUMIANT TAB 2MG	11	2	$25,564.91	5.50	$2,324.08
SUBTOTAL	**11**	**2**	**$25,564.91**	**5.50**	**$2,324.08**
BRODALUMAB PRODUCTS					
SILIQ INJ 210MG/1.5ML	9	1	$38,538.29	9.00	$4,282.03
SUBTOTAL	**9**	**1**	**$38,538.29**	**9.00**	**$4,282.03**
TIER-3 SUBTOTAL	**2,292**	**474**	**$15,965,712.78**	**4.84**	**$6,965.84**
BELIMUMAB PRODUCTS					
BENLYSTA INJ 200MG/ML	185	31	$704,263.18	5.97	$3,806.83
BENLYSTA INJ 200MG/ML	2	1	$7,593.72	2	$3,796.86
BELIMUMAB SUBTOTAL	**187**	**32**	**$711,856.90**	**5.84**	**$3,806.72**
TOTAL	**8,549**	**1,251***	**$56,932,489.33**	**6.83**	**$6,659.55**

CD = Crohn's disease; ER = extended-release; HS = hidradenitis suppurativa; INJ = injection; PED = pediatric; PREFL = prefilled; PS = psoriasis; SRCLK = SureClick; SYG = syringe; TAB = tablet; UC = ulcerative colitis; UV = uveitis

*Total number of unduplicated utilizing members.

Costs do not reflect rebated prices or net costs.

Fiscal Year 2021 = 07/01/2020 to 06/30/2021

Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
REMICADE INJ (J1745)	311	67	$807,772.06	$2,597.34	4.64
RITUXAN INJ (J9312)	229	98	$1,827,159.75	$7,978.86	2.34
BENLYSTA INJ (J0490)	187	34	$876,267.85	$4,685.92	5.50
ENTYVIO INJ (J3380)	146	33	$886,735.00	$6,073.53	4.42
ORENCIA INJ (J0129)	119	25	$520,161.36	$4,371.10	4.76
SIMPONI ARIA INJ (J1602)	114	36	$443,820.51	$3,893.16	3.17
ACTEMRA INJ (J3262)	97	11	$260,458.00	$2,685.13	8.82
STELARA INJ (J3357)	25	10	$322,618.80	$12,904.75	2.50
CIMZIA INJ (J0717)	15	4	$41,118.39	$2,741.23	3.75
TOTAL	**1,243⁺**	**310***	**$5,986,111.72**	**$4,815.86**	**4.01**

INJ = injection
⁺Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021

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Appendix J

30-Day Notice to Prior Authorize Bylvay™ (Odevixibat)

Oklahoma Health Care Authority
October 2021

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

Progressive familial intrahepatic cholestasis (PFIC) is a group of rare, autosomal recessive genetic disorders which result in the disruption of bile formation and cholestasis. Some forms of the disorder present in early infancy, while other forms may present later in childhood or early adulthood. In many cases, PFIC progresses to cirrhosis, liver failure, and death in infancy or adolescence. The estimated incidence of PFIC is 1 in 50,000 to 1 in 100,000 births worldwide, with males and females being equally affected.

Three primary types of PFIC have been identified and are caused by mutations in genes related to hepatocellular transport systems involved in bile formation. PFIC type 1 (PFIC-1) is caused by mutations in the *ATP8B1* gene encoding the familial intrahepatic cholestasis 1 (FIC1) protein. PFIC type 2 (PFIC-2) is caused by mutations in the *ABCB11* gene encoding the bile salt export pump (BSEP) protein. PFIC type 3 (PFIC-3) is caused by mutations in the *ABCB4* gene encoding the multi-drug resistant 3 (MDR3) protein. PFIC-1 and PFIC-2 are primarily associated with defects in bile salt secretion, while PFIC-3 is primarily associated with defects in biliary phospholipid secretion. Impaired bile salt secretion leads to reduced bile flow, accumulation of bile salts in hepatocytes, and progressive hepatocellular damage. Phospholipids are important for neutralizing the detergent effect of hydrophobic bile salts. Impaired phospholipid secretion in PFIC-3 can result in the injury of biliary epithelium and bile canaliculi, leading to cholestasis. Additionally, phospholipids in bile help to stabilize cholesterol in micelles; therefore, cholesterol crystallization can occur in PFIC-3, leading to increased formation of bile stones, obstruction of bile ducts, and further damage to the liver.

One of the most common and distressing symptoms of PFIC is severe pruritus, particularly in PFIC-1 and PFIC-2 patients. The specific cause of cholestatic pruritus is unknown. One proposed mechanism involves the stimulation of nonmyelinated subepidermal free nerve ends due to increased serum bile acids, although other possible causes, such as increased endogenous opioids or increased autotaxin-lysophosphatidic acid, have also been suggested. The severe, intractable pruritus experienced by some PFIC patients can have a major impact on quality of life and may lead to scarring, sleep deprivation, fatigue, and depression. In some refractory cases, persistent pruritus can be an indication for liver transplantation even in the absence of liver failure.

The diagnosis of PFIC is based on a combination of clinical manifestations, laboratory evaluation, liver ultrasonography, cholangiography, liver biopsy, histology, electron microscopy of bile composition, and genetic testing. Additionally, other more common liver and biliary diseases (e.g., biliary atresia, Alagille syndrome, alpha-1 antitrypsin deficiency, cystic fibrosis, sclerosing cholangitis, biliary obstruction) should be excluded first.

Treatment options for patients with PFIC are limited. Fat-soluble vitamin (FSV; vitamins A, D, E, and K) supplementation is commonly given to ensure proper absorption and avoid FSV deficiency. Medications such as ursodeoxycholic acid (UDCA), cholestyramine, rifampin, sertraline, and naltrexone can be used off-label to help relieve pruritus. Despite the use of these medications, many patients with PFIC continue to experience intolerable pruritus, and surgical interventions such as biliary diversion procedures and liver transplantation are often necessary. PFIC is 1 of the 5 most common indications for liver transplantation in children. Liver transplantation can improve cholestasis and relieve the symptoms associated with PFIC, but is associated with morbidity and mortality risks and the need for lifelong immunosuppression.

In July 2021, the U.S. Food and Drug Administration (FDA) approved Bylvay™ (odevixibat) as the first approved therapy for the treatment of pruritus in patients with PFIC.

Bylvay™ (Odevixibat) Product Summary[6,7,8]

Indication(s): Bylvay™ (odevixibat) is an ileal bile acid transporter (IBAT) inhibitor indicated for the treatment of pruritus in patients 3 months of age and older with PFIC.

Limitations of Use:

- Bylvay™ may not be effective in PFIC-2 patients with *ABCB11* variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3).

How Supplied: 200mcg and 600mcg oral pellets; 400mcg and 1,200mcg oral capsules

Dosing and Administration:

- 40mcg/kg by mouth once daily in the morning with a meal
- If no improvement in pruritus after 3 months, dose may be increased in 40mcg/kg increments up to 120mcg/kg once daily, not to exceed 6mg per day
- The oral pellets are intended for use by patients weighing <19.5kg:

    - The capsule containing the oral pellets should be opened and the contents mixed into soft food (e.g., apple sauce, oatmeal, banana or carrot puree, chocolate or rice pudding)
    - After mixing, the entire dose should be administered immediately and followed with water
    - The capsule contents should not be mixed in liquids
    - The capsule containing the pellets should not be swallowed, chewed, or crushed
- The oral capsules are intended for use by patients weighing ≥19.5kg:
    - Capsules should be swallowed whole with a glass of water
    - For patients unable to swallow the capsule whole, the capsules may be opened, sprinkled, and mixed with a small amount of soft food

Mechanism of Action: Odevixibat is a reversible inhibitor of the IBAT. Inhibition of the IBAT results in reduced reabsorption of bile acids from the terminal ileum. The complete mechanism by which odevixibat improves pruritus in patients with PFIC is unknown; however, it may involve inhibition of the IBAT leading to reduced reuptake of bile salts and decreased serum bile acids.

Contraindication(s): None

Safety:

- Liver Test Abnormalities: Patients with PFIC may have abnormal liver tests at baseline. During the Phase 3 study of odevixibat, treatment-emergent elevations or worsening of liver tests relative to baseline values were observed, including elevations in aspartate aminotransferase (AST), alanine aminotransferase (ALT), total bilirubin, and direct bilirubin. Baseline liver tests should be obtained before initiating treatment with odevixibat and should be monitored during treatment. Dose reductions or treatment interruptions should be considered if liver test abnormalities occur, and treatment discontinuation should be considered for persistent or recurrent liver test abnormalities. Odevixibat was not studied in PFIC patients with cirrhosis. Liver tests should be closely monitored and odevixibat should be permanently discontinued if the patient progresses to portal hypertension or experiences a hepatic decompensation event during treatment.
- Diarrhea: In the Phase 3 study of odevixibat, diarrhea was reported in 39% of patients treated with odevixibat 40mcg/kg/day, 21% of patients treated with odevixibat 120mcg/kg/day, and 10% of patients who received placebo. Treatment interruptions, lasting from 3 to 7 days, due to diarrhea occurred in 2 patients with 3 events in the odevixibat 120mcg/kg/day treatment group. One patient in the 120mcg/kg/day

group withdrew from the study due to persistent diarrhea. Patients who experience diarrhea during treatment with odevixibat should be monitored for dehydration and dehydration should be promptly treated if it occurs. If a patient experiences persistent diarrhea, treatment with odevixibat should be interrupted, and may be restarted at the initial 40mcg/kg/day dose when diarrhea resolves. Treatment with odevixibat should be discontinued if diarrhea persists and no alternate etiology is identified.

- FSV Deficiency: Patients with PFIC may have FSV deficiency at baseline. Treatment with odevixibat may affect absorption of FSVs. In the Phase 3 study of odevixibat, new onset or worsening of FSV deficiency was observed in 5% of placebo patients, 16% of patients in the 120mcg/kg/day treatment group, and none of the patients in the 40mcg/kg/day treatment group. Baseline FSV levels should be obtained before initiating treatment with odevixibat and during treatment. If FSV deficiency is diagnosed during treatment, FSV supplementation should be given. Odevixibat should be discontinued if FSV deficiency persists or worsens despite adequate FSV supplementation.
- Pregnancy: There are no human data available on the use of odevixibat in pregnant women to evaluate the drug-associated risk of major birth defects, miscarriage, or adverse developmental outcomes. Studies in animals suggest odevixibat may cause cardiac malformations when a fetus is exposed during pregnancy.
- Lactation: There are no data available on the presence of odevixibat in human milk, the effects on the breastfed child, or the effects of the drug on milk production. Following oral administration, absorption of odevixibat is low and breastfeeding is not expected to result in exposure of the infant to odevixibat at the recommended doses. Odevixibat may reduce absorption of FSVs. Levels of FSVs should be monitored, and intake should be increased, if FSV deficiency is observed during lactation.
- Pediatric Use: The safety and efficacy of odevixibat have been established in pediatric patients 3 months to 17 years of age for the treatment of pruritus in PFIC. Use of odevixibat in this age range is supported by evidence from 2 studies: a randomized, double-blind, placebo-controlled, 24-week study in 62 patients with confirmed PFIC-1 or PFIC-2 and a single-arm, open-label, 72-week extension study in 79 patients with PFIC (regardless of subtype). The safety and efficacy of odevixibat have not been established in patients younger than 3 months of age.
- Geriatric Use: The safety and efficacy of odevixibat for the treatment of pruritus in PFIC in adult patients, including those 65 years of age and older, have not been established.

- Hepatic Impairment: Patients with PFIC may have impaired hepatic function at baseline. The efficacy and safety of odevixibat in patients with clinically significant portal hypertension and in patients with decompensated cirrhosis have not been established.

Adverse Reactions: The most common adverse reactions in the Phase 3 study of odevixibat were diarrhea, liver test abnormalities, vomiting, abdominal pain, and FSV deficiency.

Efficacy: The efficacy of odevixibat for the treatment of pruritus in PFIC was assessed in the Phase 3 PEDFIC 1 study, a 24-week, randomized, double-blind, placebo-controlled study in 62 pediatric patients, 6 months to 17 years of age. The median age in the study was 3.2 years (range: 0.5 to 15.9 years of age). Patients were randomized to receive placebo (N=20), odevixibat 40mcg/kg/day (N=23), or odevixibat 120mcg/kg/day (N=19) once daily in the morning with a meal.

- Inclusion Criteria: All patients had genetically confirmed PFIC-1 or PFIC-2 and presence of significant pruritus (average caregiver-reported observed scratching score ≥2 at baseline (on a scale of 0 to 4, with higher scores indicating worse symptoms). Additionally, all patients had elevated serum bile acid levels ≥100µmol/L prior to randomization.
- Exclusion Criteria: Patients were excluded if they had *ABCB11* gene variants predicting a nonfunctional or absent BSEP protein, had experienced prior hepatic decompensation events, had other concomitant liver disease, had an international normalized ratio (INR) >1.4, had an ALT or total bilirubin >10x the upper limit of normal (ULN), or had received a liver transplant.
- Primary Endpoint: The primary efficacy endpoint was the mean percentage of assessments over the treatment period scored as 0 (no scratching) or 1 (a little scratching).
- Results: In the placebo group, an average of 13.2% of assessments were scored as 0 or 1 over the 24-week treatment period, compared with 35.4% in the 40mcg/kg/day group and 30.1% in the 120mcg/kg/day group. For the 40mcg/kg/day treatment group, the mean difference from placebo was 22.2% [95% confidence interval (CI): 4.7, 39.6], which was statistically significant in favor of odevixibat. For the 120mcg/kg/day treatment group, the mean difference from placebo of 16.9% (95% CI: -2.0, 35.7) was not statistically significant for the primary efficacy endpoint. Additionally, a secondary endpoint assessed the mean of the worst weekly average scratching scores in each treatment group for each month of treatment. Both doses of odevixibat resulted in lower scratching scores over the 6 months of treatment relative to placebo; however, there was no significant difference between the 40mcg/kg/day and 120mcg/kg/day odevixibat treatment groups.

Cost: The Wholesale Acquisition Cost (WAC) of Bylvay™ is $220 per unit for the 200mcg oral pellets, $440 per unit for the 400mcg oral capsule, $660 per unit for the 600mcg oral pellets, and $1,320 per unit for the 1,200mcg oral capsule. For a member weighing 18kg using the initial dose of 40mcg/kg/day, the estimated cost of Bylvay™ is $26,400 per 30 days and $316,800 per year. For a member weighing 18kg using the maximum dose of 120mcg/kg/day, the estimated cost of Bylvay™ is $72,600 per 30 days and $871,200 per year.

Recommendations

The College of Pharmacy recommends the prior authorization of Bylvay™ (odevixibat) with the following criteria:

Bylvay™ (Odevixibat) Approval Criteria:

1. An FDA approved indication for the treatment of pruritus in members with progressive familial intrahepatic cholestasis (PFIC); and
    a. Diagnosis must be confirmed by genetic testing identifying mutations in the *ATP8B1, ABCB11, or ABCB4* genes; and
2. Member must be 3 months of age or older; and
3. Bylvay™ must be prescribed by a gastroenterologist, hepatologist, geneticist, or other specialist with expertise in the treatment of PFIC (or an advanced care practitioner with a supervising physician who is a gastroenterologist, hepatologist, geneticist, or other specialist with expertise in the treatment of PFIC); and
4. Prescriber must verify member has a history of significant pruritus that is unresponsive to treatment with at least 3 of the following:
    a. Ursodeoxycholic acid (UDCA); or
    b. Cholestyramine; or
    c. Rifampin; or
    d. Sertraline; or
    e. Naltrexone; and
5. Member must have elevated serum bile acid concentration ≥100µmol/L at baseline; and
6. Prescriber must verify member does not have known pathologic variants of the *ABCB11* gene predicting a non-functional or absent bile salt export pump protein (BSEP-3); and
7. Prescriber must verify the member is not currently a candidate for surgical intervention (e.g., biliary diversion, liver transplantation); and
8. Prescriber must agree to monitor alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, direct bilirubin, and international normalized ratio (INR) at baseline and during treatment with Bylvay™; and
9. Member's current weight (taken within the past 3 weeks) must be provided on initial and subsequent prior authorization requests in order

to authorize the appropriate amount of drug required according to package labeling; and

10. Initial approvals will be for 40mcg/kg/day for a duration of 3 months. After 3 months of treatment, further approval may be granted at the 40mcg/kg/day dose if the prescriber documents the member is responding well to treatment and is still not a candidate for surgical intervention; or
11. Dose increases to 80mcg/kg/day (for 3 months) and 120mcg/kg/day (for 3 months) may be approved if there is no improvement in pruritus after 3 months of treatment with the lower dose(s). Further approval may be granted if the prescriber documents the member is responding well to treatment at the current dose and is still not a candidate for surgical intervention; and
12. If there is no improvement in pruritus after 3 months of treatment with the maximum 120mcg/kg/day dose, further approval of Bylvay™ will not be granted.

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Appendix K

Fiscal Year 2021 Annual Review of Beta Thalassemia and Sickle Cell Disease (SCD) Medications

Oklahoma Health Care Authority
October 2021

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

Sickle cell disease (SCD) is an inherited blood disorder in which the red blood cells (RBCs) are abnormally shaped in a crescent or "sickle" shape, which restricts the flow in blood vessels and limits oxygen delivery to the body's tissues, leading to severe pain and organ damage. It is also characterized by severe chronic inflammation that results in vaso-occlusive crises (VOCs) where patients experience episodes of extreme pain and organ damage. According to the Centers for Disease Control and Prevention (CDC), SCD affects approximately 100,000 Americans. The disease occurs most often in African-Americans, where 1 out of every 365 babies born have the disease.

Beta thalassemia, also known as Cooley's anemia, is an inherited blood disorder that reduces the production of hemoglobin (Hb). In patients with beta thalassemia, low levels of Hb lead to a lack of oxygen in many parts of the body and lead to anemia, which can cause pale skin, weakness, fatigue and more serious complications. Supportive treatment for patients with beta thalassemia often consists of lifelong regimens of chronic blood transfusions for survival and treatment for iron overload due to the transfusions. Patients with beta thalassemia are also at an increased risk of developing abnormal blood clots.

Myelodysplastic syndromes (MDS) are a group of closely related blood disorders characterized by ineffective production of healthy RBCs, white blood cells, and platelets, which can lead to anemia and frequent or severe infections. Patients with MDS who develop anemia often require regular blood transfusions to increase the number of healthy RBCs in circulation. Frequent transfusions are associated with an increased risk of iron overload, transfusion reactions, and infections. In some patients with MDS, the condition progresses to bone marrow failure or develops into acute leukemia.

Current Prior Authorization Criteria

Adakveo® (Crizanlizumab-tmca) Approval Criteria:

1. An FDA approved indication to reduce the frequency of vaso-occlusive crises (VOCs) in adult members and in pediatric members 16 years of age and older with sickle cell disease (SCD); and
2. Member must have a history of VOCs; and

3. Adakveo® must be prescribed by, or in consultation with, a hematologist or a specialist with expertise in treatment of SCD (or an advanced care practitioner with a supervising physician who is a hematologist or specialist with expertise in treating SCD); and
4. Prescriber must verify Adakveo® will be administered by a trained health care provider. The prior authorization request must indicate how Adakveo® will be administered; and
    a. Adakveo® must be shipped via cold chain supply to the facility where the member is scheduled to receive treatment; or
    b. Adakveo® must be shipped via cold chain supply to the member's home and administered by a home health provider, and the member or member's caregiver must be trained on the proper storage of Adakveo®; and
5. A recent (within the last 3 months) weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
6. Approval quantities will be dependent on the member's weight and will include loading doses at week 0 and 2, then subsequent doses every 4 weeks in accordance with package labeling; and
7. Initial approvals will be for the duration of 3 months. Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

Endari® (L-Glutamine) Approval Criteria:

1. An FDA approved diagnosis of sickle cell disease (SCD); and
2. Member must be 5 years of age or older; and
3. A trial of hydroxyurea or a patient-specific, clinically significant reason why hydroxyurea is not appropriate for the member must be provided; and
4. Endari® must be prescribed by, or in consultation with, a hematologist or a specialist with expertise in treatment of SCD (or an advanced care practitioner with a supervising physician who is a hematologist or specialist with expertise in treating SCD); and
5. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
6. Initial approvals will be for a duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment.

Oxbryta® (Voxelotor) Approval Criteria:

1. An FDA approved indication for the treatment of sickle cell disease (SCD) in members 12 years of age and older; and
2. Member must have a history of vaso-occlusive crises (VOCs); and

3. Member must have baseline hemoglobin ≥5.5 to ≤10.5g/dL; and
4. Oxbryta® must be prescribed by, or in consultation with, a hematologist or a specialist with expertise in treatment of SCD (or an advanced care practitioner with a supervising physician who is a hematologist or specialist with expertise in treating SCD); and
5. The member must not be taking concomitant strong CYP3A4 inhibitors (e.g., fluconazole, ketoconazole) or the prescriber must verify the dose of Oxbryta® will be reduced during concomitant use according to package labeling; and
6. Prescriber must verify that the dose of Oxbryta® will be reduced in accordance with package labeling for members with severe hepatic impairment; and
7. The member must not be taking concomitant strong or moderate CYP3A4 inducers (e.g., rifampin) or the prescriber must verify the dose of Oxbryta® will be adjusted during concomitant use according to package labeling; and
8. A quantity limit of 3 tablets per day will apply; and
9. Initial approvals will be for the duration of 6 months. Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

Reblozyl® (Luspatercept-aamt) Approval Criteria [Beta Thalassemia Diagnosis]:

1. An FDA approved indication for the treatment of adult members with beta thalassemia who require regular red blood cell (RBC) transfusions; and
2. Member must require regular RBC transfusions (no transfusion-free period >35 days during the prior 6 month period); and
3. Reblozyl® must be prescribed by, or in consultation with, a hematologist or a specialist with expertise in treatment of beta thalassemia (or an advanced care practitioner with a supervising physician who is a hematologist or specialist with expertise in treating beta thalassemia); and
4. The prescriber must verify the member's hemoglobin will be monitored prior to each Reblozyl® administration; and
5. Prescriber must verify Reblozyl® will be administered by a trained health care provider; and
6. A recent (within the last 3 months) weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
7. Approval quantities will be dependent on member weight and every 3 week dosing in accordance with package labeling; and
8. Initial approvals will be for the duration of 4 months. Further approvals will not be granted if the member does not experience a decrease in

transfusion burden after 9 weeks of treatment (administration of 3 doses) at the maximum dose of 1.25mg/kg (allows for initial dosing of 6 weeks at 1mg/kg). Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

Reblozyl® (Luspatercept-aamt) Approval Criteria [Myelodysplastic Syndromes (MDS) Diagnosis]:

1. An FDA approved indication for the treatment of adult members with very low-to-intermediate risk MDS with ring sideroblasts (MDS-RS) or myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T) with anemia failing an erythropoiesis stimulating agent (ESA) and requiring ≥2 red blood cell (RBC) units over 8 weeks; and
2. Member must have had an inadequate response to prior treatment with an ESA, be intolerant of ESAs, or have a serum erythropoietin level >200U/L; and
3. Member must not have been previously treated with a disease modifying agent for the treatment of MDS; and
4. Prescriber must verify the member does not have deletion 5q (del 5q); and
5. Complete blood counts (CBC) and verification that levels are acceptable to the prescriber and in accordance with package labeling; and
6. Reblozyl® must be prescribed by, or in consultation with, a hematologist, oncologist, or a specialist with expertise in treatment of MDS (or an advanced care practitioner with a supervising physician who is a hematologist, oncologist, or specialist with expertise in treating MDS); and
7. The prescriber must verify the member's hemoglobin will be monitored prior to each Reblozyl® administration; and
8. Prescriber must verify Reblozyl® will be administered by a trained health care provider; and
9. A recent (within the last 3 months) weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
10. Approval quantities will be dependent on member weight and every 3 week dosing in accordance with package labeling; and
11. Initial approvals will be for the duration of 6 months. Further approvals will not be granted if the member does not experience a decrease in transfusion burden after 9 weeks of treatment (administration of 3 doses) at the maximum dose of 1.75mg/kg or if unacceptable toxicity occurs at any time. Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

Siklos® (Hydroxyurea Tablets) Approval Criteria:

1. An FDA approved indication of sickle cell anemia; and
2. Member must be 2 years of age or older; and
3. Member must have a history of moderate-to-severe, painful vaso-occlusive crises (VOCs); and
4. A trial of hydroxyurea capsules or a patient-specific, clinically significant reason why hydroxyurea capsules are not appropriate for the member must be provided; and
5. Prescriber must agree to monitor blood counts every 2 weeks throughout therapy; and
6. Prescriber must agree to monitor the member for the development of secondary malignancies; and
7. Female members must not be pregnant and must have a negative pregnancy test prior to therapy initiation; and
8. Male and female members of reproductive potential must be willing to use effective contraception during and after treatment with Siklos® for at least 6 months after therapy; and
9. Initial approvals will be for the duration of 12 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment.

Utilization of Beta Thalassemia and SCD Medications: Fiscal Year 2021

Comparison of Fiscal Years: Pharmacy Claims

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2020	129	632	$143,377.77	$226.86	$7.11	44,168	20,170
2021	147	712	$528,199.52	$741.85	$22.35	47,803	23,632
% Change	**14.00%**	**12.70%**	**268.40%**	**227.00%**	**214.30%**	**8.20%**	**17.20%**
Change	**18**	**80**	**$384,821.75**	**$514.99**	**$15.24**	**3,635**	**3,462**

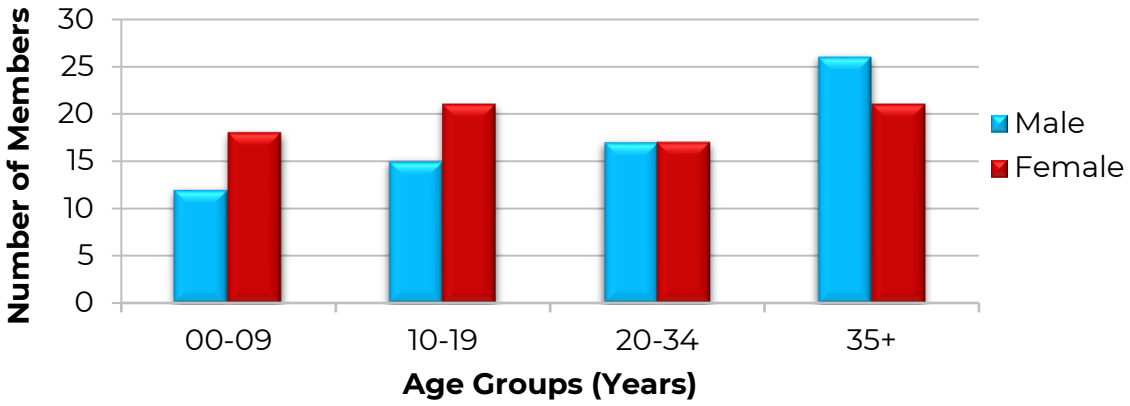
Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2020 = 07/01/2019 to 06/30/2020; Fiscal Year 2021 = 07/01/2020 to 06/30/2021

Comparison of Fiscal Years: Medical Claims

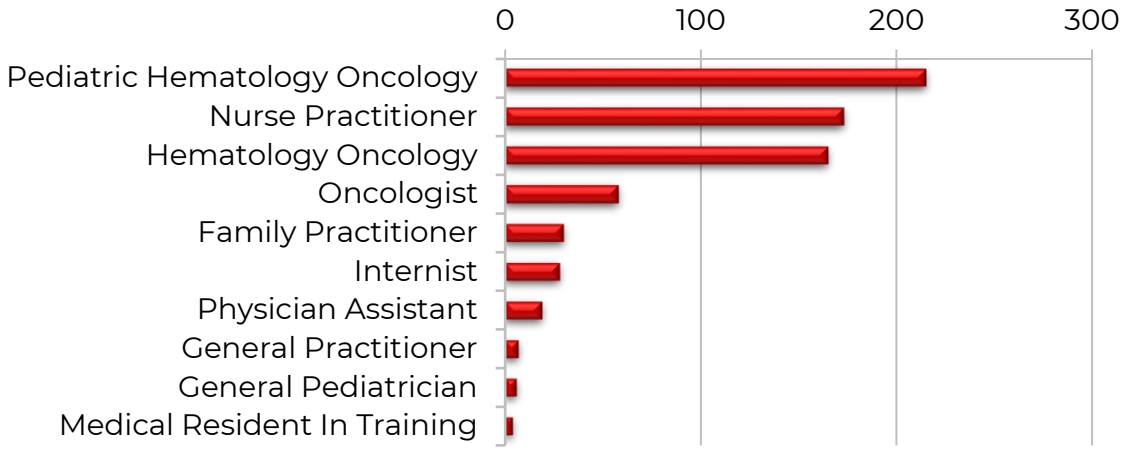
Fiscal Year	*Total Members	†Total Claims	Total Cost	Cost/ Claim	Claims/ Member
2020	15	34	$468,335.90	$13,774.58	2.27
2021	13	60	$556,675.88	$9,033.07	4.62
% Change	**-13.33%**	**76.47%**	**18.86%**	**-34.42%**	**103.52%**
Change	**-2**	**26**	**$88,339.98**	**-$4,741.51**	**2.35**

†Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2020 = 07/01/2019 to 06/30/2020; Fiscal Year 2021 = 07/01/2020 to 06/30/2021

Demographics of Members Utilizing Beta Thalassemia and SCD Medications: Pharmacy Claims



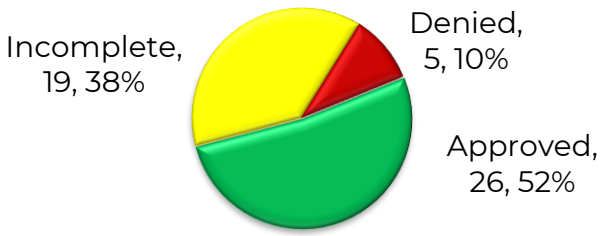
Top Prescriber Specialties of Beta Thalassemia and SCD Medications by Number of Claims: Pharmacy Claims



Prior Authorization of Beta Thalassemia and SCD Medications

There were 50 prior authorization requests submitted for beta thalassemia and SCD medications during fiscal year 2021. The following chart shows the status of the submitted petitions for fiscal year 2021.

Status of Petitions



Market News and Updates[6,7,8,9,10,11,12,13]

Anticipated Patent Expiration(s):

- Oxbryta® (voxelotor tablets): October 2027

News:

- **September 2021:** The Sickle Cell Disease Association of America Medical and Research Advisory Committee (MARAC) has released 2 statements with updated COVID-19 guidance. MARAC recommendations are making a minor shift to emphasize a more individualized approach, as follows:
  - Continue to recommend vaccination against COVID-19. For booster dose of vaccine, currently SCD is not eligible but changes are expected in CDC guidance.
  - Continue to recommend general precautions: wearing masks, keeping physical distancing, good ventilation, and washing hands. These are public health measures.
  - Recommend neutralizing monoclonal antibodies (mAb), Regeneron® (REGEN-COV™), as early treatment for mild symptomatic COVID-19 in individuals with SCD (<10 days after the test, 12 years of age or older, weight >40kg, not hospitalized, not newly on oxygen). Encourage getting tested if COVID-19 symptoms are present. Possible prophylactic treatment with Regeneron® antibodies if exposed to COVID-19.
  - There is no general recommendation for all individuals with SCD to stay home nor all to return to in-person activities. Health care providers should help patients and families make individualized assessments of risk and trade-offs of returning to work or school in-person. Factors to consider that were listed in MARAC July 2020 "checklist for return to school" (plus vaccination status): the community's rates of COVID-19 and variants, vaccination status, family socioeconomic situation, ventilation and other protective measures in the building, mental health needs, and educational needs.

Pipeline:

- **Oxbryta® (Voxelotor Tablets):** Global Blood Therapeutics, Inc. (GBT) announced in September 2021 the FDA has accepted a filing and review for a supplemental New Drug Application (sNDA) seeking accelerated approval for Oxbryta® for the treatment of SCD in children 4 to 11 years of age, together with a related separate New Drug Application (NDA) required to seek approval for a pediatric weight-based dispersible tablet formulation of Oxbryta®. Oxbryta® is currently approved by the FDA in a tablet dosage form to treat SCD in patients 12 years of age and older. The FDA granted Priority Review for both the

NDA and sNDA, providing a 6-month review and assigned a Prescription Drug User Fee Act (PDUFA) target action date for both applications of December 25, 2021. The Oxbryta® pediatric sNDA and NDA are based on data from the open-label Phase 2a HOPE-KIDS 1 study. An analysis of data presented at the European Hematology Association (EHA) 2021 Virtual Congress in 45 children with SCD 4 to 11 years of age enrolled in the study showed that weight-based treatment with the Oxbryta® dispersible tablet dosage form resulted in rapid and sustained improvements in Hb. Concurrent reduction of hemolysis was also demonstrated. The NDA seeks approval for 300mg dispersible tablets. The dispersible tablet formulation includes grape flavoring, is intended to be dispersed in room-temperature drinking water or other clear drinks for ease of swallowing, and allows for weight-based dosing in pediatric patients 4 to 11 years of age with SCD.

- **Inclacumab:** In July 2021, GBT announced 2 global, randomized, placebo-controlled, pivotal Phase 3 clinical studies of inclacumab, a novel P-selectin inhibitor, had been initiated. The studies are evaluating the safety and efficacy of inclacumab for the treatment of VOCs associated with SCD. Both studies are enrolling individuals 12 years of age and older with SCD who have experienced between 2 and 10 VOCs in the previous year. Inclacumab selectively targets P-selectin, a protein that mediates cell adhesion and is clinically validated to reduce pain crises. The first study, GBT2104-131, is evaluating the effect of inclacumab on the frequency of VOCs. Approximately 240 patients will be randomized to an intravenous (IV) infusion of 30mg/kg inclacumab or placebo every 12 weeks. The primary outcome of this Phase 3 study is the rate of VOCs during the 48-week study period. Secondary outcomes include time to first and second VOCs, proportion of participants with no VOCs, rate of VOCs that required admission to a health care facility and duration of inpatient hospitalization for VOCs. The second study, GBT2104-132, is evaluating the effect of a single dose of inclacumab on hospital readmission rates. VOCs in SCD are a leading cause of hospital readmissions and a significant burden on patients and health care resources. In this Phase 3 study (GBT2104-132), approximately 280 participants who have been admitted to a health care facility due to a VOC will be randomized to receive a 1-time IV infusion of 30mg/kg of inclacumab or placebo in the peri-discharge window (just prior to, during, or around discharge). The primary outcome is the rate of hospital readmissions for a VOC within 90 days following an initial hospitalization for a VOC. Secondary outcomes include readmission within 30 days, time to first hospital readmission for VOC, and rate of VOCs leading to health care provider visits.
- **GBT021601 (GBT601):** In July 2021, GBT announced the enrollment of the first SCD patient in the Phase 1 study evaluating GBT021601

(GBT601), a next-generation hemoglobin S (HbS) polymerization inhibitor, in patients with SCD. GBT is currently enrolling patients in GBT021601-012. This single and multiple ascending dose Phase 1 study is assessing the safety, tolerability, pharmacokinetics, and pharmacodynamics of GBT601 in up to 6 patients with SCD 18 to 60 years of age. Patients with Hb levels between 5.5g/dL and 10.5g/dL are eligible for enrollment. The primary outcome is the safety and tolerability of GBT601 as assessed at 14 weeks. Secondary outcomes include measures of pharmacokinetics and pharmacodynamics, as well as an assessment of the relationship between GBT601 and measures of anemia and hemolysis. GBT plans to submit preliminary proof-of-concept data for GBT601 for presentation at a medical meeting this year. Discovered and designed by GBT's research and development team, GBT601 has the same mechanism of action as Oxbryta®, with the potential for greater efficacy by achieving higher Hb levels and occupancy at lower doses, as demonstrated in preclinical studies. This study follows an ongoing first-in-human study to determine safe and tolerable dosing.

- **LentiGlobin Gene Therapy:** LentiGlobin gene therapy for SCD (bb1111) is an investigational treatment being studied as a potential one-time therapy for SCD. Bluebird Bio announced the FDA has lifted the clinical holds on the Phase 1/2 HGB-206 and Phase 3 HGB-210 studies of LentiGlobin gene therapy for adult and pediatric patients with SCD. Previously in February 2021, Bluebird Bio announced it had received reports of a suspected unexpected serious adverse reaction (SUSAR) of myelodysplastic syndrome (MDS) in a patient from group C of the Phase 1/2 HGB-206 study of LentiGlobin gene therapy, as well as another SUSAR of acute myeloid leukemia (AML) reported in the HGB-206 study. As a result of the SUSARs, the FDA placed clinical holds on the gene therapy. Following further assessment and analyses of both the MDS case and the AML case, the FDA has given the green light to Bluebird Bio to restart the HGB-206 study and the Phase 3 HGB-210 of LentiGlobin gene therapy for SCD, as well as the Phase 3 Northstar-2 (HGB-207) and Northstar-3 (HGB-212) studies of betibeglogene autotemcel [marketed as Zynteglo® in the European Union (EU) and United Kingdom (UK)] for adult, adolescent, and pediatric patients with transfusion-dependent beta thalassemia (TDT). Bluebird Bio's clinical development program for LentiGlobin gene therapy for SCD includes the completed Phase 1/2 HGB-205, the ongoing Phase 1/2 HGB-206, and Phase 3 HGB-210 studies. In addition, Bluebird Bio is conducting a long-term safety and efficacy follow-up study (LTF-307) for patients who have participated in Bluebird Bio sponsored clinical studies of LentiGlobin gene therapy for SCD. The FDA has granted Orphan Drug designation, Fast Track designation, Regenerative Medicine Advanced

Therapy (RMAT) designation, and Rare Pediatric Disease designation for LentiGlobin gene therapy for SCD.

- **CTX001:** In June 2021, Vertex Pharmaceuticals Inc. and CRISPR Therapeutics announced new data on 22 patients, with follow-up of at least 3 months, and ranging from 4 months to 26 months, treated with the investigational CRISPR/Cas9-based gene-editing therapy, CTX001, that show a consistent and sustained response to treatment. CTX001 is an investigational, autologous, *ex vivo* CRISPR/Cas9 gene-edited therapy that is being evaluated as a 1-time therapy for patients suffering from TDT or severe SCD, in which a patient's hematopoietic stem cells are edited to produce high levels of fetal Hb (HbF) in RBCs. HbF is a form of the oxygen-carrying Hb that is naturally present at birth, which then switches to the adult form of Hb. The elevation of HbF by CTX001 has the potential to alleviate or eliminate transfusion requirements for patients with TDT and reduce or eliminate painful and debilitating sickle crises for patients with SCD. Earlier results from these ongoing studies were published as a Brief Report in *The New England Journal of Medicine* in January of 2021. In total, more than 40 patients have been dosed across 2 ongoing Phase 1/2 clinical studies to date. All 15 patients with TDT, including 6 who have the beta zero/beta zero or other severe genotypes, were transfusion-free at last follow-up, and all 7 patients with severe SCD were free of VOCs from CTX001 infusion through last follow-up. Five patients with TDT and 2 patients with SCD now have follow-up of greater than 1 year, demonstrating a stable and durable response to treatment. These data are available as e-posters beginning on June 11, 2021 and a partial presentation of these data were presented during the Joint European Hematology Association-American Society of Hematology (EHA-ASH) Symposium on June 10, 2021. Enrollment and dosing for both studies are ongoing. CTX001 has been granted RMAT, Fast Track, Orphan Drug, and Rare Pediatric Disease designations from the FDA for both TDT and SCD.

Recommendations

The College of Pharmacy does not recommend any changes to the current beta thalassemia and SCD medications prior authorization criteria at this time.

Utilization Details of Beta Thalassemia and SCD Medications: Fiscal Year 2021

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM	% COST
HYDROXYUREA CAP 500MG	450	119	$10,397.24	4.02	$23.10	1.97%
DROXIA CAP 300MG	122	29	$6,116.90	4.05	$50.14	1.16%
DROXIA CAP 400MG	49	15	$2,475.96	4.55	$50.53	0.47%
OXBRYTA TAB 500MG	47	12	$481,634.06	3.09	$10,247.53	91.18%
DROXIA CAP 200MG	31	9	$1,493.03	1.67	$48.16	0.28%
ENDARI POW 5GM	11	1	$25,849.51	4.00	$2,349.96	4.89%
SIKLOS TAB 100MG	2	1	$232.82	3.00	$116.41	0.04%
TOTAL	**712**	**147***	**$528,199.52**	**4.90**	**$741.85**	**100%**

*Total number of unduplicated utilizing members.
CAP = capsule; POW = powder; TAB = tablet
Costs do not reflect rebated prices or net costs.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021

Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
ADAKVEO J0791	44	12	$422,135.88	$9,54.00	3.67
REBLOZYL J0896	16	1	$134,540.00	$8,408.75	16
TOTAL	**60⁺**	**13***	**$556,675.88**	**$9,277.93**	**4.62**

⁺Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
Costs do not reflect rebated prices or net costs.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021

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[2] Centers for Disease Control and Prevention (CDC). Sickle Cell Disease (SCD). Available online at: https://www.cdc.gov/ncbddd/sicklecell/index.html. Last accessed 09/16/2021.
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Appendix L

U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates (additional information can be found at http://www.fda.gov/Drugs/default.htm)

FDA NEWS RELEASE

For Immediate Release: September 10, 2021

Coronavirus (COVID-19) Update: September 10, 2021

The FDA announced the following actions taken in its ongoing response effort to the COVID-19 pandemic:

On September 10, 2021, the FDA posted a statement titled "FDA Will Follow the Science on COVID-19 Vaccines for Young Children" attributed to Acting FDA Commissioner Janet Woodcock M.D. and Peter Marks, M.D., Ph.D., director of the FDA's Center for Biologics Research and Evaluation.

On September 3, 2021, the FDA approved an abbreviated new drug application (ANDA) for dexmedetomidine injection USP, 200mcg/2mL, indicated for sedation of initially intubated and mechanically ventilated patients during treatment in an intensive-care setting and sedation of non-intubated patients prior to and/or during surgical and other procedures. The most common side effects of dexmedetomidine hydrochloride injection are hypotension, bradycardia, and dry mouth. This drug is listed in the FDA Drug Shortage Database.

The FDA recognizes the increased demand for certain products during the COVID-19 public health emergency and has prioritized the review of generic drug applications for potential treatments and supportive therapies for patients with COVID-19. The FDA remains deeply committed to facilitating access to safe and effective medical products to help address critical needs of the American public.

On September 8, 2021, the agency authorized the use, under the emergency use authorization (EUA) for the Janssen COVID-19 vaccine, of 1 additional batch of vaccine drug substance manufactured at the Emergent facility. To date, a total of 6 batches of Janssen drug substance that were manufactured at the Emergent facility have been authorized. The FDA conducted a thorough review of facility records and the results of quality testing performed by the manufacturer. Based on this review and considering the current COVID-19 public health emergency, the FDA has concluded that these batches are suitable for use. While the FDA is not yet ready to include the Emergent BioSolutions plant in the Janssen EUA as an authorized manufacturing facility, the agency continues to work through issues there with Janssen and Emergent BioSolutions management.

On September 9, 2021, the FDA revised the guidance Development of ANDAs during the COVID-19 Pandemic Questions and Answers, originally published in April 2021. The guidance provides general recommendations to prospective generic drug applicants related to generic drug product development and regulatory submissions in the form of questions and answers that have been received and addressed by the FDA during the COVID-19 public health emergency. The FDA issued this guidance so that the development of generic drugs and submission of applications can continue during the COVID-19 public health emergency, ultimately helping ensure Americans continue to have access to safe and effective generic drugs.

The following information is in regard to COVID-19 testing updates:

As of September 10, 2021, 409 tests and sample collection devices are authorized by the FDA under EUAs. These include 287 molecular tests and sample collection devices, 88 antibody and other immune response tests, and 34 antigen tests. There are 62 molecular authorizations and 1 antibody authorization that can be used with home-collected samples. There is 1 molecular prescription at-home test, 3 antigen prescription at-home tests, 7 antigen over-the-counter (OTC) at-home tests, and 2 molecular OTC at-home tests.

The FDA has authorized 14 antigen tests and 8 molecular tests for serial screening programs. The FDA has also authorized 632 revisions to EUA authorizations.

FDA NEWS RELEASE

For Immediate Release: September 9, 2021

FDA Makes Significant Progress in Science-Based Public Health Application Review, Taking Action on Over 90% of More Than 6.5 Million 'Deemed' New Tobacco Products Submitted

In September 2020, the FDA faced the unprecedented task of reviewing applications for over 6.5 million "deemed" new tobacco products, many of which were already on the market. A majority of the applications submitted by a court-ordered deadline of September 9, 2020, were for electronic nicotine delivery systems (ENDS) products, such as e-cigarettes and e-liquids, which had never been through the FDA review process.

The FDA has made significant progress in the months since, working diligently to better understand these products and, as of September 9, 2021, taking action on about 93% of the total timely-submitted applications. This includes issuing Marketing Denial Orders (MDO) for ≥946,000 flavored ENDS products because their applications lacked sufficient evidence that they have a benefit to adult smokers sufficient to overcome the public health threat posed by the well-documented, alarming levels of youth use of such products. Flavored ENDS products are extremely popular among youth, with over 80% of e-cigarette users 12 through 17 years of age using them. However, there's more work to be done to complete the remaining reviews and ensure that continued appropriate action is taken to protect the nation's youth from the dangers of all tobacco products, including e-cigarettes, which remain the most commonly used tobacco product by youth in the United States.

As required by statute, a key consideration in the review of premarket tobacco product applications submitted for products like e-cigarettes is to determine whether permitting the marketing of the product would be "appropriate for the protection of the public health," taking into account the risks and benefits to the population as a whole. This determination includes consideration of how the products may impact youth use of tobacco products and the potential for the products to completely move adult smokers away from use of combustible cigarettes. Importantly, flavored tobacco products are very appealing to young people. Therefore, assessing the impact of potential or actual youth use is a critical factor in determining as to whether the statutory standard for marketing is met.

As of September 9, 2021, the FDA has taken action on applications for over 6 million ENDS products, including refusing to file (RTF) 1 company's applications for approximately 4.5 million products because required contents were missing as well as issuing 132 MDOs for ≥946,000 flavored ENDS products, including flavors such as Apple Crumble, Dr. Cola, and Cinnamon Toast Cereal.

The FDA continues to work expeditiously on the remaining applications that were submitted by the court's September 9, 2020, deadline, many of which are in the final stages of review. For premarket tobacco product applications, the FDA's responsibility is to assess whether applicants meet the applicable statutory standard for marketing their new products. The burden is on the applicant to provide evidence to demonstrate that permitting the marketing of their product meets the applicable statutory standard. Continued review also includes a smaller number of pending applications that are being reviewed under the "substantial equivalence" standard, for cigars, pipes, and hookah tobacco and for which have been granted marketing orders covering over 350 products.

All new tobacco products on the market without the statutorily required premarket authorization are marketed unlawfully and subject to enforcement action at the FDA's discretion. The FDA is committed to completing the review of the remaining products as quickly as possible to provide regulatory certainty and will continue to keep the public informed of our progress. In the meantime, products for which no application is pending, including, for example, those with a MDO and those for which no application was submitted, are among the highest enforcement priorities. If such products are not removed from the market, the FDA intends to follow its usual enforcement practices in these circumstances and will issue a warning letter before initiating enforcement action such as civil money penalties, seizure, or injunction and afford the recipient an opportunity to respond. Since January 2021, the FDA has issued a total of 170 warning letters to firms that collectively have listed ≥17 million ENDS with the FDA and that had not submitted premarket applications for these products. Among those warning letters, and in an effort to take action on products with a likelihood of youth use or initiation, the FDA issued a warning letter in July 2021 to a single company that did not submit an application and has ≥15 million products listed with the FDA.

FDA NEWS RELEASE

For Immediate Release: September 8, 2021

FDA In Brief: FDA Announces Public Workshop to Reconsider Mandatory Prescriber Education for Opioids

The FDA is reconsidering the need for mandatory opioid prescriber education through the Opioid Analgesic (OA) Risk Evaluation and Mitigation Strategy (REMS).

The agency announced a 2-day public workshop "Reconsidering Mandatory Opioid Prescriber Education Through a Risk Evaluation and Mitigation Strategy (REMS) in an Evolving Opioid Crisis" to give stakeholders an opportunity to provide input on aspects of the current opioid crisis that could be mitigated in a measurable way by requiring mandatory prescriber education as part of a REMS.

Among the diverse topics that will be discussed, the FDA will explore the value of a single source for education on the appropriate use of opioids, risks of opioid abuse and misuse, and treatment of opioid use disorder to address multiple needs and reduce the burden on prescribers.

The number of dispensed prescriptions for opioid analgesics has been steadily declining from a peak of 84 prescriptions per 100 residents in 2012 to 43 prescriptions per 100 residents in 2020.

A wide variety of interventions intended to reduce inappropriate or unnecessary prescribing, including prescriber education initiatives are in place.

Despite a decrease in dispensing, opioid overdoses and opioid-involved deaths are higher than ever, with opioids often seen in combination with other substances such as cocaine, methamphetamine, and benzodiazepines.

This rise has been driven primarily by a surge in overdose deaths initially involving heroin and then illicitly manufactured fentanyl and fentanyl analogues. Although these overdose deaths largely involve illicit substances, many users of illicit opioids are initially exposed to opioids through nonmedical use of prescription opioids. Moreover, as of 2020, prescription opioids were involved in ≥16,000 fatal overdoses per year, higher than the number seen at the peak of opioid analgesic dispensing in 2012.

The workshop is being convened by the Duke-Margolis Center for Health Policy and supported by a cooperative agreement between the FDA and Duke-Margolis. A second public workshop is being planned to solicit input on additional issues associated with a move to mandatory prescriber education under a REMS, such as operational and technical issues related to such a system and what should be included in potential mandatory prescriber education.

FDA NEWS RELEASE

For Immediate Release: September 2, 2021

FDA In Brief: FDA Reaches Milestone in Competitive Generic Therapy Drug Approvals

The first Competitive Generic Therapy (CGT)-designated ANDA, also known as a generic drug application, was approved on August 8, 2018. The related guidance for industry, *Competitive Generic Therapies*, was published as a draft in February 2019 and finalized in March 2020. The guidance describes the process that generic drug applicants should follow to request designation of a drug as a CGT and the criteria for that designation, as well as additional information about the CGT program.

At the request of the ANDA applicant, the FDA may take steps to expedite the development and review of ANDAs for drugs that receive a CGT designation. These actions can include product development or pre-submission meetings with the agency to discuss scientific issues or questions, or the format and content of a future ANDA, as well as mid-review-cycle meetings regarding any issues identified during the FDA's review.

Additionally, applicants for drugs that receive a CGT designation may be eligible for a 180-day period of marketing exclusivity if they are the first approved applicant for that CGT and meet certain other conditions. Under a special forfeiture rule for CGTs, the applicant must commercially market the CGT within 75 calendar days after the date of approval of its ANDA, or it will forfeit its exclusivity. This marketing exclusivity blocks approval of competitive ANDAs, but only begins when the first CGT product is marketed. This provides an incentive to market the CGT quickly after it is first approved.

The CGT program is part of the FDA Drug Competition Action Plan, which seeks to foster generic competition and help address the high cost of drugs.

FDA NEWS RELEASE

For Immediate Release: August 27, 2021

FDA Approves First-of-Its-Kind Stroke Rehabilitation System

The FDA approved the MicroTransponder Vivistim Paired VNS System (Vivistim System), a first-of-its-kind, drug-free rehabilitation system intended to treat moderate to severe upper extremity motor deficits associated with chronic ischemic stroke using vagus nerve stimulation (VNS).

The Vivistim System is intended to be used, along with post-stroke rehabilitation therapy, in patients who have had ischemic stroke, to electrically stimulate the vagus nerve to reduce deficiencies in upper limb and extremity motor function and to improve patients' ability to move their arms and hands. To use the Vivistim System, an implantable

pulse generator (IPG) which generates a mild electrical pulse is implanted just under the skin in the chest of the patient. Attached to the IPG is a lead wire that is implanted under the skin and leads up to electrodes that are placed on the left side of the neck where the vagus nerve is located.

Accompanying the implantable components are clinician software preloaded onto a laptop and a wireless transmitter to be used only by a health care provider. The software allows a health care provider managing a patient's rehabilitation to input the appropriate settings on the IPG, including amplitude, frequency, and pulse width for the stimulation, and also records stimulation history, movements performed, and information about the IPG. The wireless transmitter communicates adjustments to the IPG settings made using the software.

The Vivistim System, a prescription device, may be used in both clinical and at-home settings to provide VNS. If it is to be used during home rehabilitation exercises, the software and the wireless transmitter are not used by the patient. However, the patient is supplied with a magnet that can be passed over the IPG implant site to activate the IPG to begin a 30-minute stimulation session during rehabilitative exercise. When directed by a physician and with appropriate programming to the IPG, patients are trained on how to use the Vivistim System at home, as well as its safety features, to avoid any unwanted electrical stimulation.

The FDA evaluated the safety and effectiveness of the Vivistim System in a clinical study of 108 patients at 19 clinical sites in the United States and the United Kingdom who received the Vivistim System. Patients were split into a study group (53 patients) and a control group (55 patients), whereby both groups were asked to complete 300-400 physical therapy exercises for 90 minutes a day, 3 times a week for 6 weeks. The control group received only a very low level of VNS for the first 5 exercises of the 300-400-movement series and had no stimulation whatsoever for the rest of each session. The treatment group received the appropriate amount of VNS throughout all 90-minute rehabilitation sessions. Both groups received physical therapy sessions that were equivalent in quantity and quality. Following the initial 6-week study, all patients received follow-up assessments at 1, 30, and 90 days following the study.

Effectiveness for the Vivistim System was measured using the Upper Extremity Fugl-Meyer Assessment (FMA-UE), a stroke specific measure of motor impairment. Progress was measured as an increase in motor function from baseline after 6 weeks of therapy. Patients in the treatment group had an average score increase of 5 points, whereas patients in the control group had an average score increase of 2.4 points. Additionally, 47.2% of those in the treatment group saw an improvement of 6 or more points in the FMA-UE score 90 days post-therapy as compared with 23.6% in the control group.

The Vivistim System is not approved for use outside of its intended use to stimulate the vagus nerve during chronic ischemic stroke rehabilitation therapy for moderate-to-severe loss of upper extremity function. It should not be used in patients who have undergone vagotomy.

The Vivistim System was granted Breakthrough Device designation. To qualify for such designation, a device must be intended to treat or diagnose a life-threatening or irreversibly debilitating disease or condition and meet 1 of the following criteria: the device must represent a breakthrough technology; there must be no approved or cleared alternatives; the device must offer significant advantages over existing approved or cleared alternatives; or the availability of the device is in the best interest of patients.

The FDA reviewed the MicroTransponder Vivistim Paired VNS System under the Premarket Approval (PMA) pathway. PMA is the most stringent type of device marketing application required by the FDA and is based on a determination by the FDA that the PMA application contains sufficient valid scientific evidence to provide reasonable assurance that the device is safe and effective for its intended use.

Current Drug Shortages Index (as of September 15, 2021):

The information provided in this section is provided voluntarily to the FDA by manufacturers and is not specific to Oklahoma.

Acetazolamide Injection	***Currently in Shortage***
Amifostine Injection	***Currently in Shortage***
Amino Acids	***Currently in Shortage***
Amoxapine Tablets	***Currently in Shortage***
Amphetamine Aspartate; Amphetamine Sulfate; Dextroamphetamine Saccharate; Dextroamphetamine Sulfate Tablets	***Currently in Shortage***
Atropine Sulfate Injection	***Currently in Shortage***
Atropine Sulfate Ophthalmic Ointment	***Currently in Shortage***
Azacitidine for Injection	***Currently in Shortage***
Belatacept (Nulojix®) Lyophilized Powder for	***Currently in Shortage***
Bumetanide Injection	***Currently in Shortage***
Bupivacaine Hydrochloride and Epinephrine	***Currently in Shortage***
Bupivacaine Hydrochloride Injection	***Currently in Shortage***
Calcitriol Injection 1MCG/ML	***Currently in Shortage***
Calcium Disodium Versenate Injection	***Currently in Shortage***
Calcium Gluconate Injection	***Currently in Shortage***
Cefazolin Injection	***Currently in Shortage***
Cefotaxime Sodium Injection	***Currently in Shortage***
Cefotetan Disodium Injection	***Currently in Shortage***
Cefoxitin for Injection	***Currently in Shortage***
Ceftazidime and Avibactam (Avycaz®) for Injection, 2 grams/0.5 grams	***Currently in Shortage***
Ceftolozane and Tazobactam (Zerbaxa®) Injection	***Currently in Shortage***
Chlordiazepoxide Hydrochloride Capsules	***Currently in Shortage***
Chloroprocaine Hydrochloride Injection	***Currently in Shortage***
Continuous Renal Replacement Therapy (CRRT)	***Currently in Shortage***
Cortisone Acetate Tablets	***Currently in Shortage***
Cyclopentolate Ophthalmic Solution	***Currently in Shortage***
Cysteamine Hydrochloride Ophthalmic Solution	***Currently in Shortage***
Desmopressin Acetate Nasal Spray	***Currently in Shortage***
Dexamethasone Sodium Phosphate Injection	***Currently in Shortage***
Dexmedetomidine Injection	***Currently in Shortage***
Digoxin Injection	***Currently in Shortage***
Diltiazem Hydrochloride Injection	***Currently in Shortage***
Disopyramide Phosphate (Norpace®) Capsules	***Currently in Shortage***
Dobutamine Hydrochloride Injection	***Currently in Shortage***
Dopamine Hydrochloride Injection	***Currently in Shortage***
Echothiophate Iodide (Phospholine Iodide®)	***Currently in Shortage***
Enalaprilat Injection	***Currently in Shortage***
Epinephrine Injection, 0.1 mg/mL	***Currently in Shortage***
Epinephrine Injection, Auto-Injector	***Currently in Shortage***

Famotidine Injection	***Currently in Shortage***
Famotidine Tablets	***Currently in Shortage***
Fentanyl Citrate (Sublimaze®) Injection	***Currently in Shortage***
Floxuridine for Injection	***Currently in Shortage***
Fluvoxamine ER Capsules	***Currently in Shortage***
Furosemide Injection	***Currently in Shortage***
Gemifloxacin Mesylate (Factive®) Tablets	***Currently in Shortage***
Gentamicin Sulfate Injection	***Currently in Shortage***
Guanfacine Hydrochloride Tablets	***Currently in Shortage***
Heparin Sodium and Sodium Chloride 0.9%	***Currently in Shortage***
Histreline Acetate Implant	***Currently in Shortage***
Hydrocortisone Tablets	***Currently in Shortage***
Hydromorphone Hydrochloride Injection	***Currently in Shortage***
Hydroxocobalamin Injection	***Currently in Shortage***
Hydroxypropyl (Lacrisert®) Cellulose Ophthalmic	***Currently in Shortage***
Imipenem and Cilastatin for Injection	***Currently in Shortage***
Isoniazid Injection	***Currently in Shortage***
Ketamine Injection	***Currently in Shortage***
Ketoprofen Capsules	***Currently in Shortage***
Ketorolac Tromethamine Injection	***Currently in Shortage***
Leucovorin Calcium Lyophilized Powder for	***Currently in Shortage***
Leuprolide Acetate Injection	***Currently in Shortage***
Lidocaine Hydrochloride (Xylocaine®) and	***Currently in Shortage***
Lidocaine Hydrochloride (Xylocaine®) Injection	***Currently in Shortage***
Lidocaine Hydrochloride (Xylocaine®) Injection	***Currently in Shortage***
Lithium Oral Solution	***Currently in Shortage***
Lorazepam Injection	***Currently in Shortage***
Loxapine Capsules	***Currently in Shortage***
Mepivacaine Hydrochloride Injection	***Currently in Shortage***
Methohexital Sodium (Brevital®) Injection	***Currently in Shortage***
Methyldopa Tablets	***Currently in Shortage***
Midazolam Injection	***Currently in Shortage***
Misoprostol Tablets	***Currently in Shortage***
Morphine Sulfate Injection	***Currently in Shortage***
Multi-Vitamin Infusion (Adult and Pediatric)	***Currently in Shortage***
Nefazodone Hydrochloride Tablets	***Currently in Shortage***
Nizatidine Capsules	***Currently in Shortage***
Ondansetron Hydrochloride Injection	***Currently in Shortage***
Pantoprazole Sodium for Injection	***Currently in Shortage***
Parathyroid Hormone (Natpara®) Injection	***Currently in Shortage***
Physostigmine Salicylate Injection	***Currently in Shortage***
Pindolol Tablets	***Currently in Shortage***
Potassium Acetate Injection	***Currently in Shortage***
Promethazine (Phenergan®) Injection	***Currently in Shortage***
Propofol Injectable Emulsion	***Currently in Shortage***
Protamine Sulfate Injection	***Currently in Shortage***

Rifampin Injection	***Currently in Shortage***
Rifapentine Tablets	***Currently in Shortage***
Ropivacaine Hydrochloride Injection	***Currently in Shortage***
Sclerosol Intrapleural Aerosol	***Currently in Shortage***
Sincalide (Kinevac®) Lyophilized Powder for	***Currently in Shortage***
Sodium Acetate Injection	***Currently in Shortage***
Sodium Bicarbonate Injection	***Currently in Shortage***
Sodium Chloride 23.4% Injection	***Currently in Shortage***
Sodium Chloride Injection USP, 0.9% Vials and	***Currently in Shortage***
Sodium Phosphates Injection	***Currently in Shortage***
Sulfasalazine Tablets	***Currently in Shortage***
Tacrolimus Capsules	***Currently in Shortage***
Technetium Tc99m Succimer Injection (DMSA)	***Currently in Shortage***
Teprotumumab-trbw	***Currently in Shortage***
Thiothixene Capsules	***Currently in Shortage***
Timolol Maleate Ophthalmic Gel Forming	***Currently in Shortage***
Tocilizumab Injection	***Currently in Shortage***
Triamcinolone Hexacetonide Injectable	***Currently in Shortage***
Trimethobenzamide Hydrochloride Capsules	***Currently in Shortage***
Valproate Sodium Injection	***Currently in Shortage***
Varenicline Tartrate (Chantix®) Tablets	***Currently in Shortage***
Vecuronium Bromide for Injection	***Currently in Shortage***