OKLAHOMA
Health Care Authority

Drug Utilization Review Board

Wednesday,
January 12, 2022

No live meeting scheduled for January.
January 2022 will be a packet only meeting.

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

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

MEMORANDUM

TO: Drug Utilization Review (DUR) Board Members

FROM: Michyla Adams, Pharm.D.

SUBJECT: Packet Contents for DUR Board Meeting – January 12, 2022

DATE: January 5, 2022

NOTE: No live January meeting. January 2022 is a packet-only meeting.

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

DUR Board Meeting Minutes – Appendix A

Update on the Medication Coverage Authorization Unit/SoonerCare Opioid Initiative Update – Appendix B

Annual Review of Antihyperlipidemics and 30-Day Notice to Prior Authorize Evkeeza™ (Evinacumab-dgnb) and Leqvio® (Inclisiran) – Appendix C

Annual Review of Glaucoma Medications – Appendix D

Annual Review of Gonadotropin-Releasing Hormone (GnRH) Medications and 30-Day Notice to Prior Authorize Myfembree® (Estradiol/ Norethindrone/Relugolix) – Appendix E

Annual Review of Oxlumo™ (Lumasiran) – Appendix F

Annual Review of Dry Eye Disease (DED) Medications and 30-Day Notice to Prior Authorize Tyrvaya™ (Varenicline Nasal Spray) – Appendix G

Annual Review of Imcivree™ (Setmelanotide) – Appendix H

Annual Review of Elzonris® (Tagraxofusp-erzs) and Inrebic® (Fedratinib) – Appendix I

Annual Review of Turalio® (Pexidartinib) – Appendix J

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

Future Business

Oklahoma Health Care Authority

Drug Utilization Review Board
(DUR Board)
Packet – January 12, 2022

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

NOTE: ***No live January meeting. January 2022 is a packet-only meeting.***

AGENDA

Discussion and action on the following items:

Items to be presented by Dr. Muchmore, Chairman:

1. **DUR Board Meeting Minutes – See Appendix A**
   A. December 8, 2021 DUR Board Meeting Minutes
   B. December 8, 2021 DUR Board Recommendations Memorandum
   C. Correspondence

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

2. **Update on Medication Coverage Authorization Unit/SoonerCare Opioid Initiative Update – See Appendix B**
   A. Pharmacy Helpdesk Activity for December 2021
   B. Medication Coverage Activity for December 2021
   C. SoonerCare Opioid Initiative Update

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

3. **Annual Review of Antihyperlipidemics and 30-Day Notice to Prior Authorize Evkeeza™ (Evinacumab-dgnb) and Leqvio® (Inclisiran) – See Appendix C**
   A. Current Prior Authorization Criteria
   B. Utilization of Antihyperlipidemics
   C. Prior Authorization of Antihyperlipidemics
   D. Market News and Updates
   E. Evkeeza™ (Evinacumab-dgnb) Product Summary
   F. Leqvio® (Inclisiran) Product Summary
   G. College of Pharmacy Recommendations
   H. Utilization Details of Antihyperlipidemics

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

4. **Annual Review of Glaucoma Medications – See Appendix D**
   A. Current Prior Authorization Criteria
   B. Utilization of Glaucoma Medications
   C. Prior Authorization of Glaucoma Medications
   D. Market News and Updates

E. College of Pharmacy Recommendations
F. Utilization Details of Glaucoma Medications

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

5. **Annual Review of Gonadotropin-Releasing Hormone (GnRH) Medications and 30-Day Notice to Prior Authorize Myfembree® (Estradiol/ Norethindrone/Relugolix) – See Appendix E**

A. Current Prior Authorization Criteria
B. Utilization of GnRH Medications
C. Prior Authorization of GnRH Medications
D. Market News and Updates
E. Myfembree® (Estradiol/Norethindrone/Relugolix) Product Summary
F. College of Pharmacy Recommendations
G. Utilization Details of GnRH Medications

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

6. **Annual Review of Oxlumo™ (Lumasiran) – See Appendix F**

A. Current Prior Authorization Criteria
B. Utilization of Oxlumo™ (Lumasiran)
C. Prior Authorization of Oxlumo™ (Lumasiran)
D. Market News and Updates
E. College of Pharmacy Recommendations

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

7. **Annual Review of Dry Eye Disease (DED) Medications and 30-Day Notice to Prior Authorize Tyrvaya™ (Varenicline Nasal Spray) – See Appendix G**

A. Current Prior Authorization Criteria
B. Utilization of DED Medications
C. Prior Authorization of DED Medications
D. Market News and Updates
E. Tyrvaya™ (Varenicline Nasal Spray) Product Summary
F. College of Pharmacy Recommendations
G. Utilization Details of DED Medications

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

8. **Annual Review of Imcivree™ (Setmelanotide) – See Appendix H**

A. Current Prior Authorization Criteria
B. Utilization of Imcivree™ (Setmelanotide)
C. Prior Authorization of Imcivree™ (Setmelanotide)
D. Market News and Updates
E. College of Pharmacy Recommendations

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

9. **Annual Review of Elzonris® (Tagraxofusp-erzs) and Inrebic® (Fedratinib) – See Appendix I**
   A. Introduction
   B. Current Prior Authorization Criteria
   C. Utilization of Elzonris® (Tagraxofusp-erzs) and Inrebic® (Fedratinib)
   D. Prior Authorization of Elzonris® (Tagraxofusp-erzs) and Inrebic® (Fedratinib)
   E. College of Pharmacy Recommendations

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

10. **Annual Review of Turalio® (Pexidartinib) – See Appendix J**
    A. Introduction
    B. Current Prior Authorization Criteria
    C. Utilization of Turalio® (Pexidartinib)
    D. Prior Authorization of Turalio® (Pexidartinib)
    E. College of Pharmacy Recommendations

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

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

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

12. **Future Business* (Upcoming Product and Class Reviews)**
    A. Anticonvulsants
    B. Anti-Migraine Medications
    C. Leukemia Medications
    D. Topical Acne and Rosacea Products

    *Future product and class reviews subject to change.

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 DECEMBER 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 Pharmacist		X
Wynn Phung, Pharm.D.; Clinical Pharmacist		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	
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	

Josh Holloway, J.D.; Deputy General Counsel	X	
Debra Montgomery, D.O.; Medical Director	X	
Jill Ratterman, D.Ph.; Clinical Pharmacist	X	
Paula Root, M.D.; Senior Medical Director, Interim Chief Medical Officer		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:	
Camille Kerr, Regeneron	Stormy Cameron, Artia Solutions
Chrystal Mayes, Sanofi	John Churnetski, Alexion
Garth Wright, Genentech	Kirk Culotta, Merck
Marie Abrego, Sumaira Foundation	Shellie Keast, Mercer
Robert Greely, Biogen	Gina Heinen, Novo Nordisk
Andrew Delgado, BMS	Leah Campbell, Sumaira Foundation
Kenneth Berry, Alkermes	Brian Maves, Pfizer
Nima Nabavi, Amgen	Ronald Cain, Pfizer
Bob Firnberg, Gilead	Don Napper, Apellis
Jamie Tobitt, Apellis	Pratik Parikh, Mirum
Jody Legg, Mirum	Jeff Knappen, Spark
Paul Sparks, Horizon	Marc Parker, Sunovion
Scott Hylla, Sunovion	Clint Degner, Novartis
David Prather, Novo Nordisk	Brent Parker, Merck

PRESENT FOR PUBLIC COMMENT:	
Pratik Parikh, Mirum	Jamie Tobitt, Apellis

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

1A: ROLL CALL

Dr. Muchmore called the meeting to order at 4:00pm. Roll call by Dr. Wilcox established the presence of a quorum.

ACTION: NONE REQUIRED

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

2A: AGENDA ITEM NO. 13 PRATIK PARIKH

2B: AGENDA ITEM NO. 15 JAMIE TOBITT

ACTION: NONE REQUIRED

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

3A: NOVEMBER 10, 2021 DUR MINUTES – VOTE

Materials included in agenda packet; presented by Dr. Muchmore

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

ACTION: MOTION CARRIED

AGENDA ITEM NO. 4: **UPDATE ON MEDICATION COVERAGE AUTHORIZATION UNIT/ACADEMIC DETAILING (AD) PROGRAM UPDATE**

4A: PHARMACY HELPDESK ACTIVITY FOR NOVEMBER 2021

4B: MEDICATION COVERAGE ACTIVITY FOR NOVEMBER 2021

4C: AD PROGRAM UPDATE

Materials included in agenda packet; presented by Dr. Ha, Dr. Travers

ACTION: NONE REQUIRED

AGENDA ITEM NO. 5: **MAINTENANCE DRUG LIST**

5A: INTRODUCTION

5B: SOONERCARE MAINTENANCE DRUG LIST

5C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Ha

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

ACTION: MOTION CARRIED

AGENDA ITEM NO. 6: **VOTE TO PRIOR AUTHORIZE OPZELURA™ (RUXOLITINIB 1.5% CREAM)**

6A: MARKET NEWS AND UPDATES

6B: OPZELURA™ (RUXOLITINIB 1.5% CREAM) PRODUCT SUMMARY

6C: 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

AGENDA ITEM NO. 7: **VOTE TO PRIOR AUTHORIZE ABECMA® (IDECABTAGENE VICLEUCEL), FARYDAK® (PANOBINOSTAT), AND PEPAXTO® (MELPHALAN FLUFENAMIDE) AND UPDATE THE APPROVAL CRITERIA FOR THE MULTIPLE MYELOMA MEDICATIONS**

7A: MARKET NEWS AND UPDATES

7B: ABECMA® (IDECABTAGENE VICLEUCEL) PRODUCT SUMMARY

7C: FARYDAK® (PANOBINOSTAT) PRODUCT SUMMARY

7D: PEPAXTO® (MELPHALAN FLUFENAMIDE) PRODUCT SUMMARY

7E: 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

AGENDA ITEM NO. 8: **VOTE TO PRIOR AUTHORIZE JEMPERLI® (DOSTARLIMAB-GXLY) AND UPDATE THE RENAL CELL CARCINOMA (RCC) APPROVAL CRITERIA FOR KEYTRUDA® (PEMBROLIZUMAB) AND LENVIMA® (LENVATINIB)**

8A: MARKET NEWS AND UPDATES

8B: JEMPERLI® (DOSTARLIMAB-GXLY) PRODUCT SUMMARY

8C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Borders

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

ACTION: MOTION CARRIED

AGENDA ITEM NO. 9: **ANNUAL REVIEW OF SKIN CANCER MEDICATIONS**

9A: INTRODUCTION

9B: CURRENT PRIOR AUTHORIZATION CRITERIA

9C: UTILIZATION OF SKIN CANCER MEDICATIONS

9D: PRIOR AUTHORIZATION OF SKIN CANCER MEDICATIONS

9E: MARKET NEWS AND UPDATES

9F: COLLEGE OF PHARMACY RECOMMENDATIONS

9G: UTILIZATION DETAILS OF SKIN CANCER MEDICATIONS

Materials included in agenda packet; presented by Dr. Borders

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

ACTION: MOTION CARRIED

AGENDA ITEM NO. 10: **ANNUAL REVIEW OF CROHN'S DISEASE AND ULCERATIVE COLITIS (UC) MEDICATIONS**

10A: CURRENT PRIOR AUTHORIZATION CRITERIA
10B: UTILIZATION OF CROHN'S DISEASE AND UC MEDICATIONS
10C: PRIOR AUTHORIZATION OF CROHN'S DISEASE AND UC MEDICATIONS
10D: MARKET NEWS AND UPDATES
10E: COLLEGE OF PHARMACY RECOMMENDATIONS
10F: UTILIZATION DETAILS OF CROHN'S DISEASE AND UC MEDICATIONS

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

AGENDA ITEM NO. 11: **ANNUAL REVIEW OF ANTICOAGULANTS AND PLATELET AGGREGATION INHIBITORS**

11A: CURRENT PRIOR AUTHORIZTION CRITERIA
11B: UTILIZATION OF ANTICOAGULANTS AND PLATELET AGGREGATION INHIBITORS
11C: PRIOR AUTHORIZATION OF ANTICOAGULANTS AND PLATELET AGGREGATION INHIBITORS
11D: MARKET NEWS AND UPDATES
11E: COLLEGE OF PHARMACY RECOMMENDATIONS
11F: UTILIZATION DETAILS OF ANTICOAGULANTS AND PLATELET AGGREGATION INHIBITORS

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

AGENDA ITEM NO. 12: **ANNUAL REVIEW OF ANTIDEPRESSANTS AND 30-DAY NOTICE TO PRIOR AUTHORIZE SERTRALINE CAPSULES**

12A: CURRENT PRIOR AUTHORIZATION CRITERIA
12B: UTILIZATION OF ANTIDEPRESSANTS
12C: PRIOR AUTHORIZATION OF ANTIDEPRESSANTS
12D: MARKET NEWS AND UPDATES
12E: SERTRALINE CAPSULE PRODUCT SUMMARY
12F: COLLEGE OF PHARMACY RECOMMENDATIONS
12G: UTILIZATION DETAILS OF ANTIDEPRESSANTS

Materials included in agenda packet; presented by Dr. Chandler
ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY 2022

AGENDA ITEM NO. 13: **30-DAY NOTICE TO PRIOR AUTHORIZE LIVMARLI™ (MARALIXIBAT)**

13A: INTRODUCTION
13B: LIVMARLI™ (MARALIXIBAT) PRODUCT SUMMARY
13C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Wilson
ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY 2022

AGENDA ITEM NO. 14: **30-DAY NOTICE TO PRIOR AUTHORIZE BYOOVIZ™ (RANIBIZUMAB-NUNA INJECTION) AND SUSVIMO™ (RANIBIZUMAB INTRAVITREAL IMPLANT)**

14A: INTRODUCTION
14B: MARKET NEWS AND UPDATES
14C: BYOOVIZ™ (RANIBIZUMAB-NUNA INJECTION) PRODUCT SUMMARY
14D: SUSVIMO™ (RANIBIZUMAB INTRAVITREAL IMPLANT) PRODUCT SUMMARY

14E: COLLEGE OF PHARMACY RECOMMENDATIONS
14F: UTILIZATION DETAILS OF OPHTHALMIC VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) INHIBITOR MEDICATIONS

Materials included in agenda packet; presented by Dr. Nawaz

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY 2022

AGENDA ITEM NO. 15: ANNUAL REVIEW OF ENSPRYNG™ (SATRALIZUMAB-MWGE), SOLIRIS® (ECULIZUMAB), ULTOMIRIS® (RAVULIZUMAB-CWVZ) AND UPLIZNA® (INEBILIZUMAB-CDON) AND 30-DAY NOTICE TO PRIOR AUTHORIZE EMPAVELI™ (PEGCETACOPLAN)

15A: CURRENT PRIOR AUTHORIZATION CRITERIA
15B: UTILIZATION OF ENSPRYNG™ (SATRALIZUMAB-MWGE), SOLIRIS® (ECULIZUMAB), ULTOMIRIS® (RAVULIZUMAB-CWVZ), AND UPLIZNA® (INEBILIZUMAB-CDON)
15C: PRIOR AUTHORIZATION OF ENSPRYNG™ (SATRALIZUMAB-MWGE), SOLIRIS® (ECULIZUMAB), ULTOMIRIS® (RAVULIZUMAB-CWVZ), AND UPLIZNA® (INEBILIZUMAB-CDON)
15D: MARKET NEWS AND UPDATES
15E: EMPAVELI™ (PEGCETACOPLAN) PRODUCT SUMMARY
15F: COLLEGE OF PHARMACY RECOMMENDATIONS
15G: UTILIZATION DETAILS OF ENSPRYNG™ (SATRALIZUMAB-MWGE), SOLIRIS® (ECULIZUMAB), ULTOMIRIS® (RAVULIZUMAB-CWVZ), AND UPLIZNA® (INEBILIZUMAB-CDON)

Materials included in agenda packet; presented by Dr. Ha

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY 2022

AGENDA ITEM NO. 16: 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. 17: FUTURE BUSINESS* (UPCOMING PRODUCT AND CLASS REVIEWS)

No live DUR Board meeting scheduled for January 2022. January 2022 will be a packet-only meeting.

17A: ANTIHYPERLIPIDEMICS
17B: DRY EYE DISEASE (DED) MEDICATIONS
17C: GLAUCOMA MEDICATIONS
17D: GONADOTROPIN-RELEASING HORMONE (GNRH) MEDICATIONS

*Future product and class reviews subject to change.

Materials included in agenda packet; presented by Dr. Adams

ACTION: NONE REQUIRED

AGENDA ITEM NO. 18: ADJOURNMENT

The meeting was adjourned at 5:25pm.

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

Memorandum

Date: December 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 December 8, 2021

Recommendation 1: Academic Detailing Program Update

NO ACTION REQUIRED.

Recommendation 2: Maintenance Drug List

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends adding a new medication category, Thyroid Medications, to the SoonerCare Maintenance Drug List:

- Alzheimer's Medications
- Anticonvulsants
- Antidepressants
- Antihypertensive Medications
- Antipsychotic Medications
- Anti-Ulcer Medications
- Bladder Control Medications
- Benign Prostatic Hyperplasia (BPH) Medications
- Cardiovascular Medications
- Chronic Obstructive Pulmonary Disease (COPD) Medications
- Diabetes Medications
- Glaucoma Medications

- Hyperlipidemia Medications
- Parkinson's Medications
- Thyroid Medications

Recommendation 3: Vote to Prior Authorize Opzelura™ (Ruxolitinib 1.5% Cream)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Opzelura™ (ruxolitinib 1.5% cream) with the following criteria:

Opzelura™ (Ruxolitinib 1.5% Cream) Approval Criteria:

1. An FDA approved indication for short-term and non-continuous treatment of mild-to-moderate atopic dermatitis; and
2. Member must be 12 years of age or older; and
3. Member must not be immunocompromised; and
4. Member must have a body surface area (BSA) involvement ≤20%; and
5. Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with all of the following therapies (or have a contraindication or documented intolerance):
   a. One medium potency to very-high potency Tier-1 topical corticosteroid (TCS); and
   b. One topical calcineurin inhibitor (TCI) [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
   c. Eucrisa® (crisaborole); and
6. Concurrent use with therapeutic biologics, other Janus kinase (JAK) inhibitors, or potent immunosuppressants (e.g., azathioprine, cyclosporine) will not generally be approved; and
7. Prescriber must verify female members are not breastfeeding; and
8. If the member is pregnant or becomes pregnant, prescriber must verify member has been counseled on potential risks of this medication and will report the exposure to the Opzelura™ pregnancy registry; and
9. Approvals will be for a maximum duration of 8 weeks of treatment; and
10. Reauthorization may be considered if member has a recent TCS, TCI, or Eucrisa® trial (or a contraindication or documented intolerance); and
    a. Additionally, the prescriber must document the member had a positive response to and tolerated previous treatment with Opzelura™; and
11. Subsequent approvals will only be considered once each 90-day period to ensure appropriate short-term and non-continuous utilization.

Recommendation 4: Vote to Prior Authorize Abecma® (Idecabtagene Vicleucel), Farydak® (Panobinostat), and Pepaxto® (Melphalan Flufenamide) and Update the Approval Criteria for the Multiple Myeloma Medications

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Abecma® (idecabtagene vicleucel), Farydak® (panobinostat), and Pepaxto® (melphalan flufenamide) with the following criteria (shown in red):

Abecma® (Idecabtagene Vicleucel) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM):
    a. Member has received ≥4 prior lines of therapy, including an immunomodulatory agent, a proteasome inhibitor (PI), and an anti-CD38 monoclonal antibody; and
        i. Induction with or without autologous hematopoietic stem cell transplant and with or without maintenance therapy is considered a single regimen; and
        ii. Must have undergone ≥2 consecutive cycles of treatment for each regimen unless progressive disease was seen after 1 cycle; and
    b. Member must have measurable disease, including at least 1 of the following:
        i. Serum M-protein ≥0.5g/dL; or
        ii. Urine M-protein ≥200mg/24hr; or
        iii. Serum free light chain (FLC) assay: involved FLC ≥10mg/dL (100mg/L); or
        iv. Bone marrow plasma cells >30% of total bone marrow cells; and
    c. Member must not have any central nervous system involvement with multiple myeloma.

Farydak® (Panobinostat) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM); and
2. Used in combination with bortezomib and dexamethasone after 1 or more lines of therapy; or
3. Used in combination with carfilzomib or dexamethasone and lenalidomide after 2 or more lines of therapy (including bortezomib and an immunomodulatory agent).

Pepaxto® (Melphalan Flufenamide) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM); and

2. Member has received at least 4 prior lines of therapy (including being refractory to at least 1 proteasome inhibitor, 1 immunomodulatory agent, and 1 CD-38 directed monoclonal antibody); and
3. Members who are new to treatment with Pepaxto® will generally not be approved.

The College of Pharmacy also recommends updating the approval criteria for Sarclisa® (isatuximab-irfc) based on the recent FDA approval (changes and new criteria noted in red):

Sarclisa® (Isatuximab-irfc) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM); and
2. Used in 1 of the following settings:
    a. Used in combination with pomalidomide and dexamethasone after ≥2 prior therapies [previous treatment must have included lenalidomide and a proteasome inhibitor (PI)]; or
    b. Used in combination with carfilzomib and dexamethasone after 1 to 3 prior therapies.

Finally, the College of Pharmacy recommends updating the prior authorization criteria for Darzalex® (daratumumab) and Darzalex Faspro® (daratumumab/hyaluronidase-fihj) based on National Comprehensive Cancer Network (NCCN) Compendium approval (changes noted in red):

Darzalex® (Daratumumab) and Darzalex Faspro® (Daratumumab/ Hyaluronidase-fihj) Approval Criteria [Multiple Myeloma Diagnosis]:

1. Diagnosis of multiple myeloma; and
2. Used in 1 of the following settings:
    a. In combination with lenalidomide and dexamethasone as primary therapy in members who are ineligible for autologous stem cell transplant (ASCT) or in members who have received at least 1 prior therapy; or
    b. In combination with bortezomib, melphalan, and prednisone as primary therapy in members who are ineligible for ASCT; or
    c. In combination with bortezomib, thalidomide, and dexamethasone or bortezomib, lenalidomide, and dexamethasone as primary therapy in members who are eligible for ASCT; or
    ~~d. In combination with carfilzomib and dexamethasone in members with relapsed or progressive disease; or~~
    ~~e. In combination with bortezomib and dexamethasone in members who have received at least 1 prior therapy; or~~
    ~~f. In combination with cyclophosphamide, bortezomib, and dexamethasone in members who have received at least 1 prior therapy; or~~
    ~~g. In combination with pomalidomide and dexamethasone in members who have received ≥2 prior therapies including a proteasome inhibitor (PI) and an immunomodulatory agent; or~~

h. After at least 1 prior therapy in combination with 1 of the following:
    i. Dexamethasone and bortezomib; or
    ii. Carfilzomib and dexamethasone; or
    iii. Dexamethasone and lenalidomide; or
    iv. Cyclophosphamide, bortezomib, and dexamethasone; or
    v. Pomalidomide and dexamethasone* [*previous therapy for this combination must include lenalidomide and a protease inhibitor (PI)]; or
    vi. Selinexor and dexamethasone; or
i. In combination with lenalidomide and dexamethasone for members who are ineligible for ASCT or with cyclophosphamide, bortezomib, and dexamethasone as primary therapy or for disease relapse after 6 months following primary induction therapy with the same regimen; or
j. As a single-agent in members who have received ≥3 prior therapies, including a PI and an immunomodulatory agent, or who are double refractory to a PI and an immunomodulatory agent.

Recommendation 5: Vote to Prior Authorize Jemperli® (Dostarlimab-gxly) and Update the Renal Cell Carcinoma (RCC) Approval Criteria for Keytruda® (Pembrolizumab) and Lenvima® (Lenvatinib)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Jemperli® (dostarlimab-gxly) with the following criteria (noted in red):

Jemperli® (Dostarlimab-gxly) Approval Criteria [Endometrial Cancer Diagnosis]:

1. Diagnosis of advanced, recurrent, or metastatic endometrial cancer; and
2. Mismatch repair deficient (dMMR) disease; and
3. Disease has progressed on or following prior treatment with a platinum-containing regimen.

Jemperli® (Dostarlimab-gxly) Approval Criteria [Mismatch Repair Deficient (dMMR) Solid Tumor Diagnosis]:

1. Diagnosis of recurrent or advanced solid tumors that are mismatch repair deficient (dMMR); and
2. Disease has progressed on or following prior treatment; and
3. There are no satisfactory treatment alternatives for the member.

Additionally, the College of Pharmacy recommends updating the RCC approval criteria for Keytruda® (pembrolizumab) and Lenvima® (lenvatinib) based on recent FDA approvals (changes and new criteria noted in red; only criteria with updates are listed):

Keytruda® (Pembrolizumab) Approval Criteria [Renal Cell Carcinoma (RCC) Diagnosis]:

1. Diagnosis of new or recurrent stage 4 clear-cell RCC; and
    a. Member has not received previous systemic therapy for advanced disease; and
    b. Must be used in combination with axitinib or lenvatinib; and
    c. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; or
2. Diagnosis of RCC at intermediate-high or high risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions.

Lenvima® (Lenvatinib) Approval Criteria [Renal Cell Carcinoma (RCC) Diagnosis]:

1. Diagnosis of advanced RCC; and
    a. Used in combination with pembrolizumab; or
    b. Following 1 prior anti-angiogenic therapy; and
        i. Used in combination with everolimus.

Recommendation 6: Annual Review of Skin Cancer Medications

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends updating the approval criteria for Keytruda® (pembrolizumab), Opdivo® (nivolumab), and Tecentriq® (atezolizumab) based on the recent FDA approvals (changes and new criteria noted in red):

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

1. Diagnosis of recurrent or metastatic cervical cancer; and
2. Tumor must express programmed death ligand 1 (PD-L1) [combined positive score (CPS) ≥1)]; and
3. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; and
    a. Disease progression on or after chemotherapy; or
    b. As first-line therapy in combination with chemotherapy, with or without bevacizumab.

Keytruda® (Pembrolizumab) Approval Criteria [Esophageal~~, Gastric,~~ or Gastroesophageal Junction (GEJ) Carcinoma Diagnosis]:

1. Diagnosis of locally advanced, recurrent, or metastatic esophageal~~, gastric,~~ or GEJ carcinoma; and
2. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; and
~~3. Tumor must have positive programmed death ligand 1 (PD-L1) expression [combined positive score (CPS) ≥10]; and~~
4. For first-line therapy:

a. In combination with ~~either oxaliplatin or cisplatin plus a~~ platinum- and fluoropyrimidine-based chemotherapy; or

5. For second-line or greater therapy:
   a. Following disease progression after 1 or more prior lines of systemic therapy; and
   b. Tumor must be squamous cell histology; and
   c. As a single agent~~.~~; and
   d. Tumor expresses programmed death ligand 1 (PD-L1) [combined positive score (CPS ≥10).

Keytruda® (Pembrolizumab) Approval Criteria [Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of locally advanced, unresectable, or metastatic gastric or GEJ adenocarcinoma; and
2. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Opdivo® (nivolumab)]; and
3. For first-line therapy:
   a. Human epidermal receptor 2 (HER2)-positive disease; and
   b. In combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy; or
4. For second-line or greater therapy:
   a. As a single agent; and
   b. Tumor expresses programmed death ligand 1 (PD-L1) [combined positive score (CPS) ≥1]; and
   c. Following disease progression on or after 2 or more lines of therapy including fluoropyrimidine- and platinum-containing chemotherapy and if appropriate, HER2-targeted therapy.

Opdivo® (Nivolumab) Approval Criteria [Urothelial Bladder Cancer Diagnosis]:

1. Diagnosis of urothelial carcinoma; and
   a. Member has undergone radical resection; and
   b. Disease is at high risk of recurrence; or
2. Diagnosis of metastatic or unresectable locally advanced disease; and
   a. Used as second-line or greater therapy; and
   b. Previous failure of a platinum-containing regimen; and
   c. Member has not previously failed other programmed death 1 (PD-1) inhibitors [e.g., Keytruda® (pembrolizumab)].

Opdivo® (Nivolumab) Approval Criteria [Esophageal ~~Squamous Cell Carcinoma (ESCC)~~ or Gastroesophageal Junction (GEJ) Cancer Diagnosis]:

~~1. Diagnosis of unresectable, advanced, recurrent or metastatic esophageal squamous cell carcinoma disease; and~~
   ~~a. Following prior fluoropyrimidine- and platinum-based chemotherapy; or~~

2. Diagnosis of esophageal or GEJ cancer; and
   a. Member has received preoperative chemoradiation; and

b. Member underwent R0 (complete) resection and has residual disease; and
c. As a single agent; or

3. Palliative therapy for members who are not surgical candidates or have unresectable locally advanced, recurrent, or metastatic disease; and
   a. Human epidermal receptor 2 (HER2)-negative disease; and
      i. In first-line therapy; and
         1. In combination with oxaliplatin and fluorouracil or capecitabine; and
         2. Adenocarcinoma pathology; or
      ii. In second-line or greater therapy; and
         1. As a single agent; and
         2. Squamous cell pathology.

Opdivo® (Nivolumab) Approval Criteria [Gastric Cancer Diagnosis]:

1. Diagnosis of advanced or metastatic disease; and
2. Used in combination with fluoropyrimidine- and platinum-containing chemotherapy.

Tecentriq® (Atezolizumab) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of non-squamous NSCLC; and
   a. First-line therapy for metastatic disease; and
   b. Member does not have epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), ROS1, BRAF, MET exon 14 skipping mutation, or RET mutations; and
   c. In combination with bevacizumab, paclitaxel, and carboplatin (maximum of 6 cycles) or in combination with paclitaxel (protein bound) and carboplatin; and
   d. Atezolizumab and bevacizumab may be continued after the above combination in members without disease progression (applies to the bevacizumab/paclitaxel/carboplatin regimen); or
2. Diagnosis of NSCLC; and
   a. For first-line therapy for metastatic disease:
      i. As a single-agent; and
      ii. Member does not have epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), ROS1, BRAF, MET exon 14 skipping, or RET mutations; and
      iii. High programmed death ligand-1 (PD-L1) expression determined by 1 of the following:
         1. PD-L1 stained ≥50% of tumor cells (TC≥50%); or
         2. PD-L1 stained tumor-infiltrating immune cells (IC) covering ≥10% of the tumor area (IC≥10%); or
   b. For subsequent therapy for metastatic disease:
      i. As a single-agent; or
3. Diagnosis of stage 2 or 3A NSCLC; and

a. Member has undergone resection and completed platinum-based chemotherapy; and
b. PD-L1 expression of ≥1% of TC.

Recommendation 7: Annual Review of Crohn's Disease (CD) and Ulcerative Colitis (UC) Medications

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the CD and UC prior authorization criteria (changes noted in red):

1. Removing the Giazo® prior authorization criteria based on product discontinuation; and
2. Removing the prior authorization on Pentasa® 500mg based on net costs; and
3. Updating the Pentasa® quantity limit approval criteria to include information for both strengths of Pentasa®.

~~**Giazo® (Balsalazide) Approval Criteria:**~~

~~1. An FDA approved indication of mildly-to-moderately active ulcerative colitis (UC); and~~
~~2. Member must be 18 years of age or older; and~~
~~3. Member must be male (effectiveness of Giazo® was not demonstrated in female patients in clinical trials); and~~
~~4. A patient-specific, clinically significant reason why the member cannot use generic balsalazide 750mg capsules or other products available without prior authorization must be provided; and~~
~~5. Approvals will be for the duration of 8 weeks. After 8 weeks of treatment the prescriber must document a patient-specific, clinically significant reason the member needs a longer duration of treatment.~~

~~**Pentasa® (Mesalamine 500mg Controlled-Release Capsules) Approval Criteria:**~~

~~1. An FDA approved indication for the induction of remission or for the treatment of patients with mildly-to-moderately active ulcerative colitis (UC); and~~
~~2. A patient-specific, clinically significant reason the member cannot use Pentasa® 250mg controlled-release capsules or other available mesalamine products that do not require prior authorization must be provided; and~~
~~3. Approvals will be for the duration of 8 weeks in accordance with manufacturer recommended duration of therapy; and~~
~~4. A quantity limit of 240 capsules per 30 days will apply.~~

Pentasa® (Mesalamine ~~250mg~~ Controlled-Release Capsules) Quantity Limit Approval Criteria:

1. A quantity limit of 480 capsules per 30 days will apply for the 250mg strength and a quantity limit of 240 capsules per 30 days will apply for the 500mg strength; and
2. The first 8 weeks of treatment do not require prior authorization; and
3. After 8 weeks of treatment:
    a. Provider must document a patient-specific, clinically significant reason member needs a longer duration of treatment.

The following medications do not require prior authorization: Colazal® (balsalazide) capsules, hydrocortisone enemas, Apriso® (mesalamine) extended-release capsules, Canasa® (mesalamine) suppositories, Delzicol® (mesalamine) delayed-release (DR) capsules, Lialda® (mesalamine) DR capsules, Pentasa® (mesalamine) ~~250mg~~ controlled-release capsules, Rowasa® (mesalamine) rectal suspension enemas, Dipentum® (olsalazine) capsules, sulfasalazine 500mg tablets, and sulfasalazine DR 500mg tablets.

Recommendation 8: Annual Review of Anticoagulants and Platelet Aggregation Inhibitors

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the anticoagulants and platelet aggregation inhibitors prior authorization criteria (changes noted in red):

1. Removing the Bevyxxa® (betrixaban) prior authorization criteria based on product discontinuation; and
2. Updating the approval criteria for Pradaxa® (dabigatran) based on the new FDA approved indications and formulations.

~~**Bevyxxa® (Betrixaban) Approval Criteria:**~~

~~1. An FDA approved indication for the prophylaxis of venous thromboembolism (VTE) in adult members hospitalized for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE; and~~
~~2. If the member started on the medication in the hospital, number of days of treatment with betrixaban in the hospital must be provided; and~~
~~3. Approvals will be for a maximum duration of 42 days (including use accounted for while in hospital); and~~
~~4. A quantity limit of 43 capsules per 42 days will apply.~~

Pradaxa® (Dabigatran) Approval Criteria:

1. Pradaxa® (dabigatran) capsules require the following:
    a. An FDA approved indication of 1 of the following:
        i. Non-valvular atrial fibrillation; or
        ii. Treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE) after treatment with a parenteral anticoagulant for 5 to 10 days; or
        iii. To reduce the risk of recurrent DVT or PE in members who have been previously treated; or
        iv. For the prophylaxis of DVT and PE in members who have undergone hip replacement surgery; or
        v. For the treatment of venous thromboembolic events (VTE) in pediatric members 8 to 18 years of age who have been treated with a parenteral anticoagulant for at least 5 days; or
        vi. To reduce the risk of recurrent VTE in pediatric members 8 to 18 years of age who have been previously treated.
2. Pradaxa® (dabigatran) oral pellets require the following:
    a. An FDA approved indication of 1 of the following:
        i. Treatment of VTE in members who have been treated with a parenteral anticoagulant for at least 5 days; or
        ii. To reduce the risk of recurrent VTE in members who have been previously treated; and
    b. Member must be 3 months of age or older; and
    c. Members older than 10 years of age require a patient-specific, clinically significant reason why the oral capsule formulation cannot be used.

Recommendation 9: Annual Review of Antidepressants and 30-Day Notice to Prior Authorize Sertraline Capsules

NO ACTION REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY 2022.

Recommendation 10: 30-Day Notice to Prior Authorize Livmarli™ (Maralixibat)

NO ACTION REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY 2022.

Recommendation 11: 30-Day Notice to Prior Authorize Byooviz™ (Ranibizumab-nuna Intravitreal Injection) and Susvimo™ (Ranibizumab Intravitreal Implant)

NO ACTION REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY 2022.

Recommendation 12: Annual Review of Enspryng™ (Satralizumab-mwge), Soliris® (Eculizumab), Ultomiris® (Ravulizumab-cwvz), and Uplizna® (Inebilizumab-cdon) and 30-Day Notice to Prior Authorize Empaveli™ (Pegcetacoplan)

NO ACTION REQUIRED; WILL BE AN ACTION ITEM IN FEBRUARY 2022.

Recommendation 13: U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates

NO ACTION REQUIRED.

Recommendation 14: Future Business

No live DUR Board meeting is scheduled for January 2022. January 2022 will be a packet-only meeting.

NO ACTION REQUIRED.

December 7, 2021

Good afternoon

I am Dr.Sirish Palle, Pediatric Gastroenterologist and Hepatologist at Oklahoma University Children's Hospital, I reviewed recommendation/approval criteria for Maralixibat and I would like to comment regarding approval criteria number 4 and number 7:

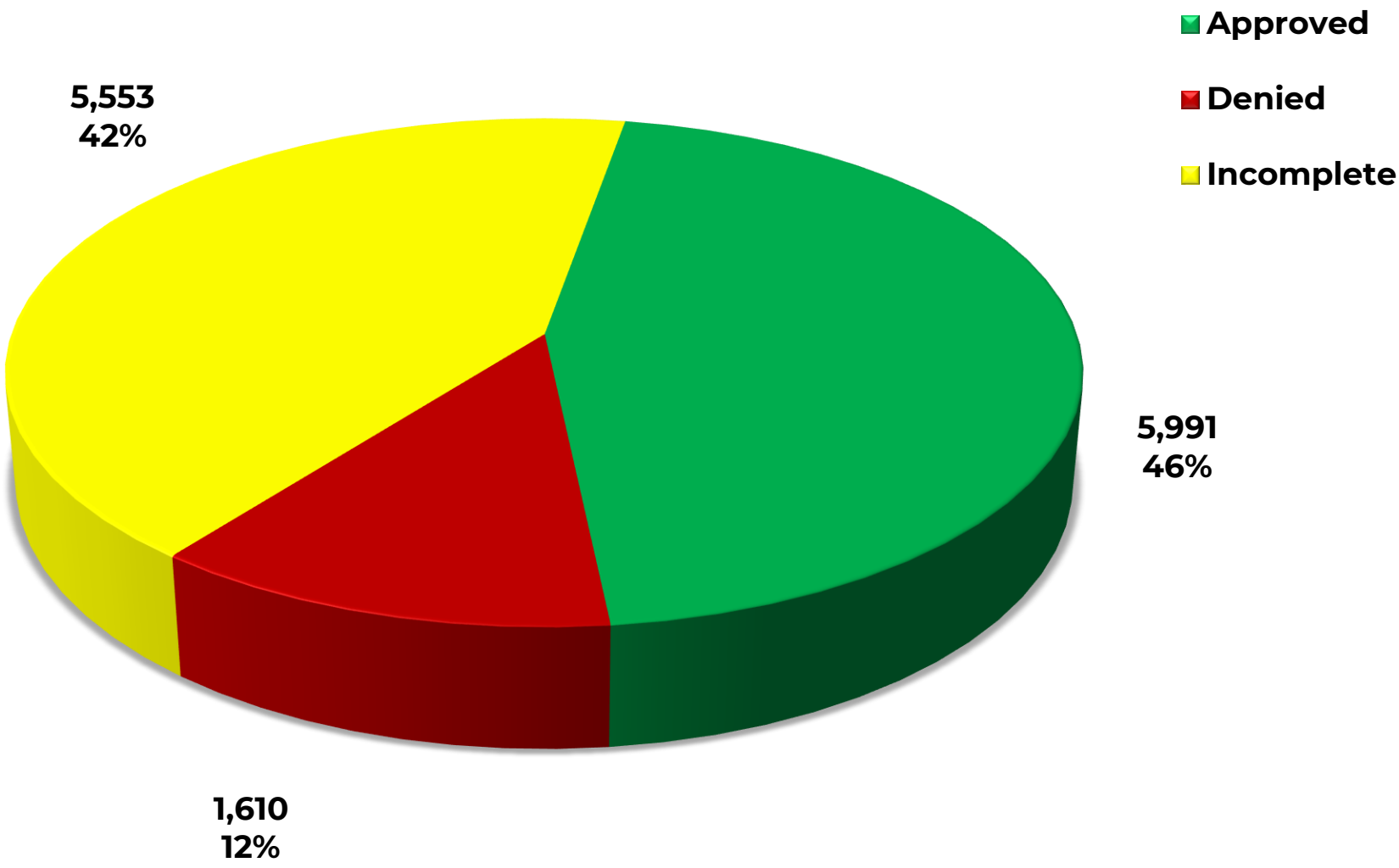
Criteria number 4: We use Ursodeoxycholic acid as a standard if we notice any cholestasis in children with Alagille syndrome - this helps with changing bile acid pool and also pruritis but in our experience other medications listed here (Cholestyramine, Rifampin, Sertraline, Naltrexone) does not work. For example, kids do not tolerate Cholestyramine at all (does not taste good and not palatable) and Sertraline/Naltrexone makes children very sleepy and drowsy. So, as pediatric gastroenterologist we are left to prescribe these mediations which have lot of adverse effects with little benefits for pruritis in Alagille syndrome when we have better medication like Maralixibat with little to no side effects. I kindly request you to consider changing the criteria pruritis unresponsive to treatment with at least only one medication ursodeoxycholic acid (UDCA)

Criteria number 7: For Alagille syndrome there is very limited data that biliary diversion works. Even in our experience (n=1) biliary diversion made things worst and mom requested take down pretty quickly. I wanted to mention my clinical experience

Please let me know if any questions
Thanks
Sirish Palle MD
Assistant Professor in Pediatrics
Section of Pediatric Gastroenterology, Hepatology and Nutrition
Department of Pediatrics
Oklahoma University Children's Hospital
1200 Children's Avenue
Oklahoma City, OK

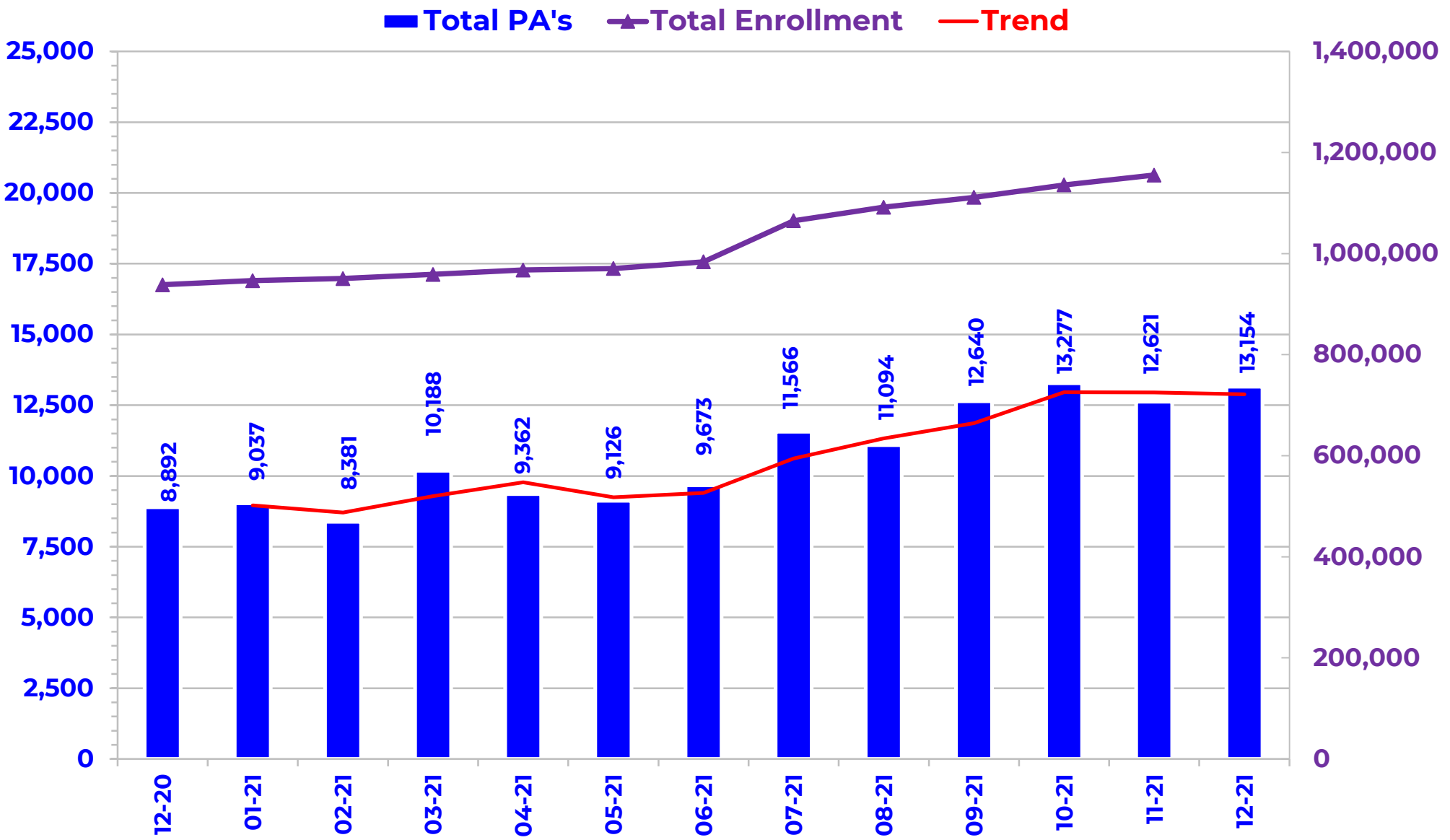
Appendix B

PRIOR AUTHORIZATION ACTIVITY REPORT: DECEMBER 2021



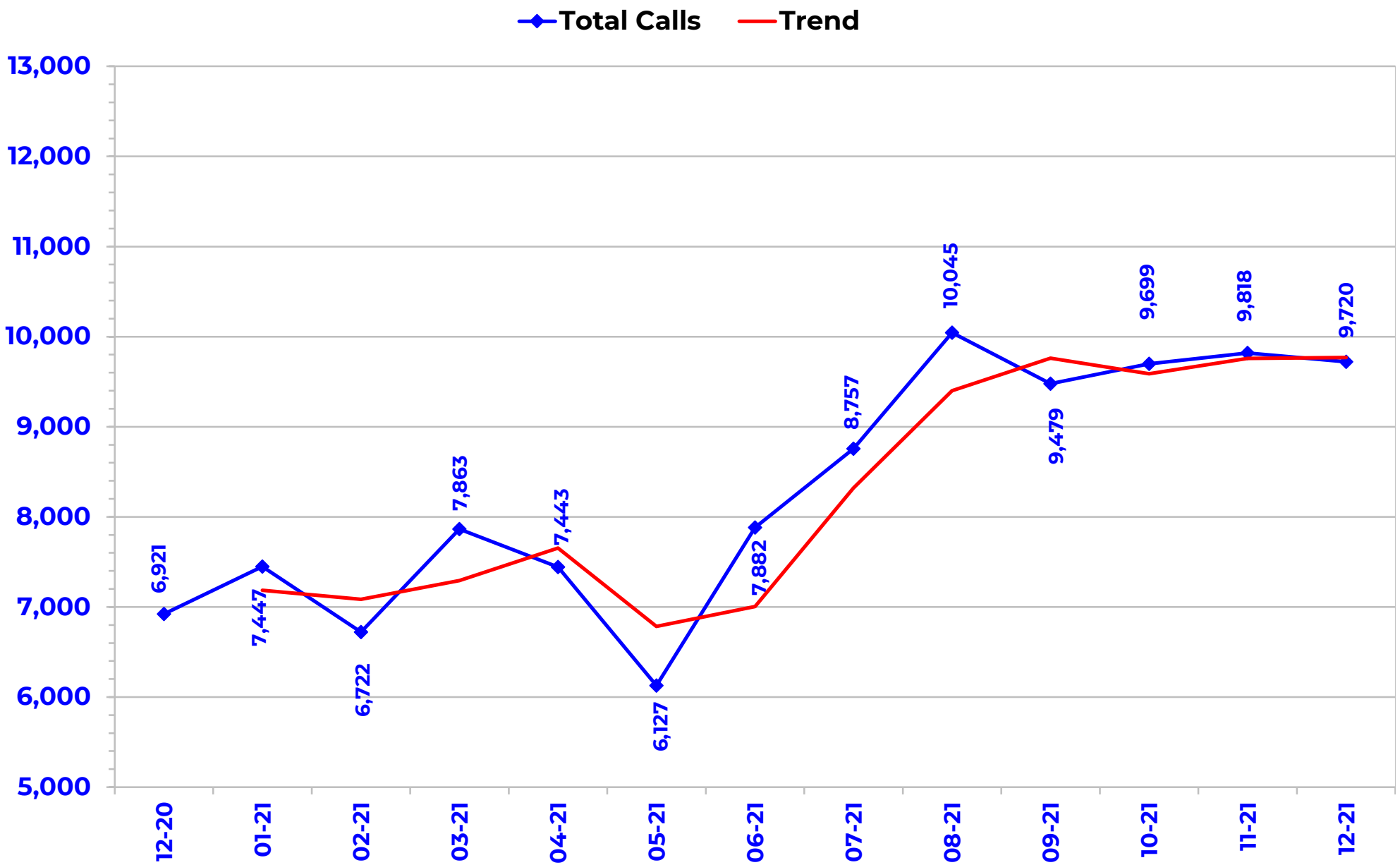
PA totals include approved/denied/incomplete/overrides

PRIOR AUTHORIZATION REPORT: DECEMBER 2020 – DECEMBER 2021



PA totals include approved/denied/incomplete/overrides

CALL VOLUME MONTHLY REPORT: DECEMBER 2020 – DECEMBER 2021



Prior Authorization Activity

12/1/2021 Through 12/31/2021

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort/Dulera	116	24	14	78	342
Analgesic - NonNarcotic	16	0	2	14	0
Analgesic, Narcotic	289	107	35	147	155
Antiasthma	80	27	15	38	308
Antibiotic	50	28	2	20	159
Anticonvulsant	204	89	12	103	297
Antidepressant	351	98	30	223	350
Antidiabetic	1,084	411	142	531	357
Antigout	21	4	2	15	358
Antihemophilic Factor	23	16	0	7	259
Antihistamine	56	12	12	32	275
Antimigraine	446	60	144	242	175
Antineoplastic	182	118	4	60	166
Antiparasitic	36	12	12	12	41
Antiparkinsons	15	3	5	7	297
Antiulcers	51	3	7	41	85
Anxiolytic	17	1	2	14	52
Atypical Antipsychotics	434	206	41	187	354
Biologics	252	137	16	99	287
Bladder Control	77	8	23	46	290
Blood Thinners	666	359	39	268	342
Botox	58	37	13	8	277
Buprenorphine Medications	85	31	9	45	81
Calcium Channel Blockers	13	2	3	8	267
Cardiovascular	120	50	11	59	301
Chronic Obstructive Pulmonary Disease	291	55	61	175	331
Constipation/Diarrhea Medications	198	35	56	107	207
Contraceptive	23	9	3	11	326
Corticosteroid	15	1	4	10	360
Dermatological	408	129	93	186	196
Diabetic Supplies	886	373	107	406	231
Endocrine & Metabolic Drugs	71	43	3	25	207
Erythropoietin Stimulating Agents	23	14	1	8	103
Fibric Acid Derivatives	12	4	2	6	359
Fibromyalgia	11	2	3	6	361
Fish Oils	32	2	13	17	358
Gastrointestinal Agents	120	34	24	62	164
Genitourinary Agents	17	0	7	10	0
Glaucoma	25	3	5	17	157
Growth Hormones	98	58	16	24	146

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

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Hematopoietic Agents	13	6	0	7	70
Hepatitis C	234	154	21	59	9
HFA Rescue Inhalers	18	0	2	16	0
Insomnia	84	6	20	58	151
Insulin	243	79	26	138	352
Miscellaneous Antibiotics	20	3	3	14	76
Multiple Sclerosis	65	28	11	26	175
Muscle Relaxant	57	3	14	40	25
Nasal Allergy	165	20	55	90	184
Neurological Agents	124	48	15	61	245
Neuromuscular Agents	10	4	2	4	267
NSAIDs	26	1	3	22	358
Ocular Allergy	18	0	7	11	0
Ophthalmic Anti-infectives	22	3	2	17	15
Ophthalmic Corticosteroid	17	4	2	11	313
Osteoporosis	31	13	5	13	342
Other*	342	81	63	198	282
Otic Antibiotic	24	5	3	16	10
Respiratory Agents	51	29	4	18	230
Smoking Cess.	38	2	27	9	84
Statins	32	10	8	14	154
Stimulant	1,288	855	44	389	345
Synagis	270	114	53	103	67
Testosterone	165	41	40	84	342
Thyroid	39	21	3	15	320
Topical Antifungal	19	3	4	12	11
Topical Corticosteroids	64	0	30	34	0
Vitamin	120	19	46	55	109
Pharmacotherapy	140	126	0	14	210
Emergency PAs	0	0	0	0	
Total	**10,711**	**4,283**	**1,506**	**4,922**	

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

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Overrides					
Brand	24	11	1	12	360
Compound	15	11	0	4	42
Cumulative Early Refill	3	2	0	1	180
Diabetic Supplies	10	7	0	3	158
Dosage Change	397	381	0	16	14
High Dose	2	1	0	1	357
Ingredient Duplication	6	3	1	2	8
Lost/Broken Rx	120	103	3	14	18
MAT Override	306	224	6	76	90
NDC vs. Age	433	292	24	117	288
NDC vs. Sex	8	5	0	3	85
Nursing Home Issue	67	61	0	6	10
Opioid MME Limit	163	65	8	90	98
Opioid Quantity	40	31	2	7	168
Other	68	42	8	18	22
Quantity vs. Days Supply	714	421	49	244	228
STBS/STBSM	15	10	1	4	78
Step Therapy Exception	1	1	0	0	360
Stolen	13	11	0	2	18
Third Brand Request	38	26	1	11	42
Overrides Total	**2,443**	**1,708**	**104**	**631**	
Total Regular PAs + Overrides	**13,154**	**5,991**	**1,610**	**5,553**	

Denial Reasons	
Unable to verify required trials.	4,616
Does not meet established criteria.	1,624
Lack required information to process request.	912
Other PA Activity	
Duplicate Requests	1,334
Letters	24,671
No Process	5
Changes to Existing PAs	929
Helpdesk Initiated Prior Authorizations	964
PAs Missing Information	1

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

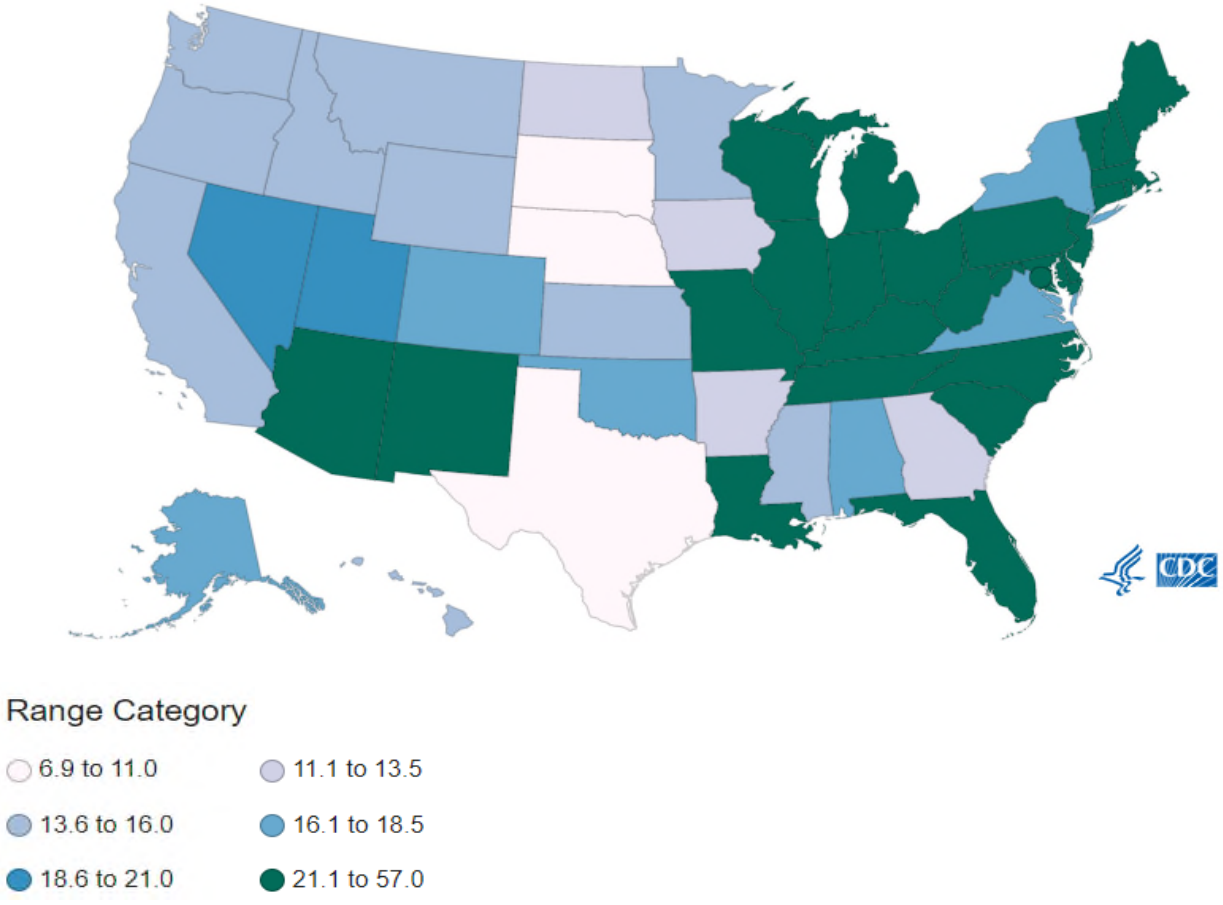
SoonerCare Opioid Initiative Update

Oklahoma Health Care Authority
January 2022

Introduction[1]

In the United States, there were 70,630 drug overdose deaths in 2019, 645 of which were in Oklahoma. Oklahoma saw a 9.92% decrease in the drug overdose death rate from 2018 to 2019. This decrease exceeds the 8.46% decrease from 2017 to 2018 and is in contrast to the 13.2% increase seen in 2016. Additionally, Oklahoma saw a statistically significant change in drug overdose death rates involving prescription opioids from 2018 to 2019. The number of deaths from prescription opioids decreased 22.67% from 2018 to 2019 in Oklahoma. The following map from the Centers for Disease Control and Prevention (CDC) highlights the age-adjusted rates of drug overdose deaths by state for 2019.

CDC Number and Age-Adjusted Rates (per 100,000) of Drug Overdose Deaths by State (2019)



Morphine Milligram Equivalent (MME) Summary[2,3,4,5,6,7,8,9]

Morphine is considered the "gold standard" for the treatment of pain and is used as the basis for comparison via morphine milligram equivalent (MME). The MME provides a conversion factor from opioid to opioid and gives a standard for comparison. The following are MME recommendations or alerts from various government organizations, medical groups, quality measurement programs, and law enforcement:

- CDC: The CDC recommends clinicians prescribe the lowest effective opioid dosage when a patient begins opioid therapy for chronic pain and encourages caution for doses exceeding 50 MME per day and avoidance of doses exceeding 90 MME per day.
- Centers for Medicare and Medicaid Services (CMS): In January 2019, CMS finalized new opioid policies for Medicare drug plans. CMS recommended that residents of long-term care facilities, those in hospice care, patients receiving palliative care or end-of-life care, and patients being treated for active cancer-related pain should be excluded from these interventions. Starting in 2020, patients with sickle cell disease were also excluded from the safety interventions. It was also recommended that these policies not impact patients' access to medication assisted treatment (MAT), such as buprenorphine. In addition, it was stated that the MME thresholds and day supply limitations are not prescribing limits, and the patient or their prescriber can request an expedited or standard coverage determination from the plan for approval of higher amounts or a longer days' supply. The following CMS safety edits became effective on January 1, 2019 for Medicare drug plans:
    - 7-day supply limit for opioid naïve patients
    - Opioid care coordination edit at 90 MME which alerts pharmacists to review when the patient's cumulative MME per day reaches or exceeds 90 MME across all opioid prescriptions; the 90 MME threshold identifies potentially high-risk patients who may benefit from closer monitoring and care coordination
        - Due to the increased burden on the health care system as a result of the COVID-19 pandemic, it was recommended that plans waive requirements for pharmacist consultation with the prescriber to confirm intent of opioid use in order to lessen the administrative burden on prescribers and pharmacists (all other existing opioid point-of-sale safety edits should be continued during the pandemic)
    - Some plans may implement a hard edit when a patient's cumulative opioid daily dosage reaches 200 MME or greater
    - Concurrent opioid and benzodiazepine use or duplicative long-acting opioid therapy (soft edits)

- Oklahoma Senate Bill (SB) 1446: In May 2018, SB 1446 was signed into law and placed a 7-day supply limit on initial opioid prescriptions for acute pain. The State Board of Osteopathic Examiners, Oklahoma State Medical Association, Oklahoma Hospital Association, and several medical associations endorsed a best practice document released in October 2018 to clarify some of the details in Oklahoma SB 1446 on opioid prescribing, including instructing prescribers to thoroughly document their rationale for prescribing >100 MME.
- Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) Prescription Monitoring Program (PMP): In February 2018, the OBNDD, via the AWARxE system, initiated 3 clinical alerts featured on the PMP. The clinical alerts were designed to help providers identify at-risk patients. One of the alerts included patients who exceed a daily MME of 100. Current Oklahoma law requires prescribers to check the PMP upon an initial opioid prescription and then at least every 180 days.
- Pharmacy Quality Alliance (PQA) Opioid Measures: PQA is a nationally recognized organization that develops measures to promote appropriate medication use and reporting of performance information related to medications. They have developed the PQA Opioid Measure Set which includes 7 measures to provide important tools to address the opioid epidemic. Included are measures to evaluate the use of opioids at high dosages (currently ≥90 MME/day; previously ≥120 MME/day), opioids from multiple prescribers and pharmacies, and concurrent opioid use with benzodiazepines. Additionally, initial opioid prescribing measures are included to evaluate new prescriptions at high dosages (≥50 MME/day), for long duration (>7 cumulative day supply), or for long-acting or extended-release opioids. Patients with a cancer diagnosis, sickle cell disease, or those receiving hospice care are excluded.

The following table contains MMEs based on strength and quantities for commonly prescribed opioid medications. Daily MMEs in red font exceed the CDC and CMS recommendation of ≤90 MME per day.

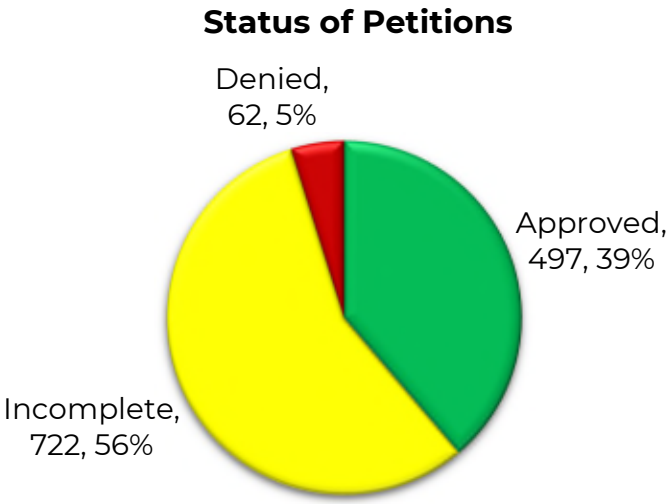
Drug/Strength	Quantity	Day Supply	Daily MME
Immediate-Release (IR) Products			
codeine 30mg	120	30	18
hydrocodone/APAP 5mg/325mg	120	30	20
hydrocodone/APAP 7.5mg/325mg	120	30	30
hydrocodone/APAP 10mg/325mg	120	30	40
hydromorphone IR 2mg	120	30	32
hydromorphone IR 4mg	120	30	64
hydromorphone IR 8mg	120	30	128
oxycodone IR 15mg	120	30	90

Drug/Strength	Quantity	Day Supply	Daily MME
oxycodone IR 20mg	120	30	120
oxycodone/APAP 7.5mg/325mg	120	30	45
tramadol 50mg	240	30	40
Extended-Release (ER) Products			
Butrans® (buprenorphine) patch 10mcg/hour	4	28	18
Butrans® (buprenorphine) patch 15mcg/hour	4	28	27
Butrans® (buprenorphine) patch 20mcg/hour	4	28	36
fentanyl patch 25mcg/hour	10	30	60
fentanyl patch 50mcg/hour	10	30	120
fentanyl patch 75mcg/hour	10	30	180
Hysingla® ER (hydrocodone ER) 100mg	30	30	100
Hysingla® ER (hydrocodone ER) 120mg	30	30	120
OxyContin® (oxycodone ER) 30mg	60	30	90

APAP = acetaminophen; ER = extended-release; IR = immediate-release; MME = morphine milligram equivalent

MME Override Requests for Opioid Medications

There were 1,281 MME override requests submitted for opioid medications for 520 unique members during fiscal year 2021 (07/01/2020 to 06/30/2021). The following chart shows the status of the submitted petitions for fiscal year 2021.



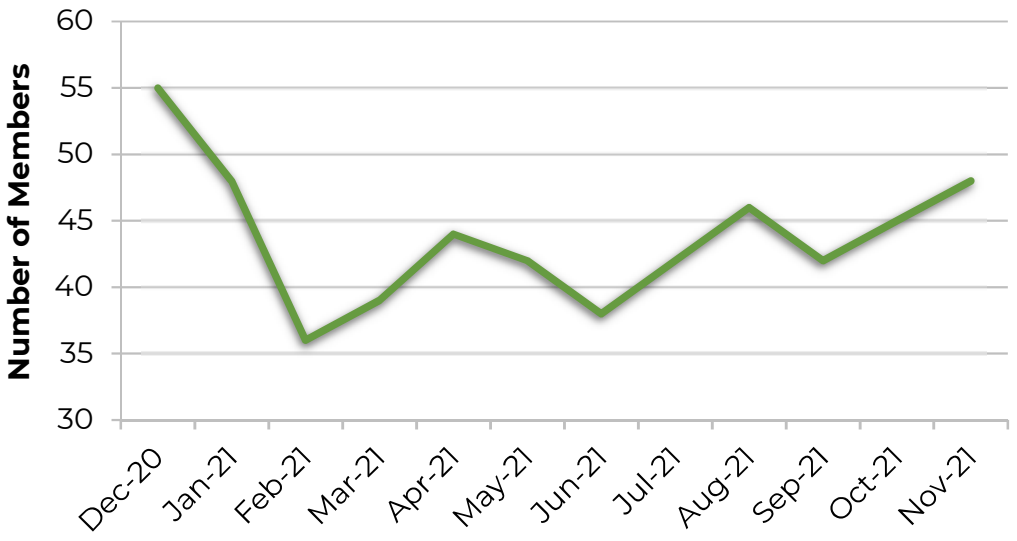
SoonerCare MME Claims Analysis[1,3,5,6,7,10,11,12,13]

In July 2018, the Drug Utilization Review (DUR) Board voted to lower the SoonerCare opioid MME limit to 100 MME to coincide with the OBNDD clinical alert on the Oklahoma PMP database. Then in July 2019, the DUR Board voted to lower the MME limit to 90 MME to coincide with CDC and

CMS recommendations. MME limits were phased in gradually beginning in January 2019 with final implementation effective October 2019. Members requiring >90 cumulative MME per day require prior authorization with patient-specific, clinically significant reasoning for use of >90 cumulative MME per day. Members with an oncology, hemophilia, or sickle cell diagnosis are excluded from the MME edit. Additionally, medications for MAT of opioid use disorder (OUD) are excluded from the MME edit.

The following chart shows SoonerCare data for the number of unduplicated utilizing members with an MME >90 per claim for Schedule II opioid medications from December 1, 2020 to November 30, 2021. The data excludes members with an oncology, hemophilia, or sickle cell diagnosis in medical claims history over the specified time period. Combination products containing buprenorphine and naloxone used for MAT of OUD were excluded from the analysis as well. In previous years, this report has included the number of unduplicated utilizing members with an MME ≥120 per claim for Schedule II opioid medications. To be consistent with the current SoonerCare MME limit, this graph was updated to show an MME >90 per claim. Additionally, the vertical axis starts at 30 to reflect the month-to-month changes more clearly. Of note, in January 2019 when the MME limit implementation began, 395 SoonerCare members had an MME ≥120 per claim. By comparison, in November 2021, 48 SoonerCare members had an MME >90 per claim.

Number of Members with an MME >90 per Claim

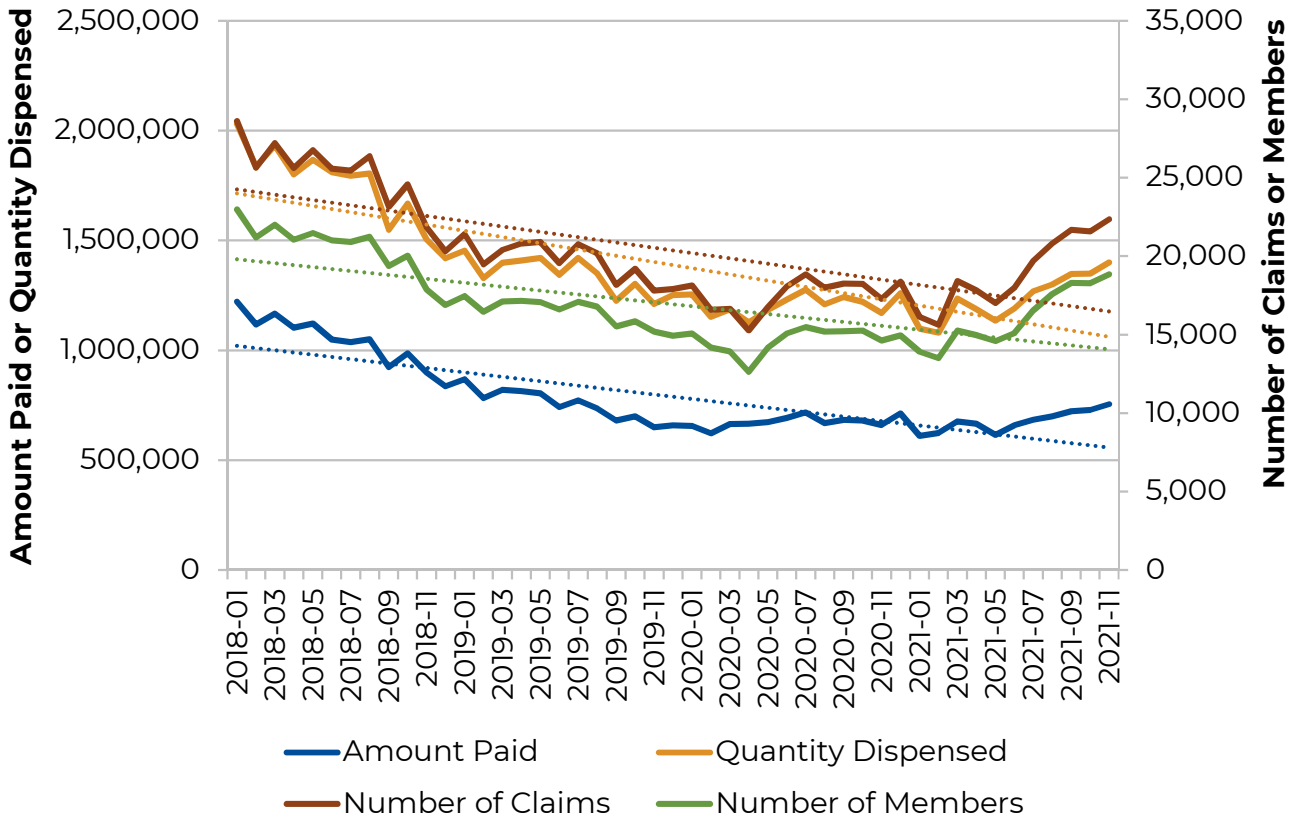


In addition to the MME edits implemented in 2019, previous edits limiting the number of solid dosage form, immediate-release (IR) opioid units per claim to a maximum quantity of 120 units per 30-day supply were implemented in late 2014 and early 2015. Numerous opioid educational efforts have been

undertaken by the Oklahoma Health Care Authority (OHCA) and the College of Pharmacy including pain management practice facilitation, naloxone education and access, Lock-In program expansion, as well as newsletter articles and educational mailings. These efforts have coincided with laws passed by the Oklahoma legislature including mandatory PMP checks, which were implemented in November 2015, and a 7-day supply limit on initial opioid prescriptions for acute pain, which was implemented in November 2018.

The following graph shows the utilization trends of all opioid analgesics. All parameters have followed a linear decline since implementation of the quantity limit; linear trends are noted in the chart by dotted lines for each parameter. The 2021 increases noted in the graph are proportional to the increased number of members covered by SoonerCare due to Medicaid expansion in Oklahoma, effective starting July 2021, as well as the lack of coverage termination due to the pandemic.

Opioid Analgesic Trends: January 2018 to November 2021



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Appendix C

Fiscal Year 2021 Annual Review of Antihyperlipidemics and 30-Day Notice to Prior Authorize Evkeeza® (Evinacumab-dgnb) and Leqvio® (Inclisiran)

Oklahoma Health Care Authority
January 2022

Current Prior Authorization Criteria

Fibric Acid Derivative Medications*	
Tier-1	**Tier-2**
choline fenofibrate DR cap 45mg (Trilipix®)	choline fenofibrate DR cap 135mg (Trilipix®)
fenofibrate micronized cap 67mg, 134mg (Lofibra®)	fenofibrate cap 50mg, 150mg (Lipofen®)
fenofibrate tab 160mg (Triglide®)	fenofibrate micronized cap 200mg (Lofibra®)
fenofibrate tab 48mg, 145mg (Tricor®)	fenofibrate micronized cap 30mg, 43mg, 90mg, 130mg (Antara®)
fenofibrate tab 54mg, 160mg (Lofibra®)	fenofibrate tab 40mg, 120mg (Fenoglide®)
fenofibric acid tab 35mg (Fibricor®)	fenofibric acid tab (Fibricor®) 105mg
gemfibrozil tab 600mg (Lopid®)	

*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).
cap = capsule; DR = delayed release; tab = tablet

Fibric Acid Derivative Medications Tier-2 Approval Criteria:

1. Laboratory documented failure with a Tier-1 medication after a 6-month trial; or
2. Documented adverse effect, drug interaction, or contraindication to all Tier-1 medication(s); or
3. Prior stabilization on the Tier-2 medication documented within the last 100 days.

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

1. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following criteria:
   a. A documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
   b. An untreated total cholesterol >500mg/dL and triglycerides <300mg/dL and at least 1 of the following:

        i. Documentation that both parents have untreated total cholesterol >250mg/dL; or
        ii. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; and
2. Documented trial of high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy at least 12 weeks in duration; and
3. Documented trial of Repatha® (evolocumab) at least 12 weeks in duration; and
4. Member requires additional lowering of LDL cholesterol (LDL-C) (baseline, current, and goal LDL-C levels must be provided); and
5. Prescriber must be certified with Juxtapid® or Kynamro® Risk Evaluation and Mitigation Strategy (REMS) program.

Nexletol® (Bempedoic Acid) and Nexlizet® (Bempedoic Acid/Ezetimibe) Approval Criteria:

1. An FDA approved indication as an adjunct to diet and maximally tolerated statin therapy for the treatment of 1 of the following:
    a. Heterozygous familial hypercholesterolemia (HeFH); and
        i. Documentation of definite HeFH using the Simon Broome Register criteria, the Dutch Lipid Network criteria, or via genetic testing; or
    b. Established atherosclerotic cardiovascular disease (ASCVD); and
        i. Supporting diagnoses/conditions and dates of occurrence signifying established ASCVD; and
2. Member must be 18 years of age or older; and
3. Member must be on a stable dose of maximally tolerated statin therapy for at least 4 weeks (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
    a. LDL-cholesterol (LDL-C) levels should be included following at least 4 weeks of treatment with each statin medication; and
    b. Member must not be taking simvastatin at doses >20mg or pravastatin at doses >40mg due to drug interactions with Nexletol® and Nexlizet®; and
    c. For statin intolerance due to myalgia, creatinine kinase (CK) labs verifying rhabdomyolysis must be provided; and
4. Member requires additional lowering of LDL-cholesterol (LDL-C) (baseline, current, and goal LDL-C levels must be provided); and
5. A quantity limit of 30 tablets per 30 days will apply; and
6. Initial approvals will be for the duration of 3 months, after which time compliance and recent LDL-C levels to demonstrate the effectiveness of this medication will be required for continued approval. Subsequent approvals will be for the duration of 1 year.

Omega-3 Fatty Acids [Epanova® (Omega-3-Carboxylic Acids) and Vascepa® (Icosapent Ethyl)] Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. Severe hypertriglyceridemia; and
        i. Laboratory documentation of severe hypertriglyceridemia (fasting triglycerides ≥500mg/dL) and controlled diabetes (fasting glucose <150mg/dL at the time of triglycerides measurement and HgA1c <7.5%); and
        ii. Previous failure with fibric acid medications; and
        iii. Use of Vascepa® (icosapent ethyl) or Epanova® (omega-3-carboxylic acids) requires a previous failure of or a patient specific, clinically significant reason why the member cannot use omega-3-acid ethyl esters (generic Lovaza®), which is available without prior authorization; or
    b. For the use of Vascepa® (icosapent ethyl) as an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult members with elevated triglyceride levels; and
        i. Member must be on a stable dose of maximally tolerated statin therapy for at least 4 weeks (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
        ii. Laboratory documentation of fasting triglycerides ≥150mg/dL; and
        iii. Member must have 1 of the following:
            1. Established cardiovascular disease; or
            2. Diabetes mellitus and ≥2 additional risk factors for cardiovascular disease; and
2. Use of Vascepa® 0.5 gram requires a patient-specific, clinically significant reason why the member cannot use Vascepa® 1 gram.

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors [Praluent® (Alirocumab) and Repatha® (Evolocumab)] Approval Criteria:

1. For Repatha® (evolocumab):
    a. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:
        i. Documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
        ii. An untreated total cholesterol >500mg/dL and at least 1 of the following:

1. Documented evidence of definite heterozygous familial hypercholesterolemia (HeFH) in both parents; or
2. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; or

b. An FDA approved diagnosis of primary hyperlipidemia (including HeFH); or
c. An FDA approved indication to reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease (CVD); and
    i. Documentation of established CVD; and
        1. Supporting diagnoses/conditions and dates of occurrence signifying established CVD; or

2. For Praluent® (alirocumab):
    a. An FDA approved diagnosis of primary hyperlipidemia (including HeFH); or
    b. An FDA approved indication to reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in adults with established CVD; and
        i. Documentation of established CVD; and
            1. Supporting diagnoses/conditions and dates of occurrence signifying established CVD; and
3. Member must be 13 years of age or older for the diagnosis of HoFH or must be 18 years of age or older for all other FDA-approved diagnoses or indications; and
4. Member must be on high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or on maximally tolerated statin therapy; and
    a. Statin trials must be at least 12 weeks in duration (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
    b. LDL-cholesterol (LDL-C) levels should be included following at least 12 weeks of treatment with each statin medication; and
    c. For statin intolerance due to myalgia, creatine kinase (CK) labs verifying rhabdomyolysis must be provided; and
    d. Tier structure rules still apply; and
5. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
6. Prescriber must verify that member has been counseled on appropriate use, storage of the medication, and administration technique; and
7. A quantity limit of 2 syringes or pens per 28 days will apply for Praluent®. A quantity limit of 2 syringes or auto-injectors per 28 days will apply for Repatha® 140mg and a quantity limit of 1 auto-injector per 28 days will apply for Repatha® 420mg. Requests for the Repatha® 420mg

dose will not be approved for multiple 140mg syringes or auto-injectors, but instead members should use (1) 420mg auto-injector; and

8. Initial approvals will be for the duration of 3 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of the medication, and compliance will be checked at that time and every 6 months thereafter for continued approval.

Statin Medications and Ezetimibe*	
Tier-1	**Special PA**
atorvastatin (Lipitor®)	fluvastatin (Lescol® & Lescol® XL)
ezetimibe (Zetia®)	lovastatin ER (Altoprev®)
lovastatin (Mevacor®)	pitavastatin calcium (Livalo®)
pravastatin (Pravachol®)	pitavastatin magnesium (Zypitamag™)
rosuvastatin tablet (Crestor®)	rosuvastatin capsule (Ezallor Sprinkle™)
simvastatin (Zocor®)	simvastatin suspension (FloLipid®)
	simvastatin/ezetimibe (Vytorin®)

*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).
ER = extended-release; PA = prior authorization

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

1. Use of any Special PA medication will require a patient-specific, clinically significant reason why lower tiered medications with similar or higher low-density lipoprotein-cholesterol (LDL-C) reduction cannot be used; and
2. Use of FloLipid® (simvastatin oral suspension) will require a patient specific, clinically significant reason why the member cannot use simvastatin oral tablets, even when the tablets are crushed; and
3. Use of Ezallor Sprinkle™ (rosuvastatin capsule) will require a patient-specific, clinically significant reason why the member cannot use rosuvastatin oral tablets, even when the tablets are crushed.

Welchol® (Colesevelam) Chewable Bar Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use other formulations of colesevelam, including oral tablets and packets for oral suspension, which are available without prior authorization, must be provided; and
3. A quantity limit of 30 chewable bars per 30 days will apply.

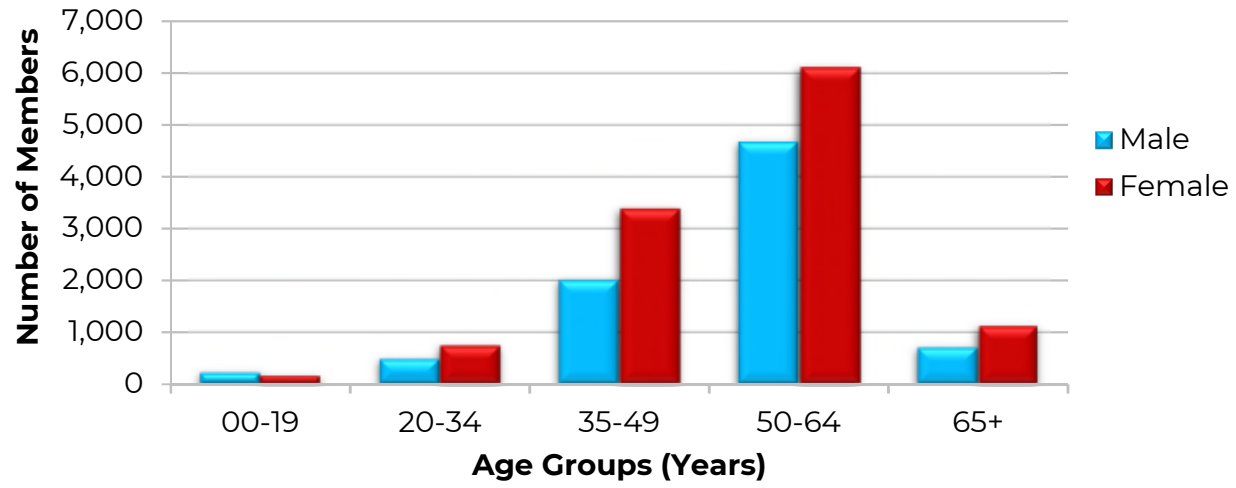
Utilization of Antihyperlipidemics: Fiscal Year 2021

Comparison of Fiscal Years

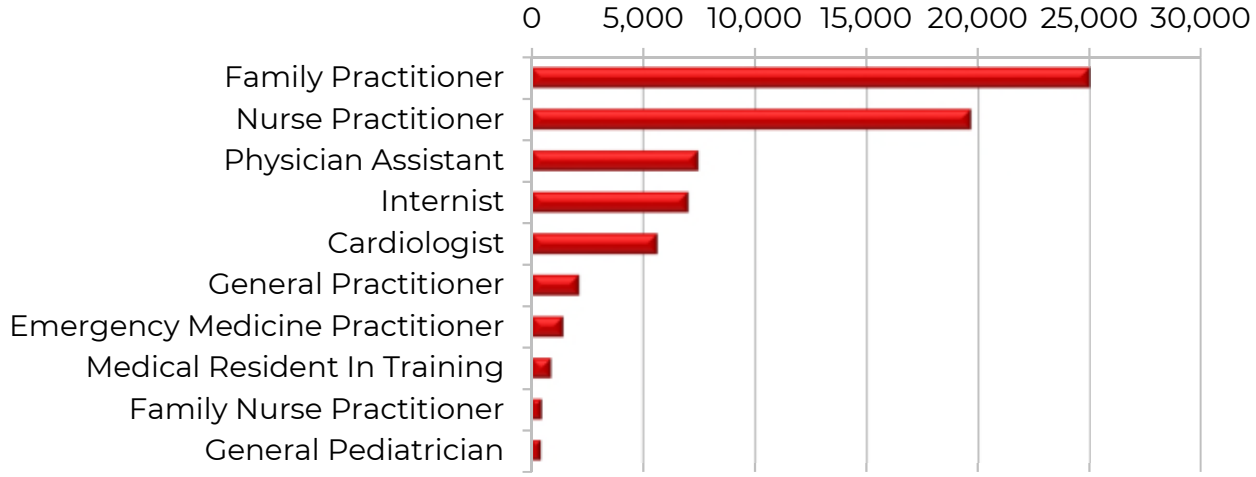
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2020	17,464	68,005	$1,122,573.76	$16.51	$0.30	3,919,725	3,751,748
2021	19,526	72,918	$1,196,028.54	$16.40	$0.28	4,443,779	4,238,317
% Change	**11.8%**	**7.2%**	**6.5%**	**-0.7%**	**-6.7%**	**13.4%**	**13.0%**
Change	**2,062**	**4,913**	**$73,454.78**	**-$0.11**	**-$0.02**	**524,054**	**486,569**

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

Demographics of Members Utilizing Antihyperlipidemics



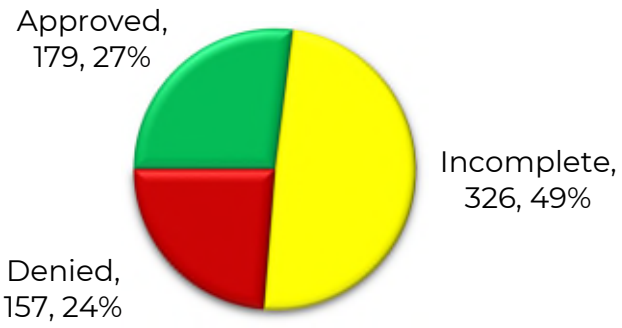
Top Prescriber Specialties of Antihyperlipidemics by Number of Claims



Prior Authorization of Antihyperlipidemics

There were 662 prior authorization requests submitted for the antihyperlipidemics 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]

Anticipated Patent Expiration(s):

- Welchol® (colesevelam chewable bar): April 2022
- Livalo® (pitavastatin calcium tablet): August 2024
- Nexletol® (bempedoic acid tablet): December 2025
- Kynamro® (mipomersen injection): January 2027; discontinued
- Juxtapid® (lomitapide capsule): August 2027
- FloLipid® (simvastatin oral suspension): February 2030
- Zypitamag™ (pitavastatin magnesium tablet): January 2031
- Epanova® (omega-3-carboxylic acids): January 2033
- Antara® (fenofibrate micronized capsule): May 2033
- Vascepa® (icosapent ethyl capsule): June 2033
- Ezallor™ Sprinkle (rosuvastatin capsule): February 2036
- Nexlizet® (bempedoic acid/ezetimibe tablet): March 2036

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

- **February 2021:** The FDA approved Evkeeza® (evinacumab-dgnb) as add-on treatment to lipid-lowering therapies for patients 12 years of age and older with homozygous familial hypercholesterolemia (HoFH), a rare genetic condition that causes severely high cholesterol. The incidence of HoFH is approximately 1 in 250,000 individuals, and patients with this condition can develop premature cardiovascular (CV) disease early in life. Evkeeza® is an angiopoietin-like protein 3 (ANGPTL3) inhibitor which allows faster breakdown of fats that lead to high cholesterol. The safety and efficacy of Evkeeza® were assessed in a 24-week Phase 3 study, ELIPSE-HoFH, which included 65 patients

diagnosed with HoFH. Patients on Evkeeza® had an average 47% decrease in low-density lipoprotein-cholesterol (LDL-C) at week 24, while patients in the placebo group had an average 2% increase in LDL-C. The most common side effects reported with evinacumab-dgnb were nasopharyngitis, influenza-like illness, dizziness, rhinorrhea, and nausea.

- **April 2021:** The FDA expanded the indication for Praluent® (alirocumab) to include adult patients with HoFH. The approval for this indication was assessed in a 12-week, double-blind, randomized, placebo-controlled study in adult patients with HoFH. In this study, 45 patients were randomized to receive Praluent® 150mg every 2 weeks, while 24 patients were randomized to receive placebo. At week 12, patients treated with Praluent® had an average LDL-C decrease of 27%, while patients on placebo had an average LDL-C increase of 9%. Patients in both arms were also taking other therapies to lower LDL-C. The most common side effects reported in this study in alirocumab-treated patients included nasopharyngitis, injection site reactions, and influenza.
- **September 2021:** The FDA expanded the indication for Repatha® (evolocumab) to include pediatric patients 10 years of age and older with heterozygous familial hypercholesterolemia (HeFH). HeFH is an inherited, genetic condition with a prevalence of 1 in 250 individuals worldwide. These patients will have high levels of LDL-C which lead to an overall increased risk of CV events. The approval for this label expansion was based on a Phase 3b study, HAUSER-RCT, which evaluated the safety and efficacy of Repatha® in pediatric patients 10 to 17 years of age. At 24 weeks, patients treated monthly with Repatha® 420mg had an average LDL-C reduction of 45% compared with a 6% reduction in patients receiving placebo. The FDA also lowered the age requirement for the use of evolocumab in pediatric patients with HoFH from 13 years of age to 10 years of age.
- **December 2021:** The FDA approved Leqvio® (inclisiran) as the first and only small interfering RNA (siRNA) therapy to reduce LDL-C via an RNA interference mechanism in patients with HeFH or atherosclerotic cardiovascular disease (ASCVD). Leqvio® works as a complement to statins and reduces LDL-C by preventing the production of the proprotein convertase subtilisin/kexin type 9 (PCSK9) protein in the liver, thus increasing hepatic uptake of LDL-C and clearing it from the blood stream. Leqvio® is dosed twice yearly via subcutaneous (sub-Q) injection by a health care professional and was shown to decrease LDL-C up to 52% at month 17 in clinical studies. The most common adverse reactions reported in clinical studies (incidence ≥3%) in patients treated with inclisiran were injection site reaction, arthralgia, urinary tract infection, diarrhea, and bronchitis.

Pipeline:

- **Olezarsen:** Olezarsen is an investigational antisense medication designed to inhibit the production of apoC-III protein, which regulates triglyceride metabolism in the blood. The manufacturer of olezarsen, Ionis, recently initiated a Phase 3 study, known as CORE, in patients with severe hypertriglyceridemia (≥500mg/dL). The primary endpoint of this study is the percent change in fasting triglycerides from baseline at month 6. In a Phase 2 study of olezarsen, 91% of patients enrolled in the study achieved a normal triglyceride level of <150mg/dL.

Evkeeza® (Evinacumab-dgnb) Product Summary[8]

Indication(s): Evkeeza® is an ANGPTL3 inhibitor indicated as an adjunct to other LDL-C lowering therapies for the treatment of adult and pediatric patients 12 years of age and older with HoFH.

- Limitation(s) of Use:
  - The safety and effectiveness of evinacumab-dgnb have not been established in patients and other causes of hypercholesterolemia, including those with HeFH.
  - The effects of evinacumab-dgnb on cardiovascular morbidity and mortality have not been determined.

How Supplied: 345mg/2.3mL (150mg/mL) and 1,200mg/8mL (150mg/mL) solution in a single-dose vial (SDV)

Dosing: The recommended dose is 15mg/kg via intravenous (IV) infusion over 60 minutes every 4 weeks.

Mechanism of Action: Evinacumab-dgnb is a recombinant monoclonal antibody that binds to and inhibits ANGPTL3, which is primarily expressed in the liver. ANGPTL3 plays a role in the regulation of lipid metabolism by inhibiting lipoprotein lipase (LPL) and endothelial lipase (EL), and the inhibition of ANGPTL3 will lead to reductions in LDL-C, HDL-C, and triglycerides.

Contraindication(s):

- History of serious hypersensitivity reaction to evinacumab-dgnb or to any excipients in Evkeeza®

Safety:

- Serious Hypersensitivity Reactions: Serious hypersensitivity reactions have occurred with evinacumab-dgnb. In clinical trials, 1 (1%) of evinacumab-dgnb-treated patient experienced anaphylaxis vs. 0 (0%) patients who received placebo. If signs or symptoms of serious hypersensitivity reactions occur, evinacumab-dgnb infusion should be

discontinued, and the patient should be treated according to standard-of-care and monitored until signs and symptoms resolve.

- Embryo-Fetal Toxicity: Based on the findings in animal reproductive studies, evinacumab-dgnb may cause fetal harm when administered to pregnant patients. A pregnancy test should be obtained prior to initiating treatment, and patients should use contraception during treatment with evinacumab-dgnb and for at least 5 months following the last dose.
- Lactation: There is no data available on the presence of evinacumab-dgnb in human milk or animal milk, the effects on the breastfed child, or the effects on milk production. Maternal immunoglobulin G (IgG) is known to be present in human milk. The effects of gastrointestinal exposure and limited systemic exposure in the breastfed child to evinacumab-dgnb are unknown. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for evinacumab-dgnb and any potential adverse effects on the breastfed child from evinacumab-dgnb or from the underlying maternal condition.
- Pediatric Use: The safety and effectiveness of evinacumab-dgnb as an adjunct to other LDL-C-lowering therapies for the treatment of HoFH have been established in pediatric patients 12 years of age and older. The safety and effectiveness of evinacumab-dgnb have not been established in pediatric patients with HoFH who are younger than 12 years of age.

Adverse Reactions: The most common adverse reactions reported in clinical studies (incidence ≥5%) were nasopharyngitis, influenza-like illness, dizziness, rhinorrhea, and nausea.

Efficacy: The safety and efficacy of evinacumab-dgnb were assessed in a 24-week, multicenter, double-blind, randomized, placebo-controlled, Phase 3 trial in 65 patients diagnosed with HoFH. Of the 65 patients, 43 patients were randomized to receive evinacumab-dgnb, while 22 patients were randomized to receive placebo. The mean LDL-C at baseline was 255mg/dL, and patients in both groups were on a background of other lipid-lowering therapies, including maximally tolerated statins, ezetimibe, PCSK9 inhibitors, lomitapide, and lipoprotein apheresis.

- Primary endpoint: The primary efficacy endpoint was the change in LDL-C from baseline to week 24.
- Results: At 24 weeks, the least squares (LS) mean treatment difference between evinacumab-dgnb and placebo in mean percent change in LDL-C from baseline was -49% [95% confidence interval (CI): -65%, -33%; P<0.0001].

Cost: The Wholesale Acquisition Cost (WAC) for Evkeeza® is $37,500 for a 1,200mg/8mL vial. For a patient weighing 80kg, the annual cost would be $487,500 at the recommended dose of 15mg/kg every 4 weeks.

Cost Comparison for HoFH Therapies:

Product	Cost Per Unit	Cost Per Month*
Juxtapid® (lomitapide mesylate) 60mg tab	$1,596.91	$44,713.48
Evkeeza® (evinacumab-dgnb) 1200mg/8mL inj	**$37,500.00**	**$37,500.00**
Repatha® (evolocumab) 140mg/mL inj	$230.89	$461.78
Praluent® (alirocumab) 150mg/mL inj	$225.00	$450.00
rosuvastatin 40mg tab	$0.13	$3.64
atorvastatin 80mg tab	$0.10	$2.80

inj = injection; tab = tablet
Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
*Cost per month based on the FDA approved maximum daily dose.

Leqvio® (Inclisiran) Product Summary[9]

Indication(s): Leqvio® is a siRNA directed to PCSK9 mRNA indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with HeFH or ASCVD who require additional lowering of LDL-C.

- Limitation(s) of Use: The effect of inclisiran on cardiovascular morbidity and mortality has not been determined.

How Supplied: 284mg/1.5mL (189mg/mL) in a single-dose prefilled syringe

Dosing:

- The recommended dose is 284mg administered as a single sub-Q injection initially, again at 3 months, and then every 6 months thereafter
- Leqvio® should be administered by a health care professional into the abdomen, upper arm, or thigh

Mechanism of Action: Inclisiran is a double-stranded siRNA that utilizes the RNA interference mechanism and directs catalytic breakdown of mRNA for PCSK9. This increases LDL-C receptor recycling, resulting in an increase in LDL-C uptake in the liver and a decrease in LDL-C levels in circulation.

Contraindication(s): None

Safety:

- Pregnancy: Leqvio® should be discontinued when pregnancy is recognized unless the benefits outweigh the risk. Inclisiran increases LDL-C uptake and lowers LDL-C levels in the circulation; therefore, inclisiran may cause fetal harm when administered to pregnant

patients based on the mechanism of action. There is no available data on the use of inclisiran in pregnant patients to evaluate the drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes.

- Lactation: There is no information on the presence of inclisiran in human milk, the effects on the breastfed child, or the effects on milk production. Inclisiran was detected in the milk of lactating rats and would therefore likely be present in human milk as well. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for inclisiran and any potential adverse effects on the breastfed child from inclisiran or from the underlying maternal condition.
- Pediatric Use: The safety and effectiveness of inclisiran have not been established in pediatric patients.

Adverse Reactions: The most common adverse reactions reported in clinical studies (incidence ≥3%) were injection site reaction, arthralgia, urinary tract infection, diarrhea, bronchitis, extremity pain, and dyspnea.

Efficacy: The safety and efficacy of inclisiran were assessed in 1 Phase 3 study in patients with HeFH and 2 Phase 3 studies in patents with ASCVD. All 3 of these studies had identical trial designs which included multi-centered, double-blind, randomized (1:1), placebo-controlled, and a duration of 18 months. Patients received either inclisiran 284mg or placebo on day 1, day 90, day 270, and day 450. The primary endpoint was also the same for all 3 studies, which was the mean percentage change from baseline to day 510 in LDL-C. Patients were on a maximally tolerated statin with or without other lipid modifying therapy. Patients on PCSK9 inhibitors were excluded from these studies.

- Orion-9: This study included 482 patients with HeFH with a mean age at baseline of 55 years (range: 21 to 80 years of age) and a mean baseline LDL-C of 153mg/dL. The difference between the treatment and placebo groups in mean percentage change in LDL-C from baseline to day 510 was -48% (95% CI: -54%, -42%; P<0.0001).
- Orion-10: This study included 1,561 patients with ASCVD with a mean age at baseline of 66 years (range: 35 to 90 years of age) and a mean baseline LDL-C of 105mg/dL. The difference between the treatment and placebo groups in mean percentage change in LDL-C from baseline to day 510 was -52% (95% CI: -56%, -49%; P<0.0001).
- Orion-11: This study included 1,414 patients with ASCVD with a mean age at baseline of 65 years (range: 35 to 88 years of age) and a mean baseline LDL-C of 101mg/dL. The difference between the treatment and placebo groups in mean percentage change in LDL-C from baseline to day 510 was -51% (95% CI: -54%, -47%; P<0.0001).

Cost: The WAC for Leqvio® is $3,250 for a 284mg/1.5mL syringe, resulting in an annual cost of $6,500 at the recommended maintenance dosing of 284mg every 6 months.

Cost Comparison for LDL-C Lowering Therapies:

Product	Cost Per Unit	Cost Per Year*
Leqvio® (inclisiran) 284mg/1.5mL inj	**$2,166.67**	**$6,500.00**
Repatha® (evolocumab) 140mg/mL inj	$230.89	$6,003.14
Praluent® (alirocumab) 150mg/mL inj	$225.00	$5,850.00
rosuvastatin 40mg tab	$0.13	$47.32
ezetimibe 10mg tab	$0.12	$43.68
atorvastatin 80mg tab	$0.10	$36.40

inj = injection; tab = tablet
Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
*Cost per month based on the FDA approved maximum daily dose.

Recommendations

The College of Pharmacy recommends the prior authorization of Evkeeza® (evinacumab-dgnb) and Leqvio® (inclisiran) with the following criteria (shown in red):

Evkeeza® (Evinacumab-dgnb) Approval Criteria:

1. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:
    a. Documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
    b. An untreated total cholesterol >500mg/dL and at least 1 of the following:
        i. Documented evidence of definite HeFH in both parents; or
        ii. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; or
2. Member must be 12 years of age or older; and
3. Documented trial of high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy at least 12 weeks in duration; and
4. Documented trial of a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent®, Repatha®) at least 12 weeks in duration; and
5. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and

6. Female members must not be pregnant and must have a negative pregnancy test prior to therapy initiation. Female members of reproductive potential must be willing to use effective contraception while on therapy and for 5 months after discontinuation of therapy; and
7. Initial approvals will be for the duration of 6 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of this medication, and compliance will be checked at that time and every 6 months thereafter for continued approval.

Leqvio® (Inclisiran) Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. Heterozygous familial hypercholesterolemia (HeFH) as confirmed by 1 of the following:
        i. Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
        ii. Both of the following:
            1. Pre-treatment total cholesterol >290mg/dL or LDL-C >190mg/dL; and
            2. History of tendon xanthomas in either the member, first degree relative, or second degree relative; or
        iii. Dutch Lipid Clinic Network Criteria score of >8; or
    b. Established atherosclerotic cardiovascular disease (ASCVD); and
        i. Supporting diagnoses/conditions and dates of occurrence signifying established ASCVD; and
2. Member must be 18 years of age or older; and
3. Documented trial of all of the following for at least 12 weeks in duration each:
    a. High dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy; and
    b. Ezetimibe; and
    c. Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor (e.g., Praluent®, Repatha®); and
4. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
5. Leqvio® must be administered by a health care professional. Approvals will not be granted for self-administration; and
    a. Prior authorization requests must indicate how Leqvio® will be administered (e.g., prescriber, pharmacist, home health care provider); and
        i. Leqvio® must be shipped to the facility where the member is scheduled to receive treatment; or

ii. Prescriber must verify the member has been counseled on the proper storage of Leqvio®; and

6. Initial approvals will be for the duration of 6 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of this medication, and compliance will be checked at that time and every 6 months thereafter for continued approval.

Additionally, the College of Pharmacy recommends updating the prior authorization criteria for PCSK9 inhibitors (changes shown in red):

Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors [Praluent® (Alirocumab) and Repatha® (Evolocumab)] Approval Criteria:

~~1. For Repatha® (evolocumab):~~
- ~~a. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:~~
  - ~~i. Documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or~~
  - ~~ii. An untreated total cholesterol >500mg/dL and at least 1 of the following:~~
    - ~~1. Documented evidence of definite heterozygous familial hypercholesterolemia (HeFH) in both parents; or~~
    - ~~2. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; or~~
- ~~b. An FDA approved diagnosis of primary hyperlipidemia (including HeFH); or~~
- ~~c. An FDA approved indication to reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease (CVD); and~~
  - ~~i. Documentation of established CVD; and~~
    - ~~1. Supporting diagnoses/conditions and dates of occurrence signifying established CVD; or~~

~~2. For Praluent® (alirocumab):~~
- ~~a. An FDA approved diagnosis of primary hyperlipidemia (including HeFH); or~~
- ~~b. An FDA approved indication to reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in adults with established CVD; and~~
  - ~~i. Documentation of established CVD; and~~
    - ~~1. Supporting diagnoses/conditions and dates of occurrence signifying established CVD; and~~

1. An FDA approved indication of 1 of the following:

a. Heterozygous familial hypercholesterolemia (HeFH) as confirmed by 1 of the following:
    i. Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
    ii. Both of the following:
        1. Pre-treatment total cholesterol >290mg/dL or LDL-C >190mg/dL; and
        2. History of tendon xanthomas in either the member, first degree relative, or second degree relative; or
    iii. Dutch Lipid Clinic Network Criteria score of >8; or
b. Homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following:
    i. Documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
    ii. An untreated total cholesterol >500mg/dL and at least 1 of the following:
        1. Documented evidence of definite HeFH in both parents; or
        2. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; or
c. As an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease (CVD); and
    i. Documentation of established CVD; and
    ii. Supporting diagnoses/conditions and dates of occurrence signifying established CVD; or
d. Primary hyperlipidemia; and
    i. Member's untreated LDL-C level must be ≥190mg/dL; and
    ii. Current LDL-C level is ≥100mg/dL; and

2. For the use of Repatha® in members with HeFH or HoFH, member must be ~~13~~ 10 years of age or older ~~for the diagnosis of HoFH or must be 18 years of age or older for all other FDA-approved diagnoses or indications~~; and
3. For the use of Repatha® for FDA approved indications other than HeFH or HoFH or for the use of Praluent® for all FDA approved indications, the member must be 18 years of age or older; and
4. Member must be on high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or on maximally tolerated statin therapy; and
    a. Statin trials must be at least 12 weeks in duration (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and

b. LDL-cholesterol (LDL-C) levels should be included following at least 12 weeks of treatment ~~with each statin medication~~; and
~~c. For statin intolerance due to myalgia, creatine kinase (CK) labs verifying rhabdomyolysis must be provided; and~~
~~d. Tier structure rules still apply; and~~

5. Members with statin intolerance must meet 1 of the following:
   a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
   b. An FDA labeled contraindication to all statins; or
   c. Documented intolerance to at least 2 different lower dose statins (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
   d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
6. Member must have a recent trial with a statin with ezetimibe, or a recent trial of ezetimibe without a statin for members with documented statin intolerance, or a patient-specific, clinically significant reason why ezetimibe is not appropriate must be provided; and
7. Member requires additional lowering of LDL-C (baseline, current, and goal LDL-C levels must be provided); and
8. Prescriber must verify that member has been counseled on appropriate use, storage of the medication, and administration technique; and
9. A quantity limit of 2 syringes or pens per 28 days will apply for Praluent®. A quantity limit of 2 syringes or auto-injectors per 28 days will apply for Repatha® 140mg and a quantity limit of 1 auto-injector per 28 days will apply for Repatha® 420mg. Requests for the Repatha® 420mg dose will not be approved for multiple 140mg syringes or auto-injectors, but instead members should use (1) 420mg auto-injector; and
10. Initial approvals will be for the duration of 3 months. Continued authorization at that time will require the prescriber to provide recent LDL-C levels to demonstrate the effectiveness of the medication, and compliance will be checked at that time and every 6 months thereafter for continued approval.

Further, the College of Pharmacy recommends updating the prior authorization criteria for Nexletol® (bempedoic acid) and Nexlizet® (bempedoic acid/ezetimibe) (changes shown in red):

Nexletol® (Bempedoic Acid) and Nexlizet® (Bempedoic Acid/Ezetimibe) Approval Criteria:

1. An FDA approved indication as an adjunct to diet and maximally tolerated statin therapy for the treatment of 1 of the following:

a. Heterozygous familial hypercholesterolemia (HeFH)~~; and~~ as confirmed by 1 of the following:
    i. Documented functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
    ii. Both of the following:
        1. Pre-treatment total cholesterol >290mg/dL or LDL-C >190mg/dL; and
        2. History of tendon xanthomas in either the member, first degree relative, or second degree relative; or
    iii. Dutch Lipid Clinic Network Criteria score of >8; or
    ~~iv. Documentation of definite HeFH using the Simon Broome Register criteria, the Dutch Lipid Network criteria, or via genetic testing; or~~
b. Established atherosclerotic cardiovascular disease (ASCVD); and
    i. Supporting diagnoses/conditions and dates of occurrence signifying established ASCVD; and

2. Member must be 18 years of age or older; and
3. Member must be on a stable dose of maximally tolerated statin therapy for at least 4 weeks (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
    a. LDL-cholesterol (LDL-C) levels should be included following at least 4 weeks of treatment ~~with each statin medication~~; and
    b. Member must not be taking simvastatin at doses >20mg or pravastatin at doses >40mg due to drug interactions with Nexletol® and Nexlizet®; and
    ~~c. For statin intolerance due to myalgia, creatinine kinase (CK) labs verifying rhabdomyolysis must be provided; and~~
4. Members with statin intolerance must meet 1 of the following:
    a. Creatine kinase (CK) labs verifying rhabdomyolysis; or
    b. An FDA labeled contraindication to all statins; or
    c. Documented intolerance to at least 2 different lower dose statins (dosing, dates, duration of treatment, and reason for discontinuation must be provided); or
    d. Documented intolerance to at least 2 different statins at intermittent dosing (dosing, dates, duration of treatment, and reason for discontinuation must be provided); and
5. Member requires additional lowering of LDL-cholesterol (LDL-C) (baseline, current, and goal LDL-C levels must be provided); and
6. A quantity limit of 30 tablets per 30 days will apply; and
7. Initial approvals will be for the duration of 3 months, after which time compliance and recent LDL-C levels to demonstrate the effectiveness of this medication will be required for continued approval. Subsequent approvals will be for the duration of 1 year.

Lastly, the College of Pharmacy recommends to remove the Kynamro® (mipomersen) prior authorization criteria based on product discontinuation (changes shown in red):

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

1. An FDA approved diagnosis of homozygous familial hypercholesterolemia (HoFH) defined by the presence of at least 1 of the following criteria:
   a. A documented functional mutation(s) in both low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality via genetic testing; or
   b. An untreated total cholesterol >500mg/dL and triglycerides <300mg/dL and at least 1 of the following:
      i. Documentation that both parents have untreated total cholesterol >250mg/dL; or
      ii. Presence of tendinous/cutaneous xanthoma prior to 10 years of age; and
2. Documented trial of high dose statin therapy (LDL reduction capability equivalent to rosuvastatin 40mg) or maximally tolerated statin therapy at least 12 weeks in duration; and
3. Documented trial of Repatha® (evolocumab) at least 12 weeks in duration; and
4. Member requires additional lowering of LDL cholesterol (LDL-C) (baseline, current, and goal LDL-C levels must be provided); and
5. Prescriber must be certified with Juxtapid® ~~or Kynamro®~~ Risk Evaluation and Mitigation Strategy (REMS) program.

Utilization Details of Antihyperlipidemics: Fiscal Year 2021

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
STATIN MEDICATIONS AND EZETIMIBE						
TIER-1 UTILIZATION						
ATORVASTATIN TAB 40MG	17,163	5,406	$234,813.88	$13.68	3.17	19.63%
ATORVASTATIN TAB 20MG	12,052	3,998	$153,522.54	$12.74	3.01	12.84%
ATORVASTATIN TAB 10MG	7,272	2,267	$85,802.08	$11.80	3.21	7.17%
ATORVASTATIN TAB 80MG	5,699	1,833	$92,877.34	$16.30	3.11	7.77%
SIMVASTATIN TAB 20MG	3,381	982	$36,020.80	$10.65	3.44	3.01%
PRAVASTATIN TAB 40MG	2,724	738	$40,477.43	$14.86	3.69	3.38%
SIMVASTATIN TAB 40MG	2,580	698	$29,099.26	$11.28	3.7	2.43%
ROSUVASTATIN TAB 20MG	2,146	777	$30,128.76	$14.04	2.76	2.52%
PRAVASTATIN TAB 20MG	1,863	579	$24,734.90	$13.28	3.22	2.07%
ROSUVASTATIN TAB 10MG	1,778	609	$23,188.63	$13.04	2.92	1.94%
ROSUVASTATIN TAB 40MG	1,496	538	$23,052.36	$15.41	2.78	1.93%
EZETIMIBE TAB 10MG	1,475	461	$25,391.55	$17.21	3.2	2.12%
SIMVASTATIN TAB 10MG	1,361	390	$14,381.22	$10.57	3.49	1.20%
LOVASTATIN TAB 20MG	1,228	380	$14,073.40	$11.46	3.23	1.18%
PRAVASTATIN TAB 10MG	639	197	$8,863.89	$13.87	3.24	0.74%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
ROSUVASTATIN TAB 5MG	628	224	$8,619.06	$13.72	2.8	0.72%
LOVASTATIN TAB 40MG	598	195	$7,444.30	$12.45	3.07	0.62%
PRAVASTATIN TAB 80MG	538	147	$9,775.27	$18.17	3.66	0.82%
LOVASTATIN TAB 10MG	258	85	$2,960.49	$11.47	3.04	0.25%
SIMVASTATIN TAB 80MG	216	63	$2,816.77	$13.04	3.43	0.24%
SIMVASTATIN TAB 5MG	66	25	$770.33	$11.67	2.64	0.06%
TIER-1 SUBTOTAL	**65,161**	**20,592**	**$868,814.26**	**$13.33**	**3.16**	**72.64%**
SPECIAL PA UTILIZATION						
LIVALO TAB 4MG	33	6	$18,637.81	$564.78	5.5	1.56%
LIVALO TAB 2MG	15	5	$10,105.65	$673.71	3	0.84%
EZETIM/SIMVA TAB 10-40MG	6	2	$724.39	$120.73	3	0.06%
VYTORIN TAB 10-80MG	6	1	$4,489.56	$748.26	6	0.38%
EZETIM/SIMVA TAB 10-80MG	2	1	$142.82	$71.41	2	0.01%
FLUVASTATIN CAP 40MG	1	1	$318.60	$318.60	1	0.03%
LIVALO TAB 1MG	1	1	$309.04	$309.04	1	0.03%
SPECIAL PA SUBTOTAL	**64**	**17**	**$34,727.87**	**$542.62**	**3.76**	**2.91%**
STATINS AND EZETIMIBE TOTAL	**65,225**	**20,609**	**$903,542.13**	**$13.85**	**3.16**	**75.55%**
FIBRIC ACID DERIVATIVE MEDICATIONS						
TIER-1 UTILIZATION						
FENOFIBRATE TAB 145MG	1,762	488	$30,706.19	$17.43	3.61	2.57%
GEMFIBROZIL TAB 600MG	1,559	417	$25,627.34	$16.44	3.74	2.14%
FENOFIBRATE TAB 160MG	1,245	355	$26,068.67	$20.94	3.51	2.18%
FENOFIBRATE TAB 48MG	521	146	$9,393.60	$18.03	3.57	0.79%
FENOFIBRATE TAB 54MG	386	100	$7,209.69	$18.68	3.86	0.60%
FENOFIBRATE CAP 134MG	270	74	$5,903.12	$21.86	3.65	0.49%
FENOFIBRIC CAP 45MG DR	143	25	$3,837.89	$26.84	5.72	0.32%
FENOFIBRATE CAP 67MG	50	12	$948.66	$18.97	4.17	0.08%
TIER-1 SUBTOTAL	**5,936**	**1,617**	**$109,695.16**	**$18.48**	**3.67**	**9.17%**
TIER-2 UTILIZATION						
FENOFIBRIC CAP 135MG DR	155	33	$9,415.90	$60.75	4.7	0.79%
FENOFIBRATE CAP 200MG	52	11	$1,451.84	$27.92	4.73	0.12%
FENOFIBRATE TAB 120MG	18	8	$18,277.25	$1,015.40	2.25	1.53%
FENOFIBRATE CAP 150MG	15	3	$3,806.60	$253.77	5	0.32%
FENOFIBRATE CAP 130MG	6	2	$705.08	$117.51	3	0.06%
FENOFIBRATE TAB 40MG	4	1	$2,553.17	$638.29	4	0.21%
TIER-2 SUBTOTAL	**250**	**58**	**$36,209.84**	**$144.84**	**4.31**	**3.03%**
FIBRIC ACID DERIVATIVE MEDICATIONS TOTAL	**6,186**	**1,675**	**$145,905.00**	**$23.59**	**3.69**	**12.20%**
OMEGA-3 FATTY ACIDS						
OMEGA-3-ACID CAP 1GM	1,029	332	$37,229.00	$36.18	3.1	3.11%
VASCEPA CAP 1GM	96	24	$31,500.26	$328.13	4	2.63%
ICOSAPENT CAP 1GM	15	7	$3,925.33	$261.69	2.14	0.33%
OMEGA-3 FATTY ACIDS TOTAL	**1,140**	**363**	**$72,654.59**	**$63.73**	**3.14**	**6.07%**
COLESEVELAM MEDICATIONS						
COLESEVELAM TAB 625MG	262	66	$19,528.77	$74.54	3.97	1.63%
COLESEVELAM PAK 3.75GM	10	7	$11,300.85	$1,130.09	1.43	0.98%
COLESEVELAM MEDICATIONS TOTAL	**272**	**73**	**$31,259.50**	**$114.92**	**3.73**	**2.61%**
PCSK9 INHIBITORS						
REPATHA AUTO-INJ 140MG/ML	59	15	$26,792.41	$454.11	3.93	2.24%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
REPATHA INJ 140MG/ML	14	2	$6,078.09	$434.15	7	0.51%
PRALUENT INJ 150MG/ML	11	2	$4,906.38	$446.03	5.5	0.41%
PRALUENT INJ 75MG/ML	11	1	$4,890.44	$444.59	11	0.41%
PCSK9 INHIBITORS TOTAL	**95**	**20**	**$42,667.32**	**$449.13**	**4.75**	**3.57%**
TOTAL	**72,918**	**19,526***	**$1,196,028.54**	**$16.40**	**3.73**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CAP = capsule; DR = delayed-release; EZETIM/SIMVA = ezetimibe/simvastatin; INJ = injection; PA = prior authorization; PAK = packet; TAB = tablet
Fiscal Year 2021 = 07/01/2020 to 06/30/2021

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[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/. Last revised 12/2021. Last accessed 12/15/2021.
[2] U.S. FDA. FDA Approves Add-On Therapy For Patients With Genetic Form Of Severely High Cholesterol. Available online at: https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-add-therapy-patients-genetic-form-severely-high-cholesterol-0. Issued 02/11/2021. Last accessed 12/15/2021.
[3] U.S. FDA. FDA Approves Add-On Therapy For Patients With Genetic Form Of Severely High Cholesterol. Available online at: https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-add-therapy-patients-genetic-form-severely-high-cholesterol. Issued 04/01/2021. Last Accessed 12/15/2021.
[4] Amgen. FDA Approves Repatha® (Evolocumab) In Pediatric Patients Age 10 and Older with Heterozygous Familial Hypercholesterolemia. Available online at: https://www.amgen.com/newsroom/press-releases/2021/09/fda-approves-repatha-evolocumab-in-pediatric-patients-age-10-and-older-with-heterozygous-familial-hypercholesterolemia. Issued 09/24/2021. Last Assessed 12/15/2021.
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[6] Novartis. FDA Approves Novartis Leqvio® (Inclisiran), First-In-Class siRNA to Lower Cholesterol and Keep It Low with Two Doses a Year. Available online at: https://www.novartis.com/news/media-releases/fda-approves-novartis-leqvio-inclisiran-first-class-sirna-lower-cholesterol-and-keep-it-low-two-doses-year. Issued 12/22/2021. Last accessed 12/27/2021.
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[9] Leqvio® (Inclisiran) Prescribing Information. Novartis. Available online at: https://www.novartis.us/sites/www.novartis.us/files/leqvio.pdf. Last revised 12/2021. Last accessed 12/27/2021.

Appendix D

Fiscal Year 2021 Annual Review of Glaucoma Medications

Oklahoma Health Care Authority
January 2022

Current Prior Authorization Criteria

Glaucoma Medications*		
Tier-1	**Tier-2**	**Special PA**
Alpha-2 Adrenergic Agonists		
brimonidine (Alphagan® 0.2%)	apraclonidine (Iopidine® 0.5%, 1%)	brimonidine (Alphagan-P® 0.15%)
brimonidine (Alphagan® P 0.1%)		
brimonidine/timolol (Combigan® 0.2%/0.5%)		
brinzolamide/brimonidine (Simbrinza® 0.2%/1%)		
Beta-Blockers		
brimonidine/timolol (Combigan® 0.2%/0.5%)	betaxolol (Betoptic® 0.5%, Betoptic-S® 0.25%)	dorzolamide/timolol (Cosopt® PF 2%/0.5%)
carteolol (Ocupress® 1%)		timolol maleate (Timoptic® in Ocudose® 0.25%, 0.5%; Timoptic-XE® 0.25%, 0.5%)
dorzolamide/timolol (Cosopt® 22.3/6.8mg/mL)		
levobunolol (Betagan® 0.25%, 0.5%)		
timolol maleate (Istalol® 0.5%, Timoptic® 0.25%, 0.5%)		
Carbonic Anhydrase Inhibitors		
acetazolamide (Diamox® 500mg caps; 125mg, 250mg tabs)+		dorzolamide/timolol (Cosopt® PF 2%/0.5%)
brinzolamide (Azopt® 1%)		methazolamide (Neptazane® 25mg, 50mg tabs)+
brinzolamide/brimonidine (Simbrinza® 0.2%/1%)		
dorzolamide (Trusopt® 2%)		

Glaucoma Medications*		
Tier-1	**Tier-2**	**Special PA**
dorzolamide/timolol (Cosopt® 22.3/6.8mg/mL)		
Cholinergic Agonists/Cholinesterase Inhibitors		
echothiophate iodide (Phospholine Iodide® 0.125%)	pilocarpine (Isopto® Carpine 1%, 2%, 4%)	
Prostaglandin Analogs		
latanoprost (Xalatan® 0.005%)	bimatoprost (Lumigan® 0.01%, 0.03%)	latanoprost (Xelpros™ 0.005%)
netarsudil/latanoprost (Rocklatan®)	tafluprost (Zioptan® 0.0015%)	latanoprostene bunod (Vyzulta® 0.024%)
travoprost (Travatan-Z® 0.004%) – **Brand Preferred**		
Rho Kinase Inhibitors		
netarsudil (Rhopressa® 0.02%)		
netarsudil/latanoprost (Rocklatan®)		

*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).
†Indicates available oral medications.
Please note: Combination products are included in both applicable pharmaceutical classes; therefore, combination products are listed twice in the tier chart.
caps = capsules; PA = prior authorization; tabs = tablets

Glaucoma Medications Tier-2 Approval Criteria:

1. An FDA approved diagnosis; and
2. The member must have documented, recent (within the last 120 days) trials with at least 3 Tier-1 medications for a minimum of 4 weeks duration each. Tier-1 trials may be from any pharmacologic class; or
3. Approvals may be granted if there is a documented adverse effect, drug interaction, or contraindication to all Tier-1 medications; or
4. Approvals may be granted if there is a unique FDA approved indication not covered by all Tier-1 medications; and
5. The member must have had a comprehensive, dilated eye exam within the last 365-day period as recommended by the National Institutes of Health; and
6. Approvals will be for the duration of 1 year.

Glaucoma Medications Special Prior Authorization (PA) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why a special formulation is needed over a Tier-1 or Tier-2 medication must be provided; or

3. Approvals may be granted if there is a documented adverse effect, drug interaction, or contraindication to all Tier-1 and Tier-2 medications; or
4. Approvals may be granted if there is a unique FDA approved indication not covered by all Tier-1 and Tier-2 medications; and
5. The member must have had a comprehensive, dilated eye exam within the last 365-day period as recommended by the National Institutes of Health; and
6. Approvals will be for the duration of 1 year.

Durysta™ (Bimatoprost Implant) Approval Criteria:

1. An FDA approved indication to reduce intraocular pressure (IOP) in members with open-angle glaucoma (OAG) or ocular hypertension (OHT); and
2. Member must be 18 years of age or older; and
3. Durysta™ must be prescribed by, or in consultation with, an ophthalmologist; and
4. A patient-specific, clinically significant reason why the member requires Durysta™ and cannot utilize ophthalmic preparations, such as solution or suspension, to treat OAG or OHT must be provided; and
5. The affected eye has not received prior treatment with Durysta™; and
6. The member has no contraindications to Durysta™; and
7. A quantity limit of (1) Durysta™ 10mcg implant per eye per lifetime will apply.

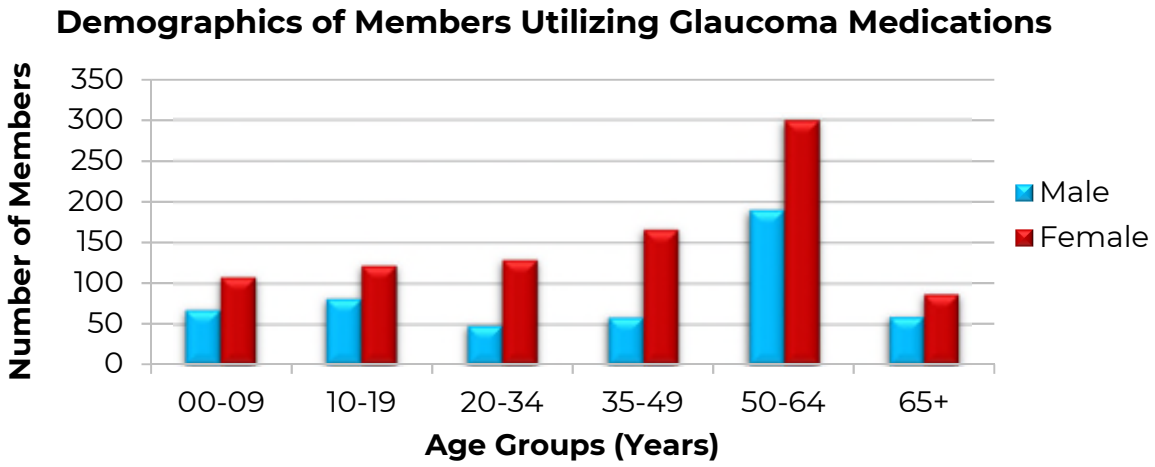
Utilization of Glaucoma Medications: Fiscal Year 2021

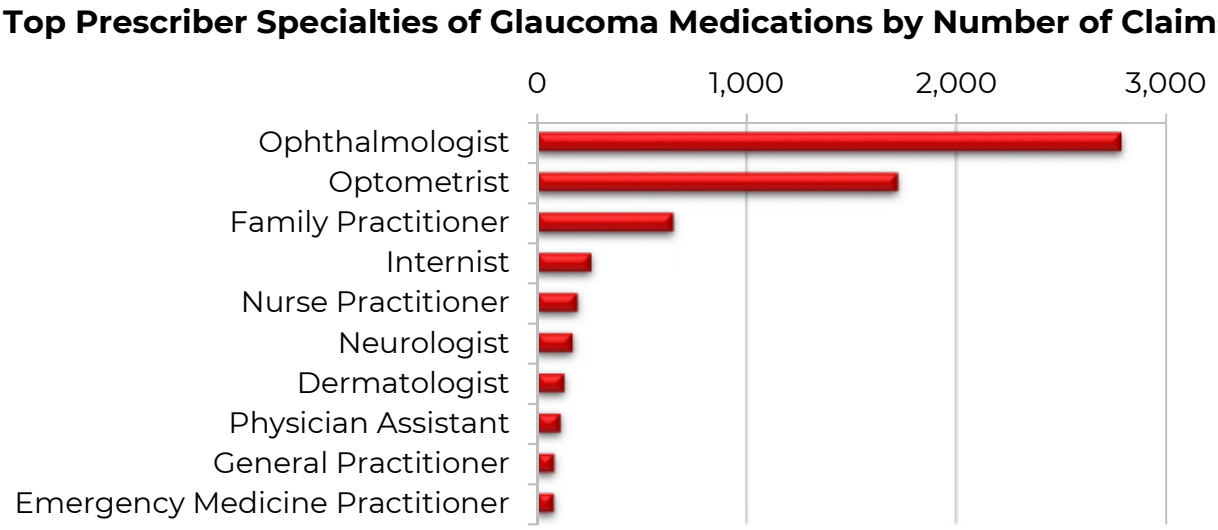
Comparison of Fiscal Years: Pharmacy Claims

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2020	1,321	6,419	$599,804.54	$93.44	$2.55	81,558	234,967
2021	1,408	6,608	$572,239.93	$86.60	$2.24	91,084	255,420
% Change	**6.60%**	**2.90%**	**-4.60%**	**-7.30%**	**-12.20%**	**11.70%**	**8.70%**
Change	**87**	**189**	**-$27,564.61**	**-$6.84**	**-$0.31**	**9,526**	**20,453**

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

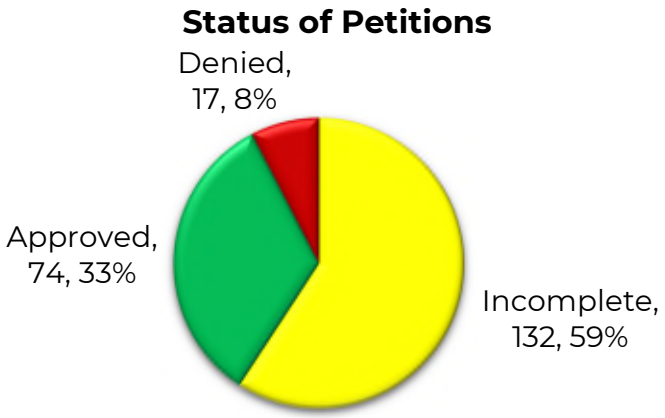
- There were no medical claims for Durysta™ (bimatoprost implant) during fiscal year 2021.





Prior Authorization of Glaucoma Medications

There were 223 prior authorization requests submitted for glaucoma medications during fiscal year 2021. Computer edits are in place to detect lower tiered medications in a member's recent claims history and generate automated prior authorizations where possible. The following chart shows the status of the submitted petitions for fiscal year 2021.



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

Anticipated Patent Expiration(s):

- Combigan® (brimonidine/timolol 0.2%/0.5%): April 2022
- Alphagan® P (brimonidine 0.1%): March 2024
- Vyzulta® (latanoprostene bunod 0.024%): October 2025
- Lumigan® (bimatoprost 0.01%): June 2027
- Zioptan® (tafluprost 0.0015%): May 2029
- Xelpros™ (latanoprost 0.005%): September 2029
- Simbrinza® (brinzolamide/brimonidine 0.2%/1%): October 2030
- Rhopressa® (netarsudil 0.02%): March 2034
- Rocklatan® (netarsudil/latanoprost 0.02%/0.005%): March 2034

Pipeline:

- **Omidenepag Isopropyl (STN1011700/DE-117):** In February 2021, the U.S. Food and Drug Administration (FDA) accepted a New Drug Application (NDA) for omidenepag isopropyl, an investigational topical ophthalmic solution for the treatment of patients with glaucoma and ocular hypertension (OHT). The FDA set a Prescription Drug User Fee Act (PDUFA) date of November 19, 2021 and on November 18, 2021, Santen Pharmaceutical Co., Ltd. and Ube Industries, Ltd. received a complete response letter (CRL) from the FDA. According to the CRL, the FDA has identified deficiencies at contract manufacturing facilities used for omidenepag isopropyl as not fully complying with current Good Manufacturing Practice (cGMP) regulations. Santen and Ube Industries will continue to work closely with the FDA to determine the appropriate next steps for this NDA. Omidenepag isopropyl, licensed out from Ube Industries to Santen, is a selective prostaglandin E_2 (EP2) receptor agonist and is an ocular hypotensive agent with a new mechanism of action. Omidenepag isopropyl binds to the EP2 receptor, which results in an increase in aqueous humor outflow via both the conventional and uveoscleral pathways. A Phase 3 non-inferiority study (AYAME) concluded omidenepag isopropyl 0.002% was non-inferior to

latanoprost 0.005% in reducing intraocular pressure in patients with OHT or primary open-angle glaucoma at week 4. In November 2018, omidenepag isopropyl was launched in Japan as Eybelis® ophthalmic solution 0.002% and was launched in South Korea in February 2021.

Recommendations

The College of Pharmacy recommends the following changes to the current glaucoma medications Product Based Prior Authorization (PBPA) category based on net cost:

1. Moving Istalol® 0.5% (timolol maleate ophthalmic solution) from Tier-1 to the Special Prior Authorization (PA) Tier of the glaucoma medications PBPA category; and
2. Making Azopt® (brinzolamide 1% suspension) brand preferred; and
3. Moving Lumigan® (bimatoprost 0.01% solution) and Zioptan® (tafluprost 0.0015% solution) from Tier-2 to Tier-1 of the glaucoma medications PBPA category; and
4. Moving Timoptic-XE® (timolol maleate ophthalmic gel-forming solution) and Cosopt® PF (dorzolamide/timolol 2%/0.5% preservative free solution) from the Special PA Tier to Tier-2 of the glaucoma medications PBPA category.

Glaucoma Medications*		
Tier-1	**Tier-2**	**Special PA**
Alpha-2 Adrenergic Agonists		
brimonidine (Alphagan® 0.2%)	apraclonidine (Iopidine® 0.5%, 1%)	brimonidine (Alphagan-P® 0.15%)
brimonidine (Alphagan® P 0.1%)		
brimonidine/timolol (Combigan® 0.2%/0.5%)		
brinzolamide/brimonidine (Simbrinza® 0.2%/1%)		
Beta-Blockers		
brimonidine/timolol (Combigan® 0.2%/0.5%)	betaxolol (Betoptic® 0.5%, Betoptic-S® 0.25%)	~~**dorzolamide/timolol (Cosopt® PF 2%/0.5%)**~~
carteolol (Ocupress® 1%)	**dorzolamide/timolol (Cosopt® PF 2%/0.5%)**	**timolol maleate (Istalol® 0.5%)**
dorzolamide/timolol (Cosopt® 22.3/6.8mg/mL)	**timolol maleate (Timoptic-XE® 0.25%, 0.5%)**	timolol maleate (Timoptic® in Ocudose® 0.25%, 0.5%; ~~**Timoptic-XE® 0.25%, 0.5%**~~)
levobunolol (Betagan® 0.25%, 0.5%)		
timolol maleate		

Glaucoma Medications*		
Tier-1	**Tier-2**	**Special PA**
(~~**Istalol® 0.5%,**~~ Timoptic® 0.25%, 0.5%)		
Carbonic Anhydrase Inhibitors		
acetazolamide (Diamox® 500mg caps; 125mg, 250mg tabs)+	**dorzolamide/timolol (Cosopt® PF 2%/0.5%)**	~~**dorzolamide/timolol (Cosopt® PF 2%/0.5%)**~~
brinzolamide (Azopt® 1%) – **Brand Preferred**		methazolamide (Neptazane® 25mg, 50mg tabs)+
brinzolamide/brimonidine (Simbrinza® 0.2%/1%)		
dorzolamide (Trusopt® 2%)		
dorzolamide/timolol (Cosopt® 22.3/6.8mg/mL)		
Cholinergic Agonists/Cholinesterase Inhibitors		
echothiophate iodide (Phospholine Iodide® 0.125%)	pilocarpine (Isopto® Carpine 1%, 2%, 4%)	
Prostaglandin Analogs		
bimatoprost (Lumigan® 0.01%)	bimatoprost (Lumigan® ~~**0.01%,**~~ 0.03%)	latanoprost (Xelpros™ 0.005%)
latanoprost (Xalatan® 0.005%)	~~**tafluprost (Zioptan® 0.0015%)**~~	latanoprostene bunod (Vyzulta® 0.024%)
netarsudil/latanoprost (Rocklatan®)		
tafluprost (Zioptan® 0.0015%)		
travoprost (Travatan-Z® 0.004%) Brand Preferred		
latanoprost (Xalatan® 0.005%)		
Rho Kinase Inhibitors		
netarsudil (Rhopressa® 0.02%)		
netarsudil/latanoprost (Rocklatan®)		

*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).
+Indicates available oral medications.
Please note: Combination products are included in both applicable pharmaceutical classes; therefore, combination products are listed twice in the tier chart.
caps = capsules; tabs = tablets; PA = prior authorization

Glaucoma Medications Tier-2 Approval Criteria:

1. An FDA approved diagnosis; and
2. The member must have documented, recent (within the last 120 days) trials with at least 3 Tier-1 medications for a minimum of 4 weeks duration each. Tier-1 trials may be from any pharmacologic class; or
3. Approvals may be granted if there is a documented adverse effect, drug interaction, or contraindication to all Tier-1 medications; or
4. Approvals may be granted if there is a unique FDA approved indication not covered by all Tier-1 medications; and
5. The member must have had a comprehensive, dilated eye exam within the last 365-day period as recommended by the National Institutes of Health; and
6. Approvals will be for the duration of 1 year.

Glaucoma Medications Special Prior Authorization (PA) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why a special formulation is needed over a Tier-1 or Tier-2 medication must be provided; or
3. Approvals may be granted if there is a documented adverse effect, drug interaction, or contraindication to all Tier-1 and Tier-2 medications; or
4. Approvals may be granted if there is a unique FDA approved indication not covered by all Tier-1 and Tier-2 medications; and
5. The member must have had a comprehensive, dilated eye exam within the last 365-day period as recommended by the National Institutes of Health; and
6. Approvals will be for the duration of 1 year.

Utilization Details of Glaucoma Medications: Fiscal Year 2021

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM	% COST
TIER-1 PRODUCTS						
LATANOPROST SOL 0.005%	2,039	562	$32,888.74	3.63	$16.13	5.75%
TIMOLOL MAL SOL 0.5% OP	651	275	$10,050.95	2.37	$15.44	1.76%
DORZOL/TIMOL SOL 22.3-6.8MG/ML	618	192	$15,174.36	3.22	$24.55	2.65%
TRAVATAN Z DRO 0.004%	496	123	$139,520.65	4.03	$281.29	24.38%
COMBIGAN SOL 0.2/0.5%	473	111	$123,546.67	4.26	$261.20	21.59%
BRIMONIDINE SOL 0.2% OP	438	162	$7,161.06	2.7	$16.35	1.25%
ACETAZOLAMIDE TAB 250MG	397	119	$22,050.96	3.34	$55.54	3.85%
ACETAZOLAMIDE CAP 500MG ER	291	103	$12,120.27	2.83	$41.65	2.12%
DORZOLAMIDE SOL 2% OP	274	87	$7,094.90	3.15	$25.89	1.24%
ALPHAGAN-P SOL 0.1%	167	53	$45,371.04	3.15	$271.68	7.93%
SIMBRINZA SUS 1-0.2%	90	34	$16,848.36	2.65	$187.20	2.94%
TIMOLOL MAL SOL 0.25% OP	82	36	$1,185.15	2.28	$14.45	0.21%
RHOPRESSA SOL 0.02%	80	20	$23,005.64	4	$287.57	4.02%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM	% COST
ACETAZOLAMIDE TAB 125MG	58	21	$3,200.67	2.76	$55.18	0.56%
ROCKLATAN DRO 0.02%/0.005%	55	12	$16,536.42	4.58	$300.66	2.89%
AZOPT SUS 1% OP	52	21	$18,198.77	2.48	$349.98	3.18%
TIMOLOL MAL SOL 0.5%	23	11	$4,421.06	2.09	$192.22	0.77%
BRINZOLAMIDE SUS 1%	12	8	$3,998.80	1.5	$333.23	0.70%
LEVOBUNOLOL SOL 0.5% OP	5	2	$72.20	2.5	$14.44	0.01%
SUBTOTAL	**6,301**	**1,952**	**$502,446.67**	**3.23**	**$79.74**	**87.80%**
TIER-2 PRODUCTS						
LUMIGAN SOL 0.01%	144	28	$47,908.60	5.14	$332.70	8.37%
BIMATOPROST SOL 0.03%	13	2	$1,362.95	6.5	$104.84	0.24%
PILOCARPINE SOL 4% OP	6	1	$461.75	6	$76.96	0.08%
ZIOPTAN DRO 0.0015%	6	1	$1,270.72	6	$211.79	0.22%
SUBTOTAL	**169**	**32**	**$51,004.02**	**5.28**	**$301.80**	**8.91%**
SPECIAL PA PRODUCTS						
TIMOLOL GEL SOL 0.5% OP	51	28	$3,602.63	1.82	$70.64	0.63%
DORZOL/TIMOL SOL 2%-0.5% PF	37	8	$3,979.56	4.63	$107.56	0.70%
VYZULTA SOL 0.024%	18	3	$3,362.16	6	$186.79	0.59%
METHAZOLAMIDE TAB 50MG	17	3	$4,734.79	5.67	$278.52	0.83%
BRIMONIDINE SOL 0.15%	13	2	$2,839.06	6.5	$218.39	0.50%
METHAZOLAMIDE TAB 25MG	2	1	$271.04	2	$135.52	0.05%
SUBTOTAL	**138**	**45**	**$18,789.24**	**3.07**	**$136.15**	**3.30%**
TOTAL	**6,608**	**1,408***	**$572,239.93**	**4.69**	**$86.60**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CAP = capsule; DORZ = dorzolamide; DRO = drop; ER = extended-release; MAL = maleate; OP = ophthalmic; PA = prior authorization; PF = preservative free; SOL = solution; SUS = suspension; TAB = tablet; TIMOL = timolol
Fiscal Year 2021 = 07/01/2020 to 06/30/2021

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm. Last revised 12/2021. Last accessed 12/18/2021.
[2] Santen Pharmaceuticals Co., Ltd. Santen and Ube Announces U.S. FDA Acceptance of New Drug Application for STN10117 (DE-117) (JAN: Omidenepag Isopropyl) as a Treatment for Patients with Glaucoma and Ocular Hypertension. Available online at: https://www.santen.com/en/news/20210202.pdf. Issued 02/02/2021. Last accessed 12/18/2021.
[3] Santen Pharmaceuticals Co., Ltd. Santen and Ube Industries Receives Complete Response Letter from FDA for STN10117700/DE-117 Citing Contract Manufacturer's Non-Compliance with Good Manufacturing Practice (cGMP). Available online at: https://www.santen.com/en/news/20211118.pdf. Issued 11/18/2021. Last accessed 12/18/2021.
[4] Aihara M, Lu F, Kawata H, et al. Omidenepag Isopropyl Versus Latanoprost in Primary Open-Angle Glaucoma and Ocular Hypertension: The Phase 3 AYAME Study. *Am J Ophthalmol* 2020; 220:53–63. doi: 10.1016/j.ajo.2020.06.003.

Appendix E

Fiscal Year 2021 Annual Review of Gonadotropin-Releasing Hormone (GnRH) Medications and 30-Day Notice to Prior Authorize Myfembree® (Relugolix/ Estradiol/Norethindrone)

Oklahoma Health Care Authority
January 2022

Current Prior Authorization Criteria

Gonadotropin-Releasing Hormone (GnRH) Agonist Medications		
Tier-1	**Tier-2**	**Tier-3**
histrelin (Supprelin® LA)		
leuprolide (Fensolvi®)		
leuprolide (Lupron Depot®)		
leuprolide (Lupron Depot-Ped®)		
nafarelin (Synarel®)		
triptorelin (Triptodur®)		

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).

Lupaneta Pack™ [Leuprolide Acetate for Depot Suspension (3.75mg for Intramuscular Injection) and Norethindrone Acetate Tablet (5mg for Oral Administration)] Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use the individual components must be provided.

Oriahnn® (Elagolix/Estradiol/Norethindrone and Elagolix) Approval Criteria:

1. An FDA approved diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women; and
2. Member must be 18 years of age or older; and
3. Member must not have any contraindications to Oriahnn® therapy including:
    a. Osteoporosis; and
    b. Pregnancy; and
        i. Female members must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
        ii. Female members of reproductive potential must be willing to use effective non-hormonal contraception during treatment with Oriahnn® and for at least 1 week after discontinuing treatment; and
    c. Hepatic impairment or disease; and

   d. Undiagnosed abnormal uterine bleeding; and
   e. High risk of arterial, venous thrombotic, or thromboembolic disease; and
   f. Current or history of breast cancer or other hormonally-sensitive malignancies; and
   g. Known hypersensitivity to ingredients in Oriahnn®; and
   h. Concomitant use with an organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine, gemfibrozil); and
4. Oriahnn® must be prescribed by, or in consultation with, an obstetrician/gynecologist or a specialist with expertise in the treatment of uterine leiomyomas (fibroids); and
5. A failed trial at least 1 month in duration with nonsteroidal anti-inflammatory drugs (NSAIDs) or a patient-specific, clinically significant reason why the member cannot use NSAIDs must be provided; and
6. A failed trial at least 3 months in duration of hormonal contraceptives or a patient-specific, clinically significant reason why the member cannot use hormonal contraceptives must be provided; and
7. A quantity limit of 56 capsules per 28 days will apply; and
8. Lifetime approval duration will be limited to a maximum of 24 months.

Orilissa® (Elagolix) Approval Criteria:

1. An FDA approved indication of moderate-to-severe pain associated with endometriosis; and
2. Member must be 18 years of age or older; and
3. Member must not have known osteoporosis; and
4. Female members must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
5. Female members of reproductive potential must be willing to use effective non-hormonal contraception during treatment with Orilissa® and for at least 1 week after discontinuing treatment; and
6. Member must not have severe hepatic impairment (Child-Pugh C); and
7. Member must not be taking a strong organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine, gemfibrozil); and
8. Orilissa® must be prescribed by, or in consultation with, an obstetrician/gynecologist or a specialist with expertise in the treatment of endometriosis; and
9. A failed trial at least 1 month in duration with nonsteroidal anti-inflammatory drugs (NSAIDs) or a patient-specific, clinically significant reason why the member cannot use NSAIDs must be provided; and
10. A failed trial at least 3 months in duration of hormonal contraceptives or a patient-specific, clinically significant reason why the member cannot use hormonal contraceptives must be provided; and
11. Dosing and lifetime approval duration will be limited based on the following:

a. Coexisting condition of moderate hepatic impairment (Child-Pugh B):
    i. 150mg once daily for a maximum of 6 months; or
b. Normal liver function or mild hepatic impairment (Child-Pugh A):
    i. 150mg once daily for a maximum of 24 months; or
    ii. 200mg twice daily for a maximum of 6 months.

Utilization of GnRH 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	151	364	$1,884,575.73	$5,177.41	$80.65	3,847	23,368
2021	137	313	$1,910,213.86	$6,102.92	$82.37	4,333	23,191
% Change	**-9.30%**	**-14.00%**	**1.40%**	**17.90%**	**2.10%**	**12.60%**	**-0.80%**
Change	**-14**	**-51**	**$25,638.13**	**$925.52**	**$1.72**	**486**	**-177**

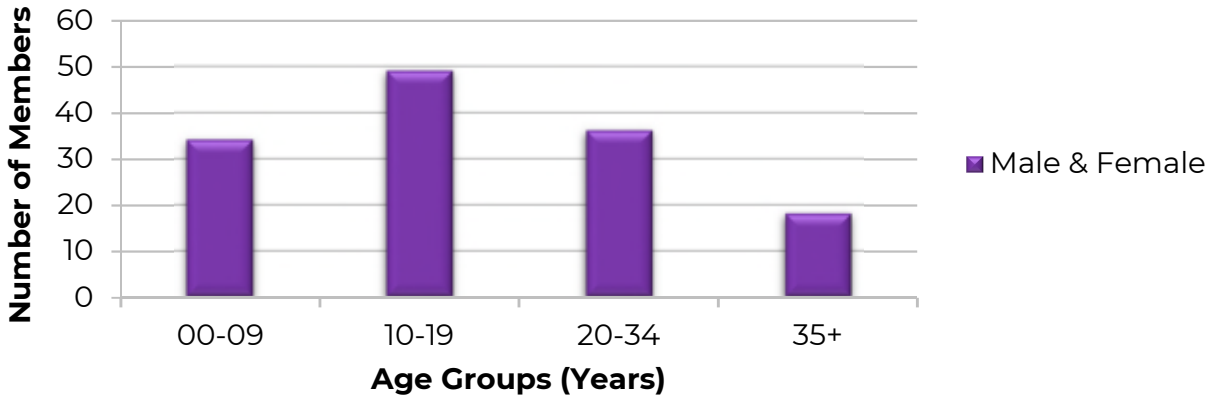
Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2020 = 07/01/2019 to 06/30/2020; Fiscal Year 2021 = 07/01/2020 to 06/30/2021

Comparison of Fiscal Years: Medical Claims

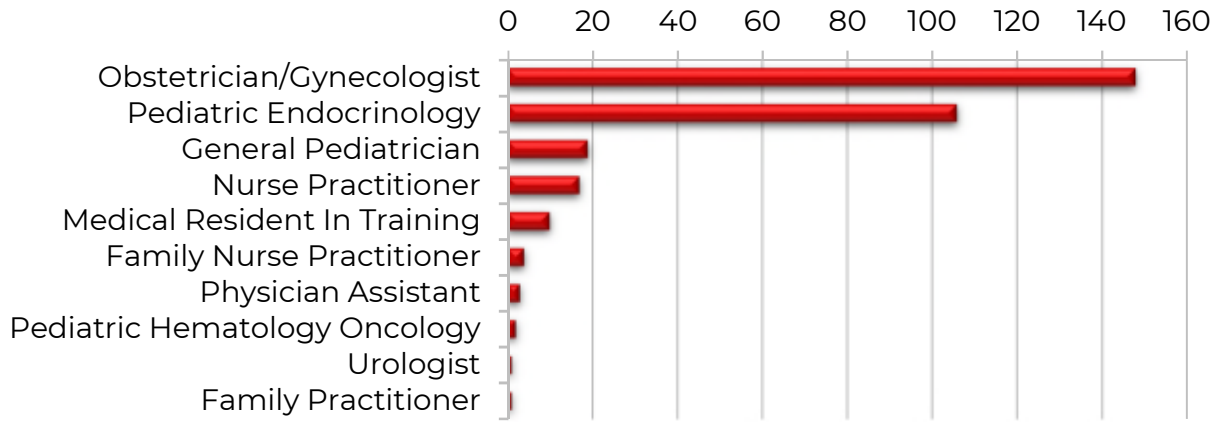
Fiscal Year	*Total Members	†Total Claims	Total Cost	Cost/ Claim	Total Units
2020	91	182	$186,176.97	$1,022.95	433
2021	90	231	$187,591.29	$812.08	455
% Change	**-1.10%**	**26.92%**	**0.76%**	**-20.61%**	**5.08%**
Change	**-1**	**49**	**$1,414.32**	**-$210.87**	**22**

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

Demographics of Members Utilizing GnRH Medications: Pharmacy Claims



Top Prescriber Specialties of GnRH Medications by Number of Claims: Pharmacy Claims



Prior Authorization of GnRH Medications

There were 203 prior authorization requests submitted for GnRH 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]

Anticipated Patent Expiration(s):

- Fensolvi® (leuprolide acetate injection): October 2023
- Supprelin® LA (histrelin implant): June 2026
- Triptodur® (triptorelin injection): June 2029
- Lupron Depot® (leuprolide injection): February 2031
- Oriahnn® (elagolix/estradiol/norethindrone and elagolix capsule): March 2034
- Orilissa® (elagolix tablet): September 2036
- Myfembree® (relugolix/estradiol/norethindrone tablet): September 2037

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

- **May 2021:** The FDA approved Myfembree® (relugolix/estradiol/ norethindrone) for the management of heavy menstrual bleeding associated with uterine leiomyomas, also known as fibroids, in premenopausal women. Myfembree® is a combination of relugolix (a GnRH receptor antagonist), estradiol (an estrogen), and norethindrone (a progestin) and is available in a fixed-dose oral tablet formulation. Myfembree® is the first once-daily treatment option to be FDA approved for this indication. Uterine fibroids are benign neoplasms originating from uterine smooth muscle tissue and are the most common solid pelvic tumors in women. Many women with fibroids are asymptomatic and can be monitored without active treatment. However, approximately 25% of cases are clinically significant enough to require intervention. The most common symptoms are excessive menstrual bleeding and pelvic discomfort or pressure. Although hysterectomy is the most common surgical treatment for fibroids, accounting for 39% of hysterectomies performed in the United States, medical therapy is available as an alternative option for women who anticipate future childbearing or wish to retain their uteri. Additional options for medical therapy include hormonal contraceptives, nonsteroidal anti-inflammatory drugs (NSAIDs), GnRH agonists, and tranexamic acid.

Pipeline:

- **Linzagolix:** Obseva is in Phase 3 development of linzagolix for patients with endometriosis or uterine fibroids. Linzagolix is an oral, once daily GnRH receptor antagonist. Linzagolix may lower estradiol in a dose-dependent manner, potentially allowing the estradiol level to be maintained within an optimal range to reduce bone mineral density loss. Linzagolix is being evaluated both as monotherapy and in combination with hormonal add-back therapy (estradiol 1mg/ norethindrone acetate 0.5mg). In November 2021, Obseva announced the FDA has accepted their New Drug Application (NDA) for linzagolix for the management of heavy menstrual bleeding associated with uterine fibroids. The NDA submission is supported by data from the Phase 3 PRIMROSE 1 and PRIMROSE 2 studies, which evaluated 2 doses of linzagolix (100mg or 200mg) with or without hormonal add-back therapy. The Prescription Drug User Fee Act (PDUFA) action date is September 13, 2022.
- **Relugolix:** Myovant is in Phase 3 development of relugolix for 2 potential new indications, for the treatment of endometriosis-associated pain and for the prevention of pregnancy. Relugolix is an oral GnRH receptor antagonist administered in combination with estradiol 1mg and norethindrone acetate 0.5mg hormonal add-back

therapy. In September 2021, Myovant announced the FDA has accepted their supplemental NDA (sNDA) for relugolix/estradiol/norethindrone for the management of moderate-to-severe pain associated with endometriosis. The sNDA is supported by data from the Phase 3 SPIRIT 1 and SPIRIT 2 studies in more than 1,200 women with endometriosis. The PDUFA action date is May 6, 2022.

Myfembree® (Relugolix/Estradiol/Norethindrone) Product Summary[9,10]

Indication(s): Myfembree® (relugolix/estradiol/norethindrone) is indicated for the management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women.

- Limitation(s) of Use: Use should be limited to 24 months due to the risk of continued bone loss, which may not be reversible.

Boxed Warning: Thromboembolic Disorders and Vascular Events

- Estrogen and progestin combinations, including Myfembree®, increase the risk of thrombotic or thromboembolic disorders including pulmonary embolism, deep vein thrombosis, stroke, and myocardial infarction, especially in women at increased risk for these events
- Myfembree® is contraindicated in women with current or history of thrombotic or thromboembolic disorders and in women at increased risk for these events, including women older than 35 years of age who smoke or women with uncontrolled hypertension (HTN)

How Supplied:

- Relugolix/estradiol/norethindrone 40mg/1mg/0.5mg oral tablets

Dosing:

- 1 tablet by mouth once daily for up to 24 months

Mechanism of Action: Myfembree® contains a combination of relugolix (a GnRH receptor antagonist), estradiol (an estrogen), and norethindrone acetate (a progestin):

- Relugolix binds competitively to GnRH receptors in the pituitary gland, causing suppression of luteinizing hormone (LH) and follicle-stimulating hormone (FSH) and a subsequent decrease in the blood concentrations of ovarian sex hormones estradiol and progesterone. This ultimately reduces bleeding associated with uterine fibroids.
- Estradiol binds to nuclear receptors in estrogen-responsive tissues. The addition of estradiol may help to decrease bone loss that could occur due to a decrease in circulating estrogen from using relugolix alone.
- Norethindrone binds to nuclear receptors in progesterone-responsive tissues. The addition of norethindrone may help protect the uterus from potential adverse endometrial effects of unopposed estrogen.

Contraindication(s):

- High risk of arterial, venous thrombotic, or thromboembolic disorder
- Pregnancy
- Known osteoporosis
- Current or history of breast cancer, or other hormonally-sensitive malignancies
- Known hepatic impairment or disease
- Undiagnosed abnormal uterine bleeding
- Known hypersensitivity to ingredients in Myfembree®

Safety:

- Thromboembolic Disorders and Vascular Events: Myfembree® is contraindicated in women with current or history of thrombotic or thromboembolic disorders and women at increased risk for these events. In general, the risk is greatest for women older than 35 years of age who smoke or for women with uncontrolled HTN, dyslipidemia, vascular disease, or obesity.
- Bone Loss: Myfembree® is contraindicated in women with known osteoporosis. Bone mineral density loss may be greater with increased duration of use and may not be completely reversible after stopping treatment.
- Hormone-Sensitive Malignancies: Myfembree® is contraindicated in women with current or history of breast cancer and in women at an increased risk of hormonally-sensitive malignancies. Myfembree® should be discontinued if a hormonally-sensitive malignancy is diagnosed.
- Depression, Mood Disorders, and Suicidal Ideation: In clinical studies of Myfembree®, depression, irritability, and anxiety occurred at a higher frequency than with placebo. Additionally, suicidal ideation occurred in a separate study of relugolix conducted for a different indication.
- Hepatic Impairment and Transaminase Elevations: Myfembree® is contraindicated in women with known hepatic impairment or disease. The use of estradiol in patients with hepatic impairment is expected to increase the exposure of estradiol and increase the risk of estradiol-associated adverse reactions. Elevations ≥3 times the upper limit of normal (ULN) in alanine aminotransferase (ALT) and aspartate aminotransferase (AST) were seen in 0.4% and 0.8% of patients, respectively, treated with Myfembree® in clinical studies.
- Elevated Blood Pressure (BP): Myfembree® is contraindicated in women with uncontrolled HTN. In clinical studies, new or worsening HTN was observed in 7% of patients treated with Myfembree® vs. 0.8% of patients who received placebo. Women with well-controlled HTN should continue to monitor BP and should discontinue treatment if BP increases significantly.

- Change in Menstrual Bleeding Pattern and Reduced Ability to Recognize Pregnancy: Pregnancy should be excluded before initiating treatment with Myfembree®. The ability to recognize pregnancy may be impaired or delayed while taking Myfembree® due to its effects on the amount, intensity, or duration of menstrual bleeding. Non-hormonal contraception should be used during treatment with Myfembree® and for 1 week after discontinuation.
- Pregnancy and Risk of Early Pregnancy Loss: Myfembree® is contraindicated in pregnant women. Based on animal data and its mechanism of action, relugolix can cause early pregnancy loss. There are insufficient human data to determine whether there is increased risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. Myfembree® should be discontinued if pregnancy occurs during treatment.
- Lactation: There are no data available on the presence of relugolix in human milk, the effects on the breastfed child, or the effects on milk production. Relugolix was detected in the milk of lactating rats and would therefore likely be present in human milk as well. Estrogen and progestin medications can be detected in human milk and can reduce milk production.
- Pediatric Use: The safety and effectiveness of Myfembree® have not been established in pediatric patients.

Adverse Reactions: The most common adverse reactions with Myfembree® (occurring in ≥3% of patients and at a greater frequency than placebo) were hot flash, hyperhidrosis, or night sweats (10.6%); abnormal uterine bleeding (6.3%); alopecia (3.5%); and decreased libido (3.1%). Additionally, in 1 of the 2 Phase 3 studies, new or worsening HTN was observed in 7% of patients treated with Myfembree® vs. 0.8% in the placebo group.

Efficacy: The safety and efficacy of Myfembree® were established in 2 identical randomized, double-blind, placebo-controlled studies (LIBERTY 1 and LIBERTY 2). In the 2 studies, a total of 768 premenopausal women (387 in LIBERTY 1 and 381 in LIBERTY 2) with heavy menstrual bleeding associated with uterine fibroids were randomized 1:1:1 to receive Myfembree® for 24 weeks, relugolix 40mg monotherapy for 12 weeks followed by Myfembree® for 12 weeks, or placebo for 24 weeks. The median age of patients in both studies was 43 years (range: 19 to 51 years of age). Approximately 53% of women were black or African American, 41% were white, and 6% were of other races.

- Key Inclusion Criteria: Patients were eligible for inclusion if they were premenopausal women between 18 years and 50 years of age at the time of screening and had an ultrasound-confirmed diagnosis of uterine fibroids. Additionally, included patients had a history of heavy

menstrual bleeding as assessed by alkaline hematin, an objective and validated method of quantifying blood volume on sanitary products.

- Key Exclusion Criteria: Patients were excluded if they were pregnant, had pathology other than uterine fibroids that could contribute to heavy menstrual bleeding, had a history of osteoporosis, or had a bone mineral density z-score <-2 at the spine, total hip, or femoral neck.
- Primary Endpoint: The primary endpoint was the proportion of patients achieving menstrual blood loss <80mL and ≥50% reduction in menstrual blood loss from baseline over the last 35 days of treatment.
- Results: In LIBERTY 1 and LIBERTY 2, the primary endpoint was met in 72.1% and 71.2% of patients receiving Myfembree® vs. 16.8% and 14.7% of patients receiving placebo, respectively (P<0.0001 in both studies).

Cost Comparison:

Product	Cost Per Unit*	Cost Per Year⁺
Myfembree® (relugolix/estradiol/norethindrone) 40mg/1mg/0.5mg tablet	**$34.81**	**$12,531.60**
Lupron Depot® (leuprolide) 11.25mg injection (3-month kit)	$4,334.37	$17,337.48
Lupron Depot® (leuprolide) 3.75mg injection (1-month kit)	$1,435.16	$17,221.92
Oriahnn® (elagolix/estradiol/norethindrone and elagolix) 300mg/1mg/0.5mg and 300mg capsule	$16.84	$12,124.80
norgestimate/ethinyl estradiol 0.25mg/0.035mg tablet	$0.21	$75.60

Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
*Unit = each capsule for Oriahnn®, each tablet for Myfembree® and norgestimate/ethinyl estradiol, and each package for Lupron Depot®
⁺Cost per year based on 1 capsule twice daily for Oriahnn®, 1 tablet daily for Myfembree® and norgestimate/ethinyl estradiol, 1 injection monthly for Lupron® Depot 1-month kit, and 1 injection every 3 months for Lupron® Depot 3-month kit.

Recommendations

The College of Pharmacy recommends the prior authorization of Myfembree® (relugolix/estradiol/norethindrone) with criteria similar to Oriahnn® (elagolix/estradiol/norethindrone and elagolix) (updates and new criteria shown in red):

Myfembree® (Relugolix/Estradiol/Norethindrone) and Oriahnn® (Elagolix/Estradiol/Norethindrone and Elagolix) Approval Criteria:

1. An FDA approved diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women; and
2. Member must be 18 years of age or older; and
3. Member must not have any contraindications to therapy including:
   a. Osteoporosis; and
   b. Pregnancy; and

i. Female members must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
ii. Female members of reproductive potential must be willing to use effective non-hormonal contraception during treatment and for at least 1 week after discontinuing treatment; and

c. Hepatic impairment or disease; and
d. Undiagnosed abnormal uterine bleeding; and
e. High risk of arterial, venous thrombotic, or thromboembolic disease, including uncontrolled hypertension; and
f. Current or history of breast cancer or other hormonally-sensitive malignancies; and
g. Known hypersensitivity to ingredients in Myfembree® or Oriahnn®; and
~~h. Concomitant use with an organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine, gemfibrozil); and~~

4. Must be prescribed by, or in consultation with, an obstetrician/gynecologist or a specialist with expertise in the treatment of uterine leiomyomas (fibroids); and
5. A failed trial at least 1 month in duration with nonsteroidal anti-inflammatory drugs (NSAIDs) or a patient-specific, clinically significant reason why the member cannot use NSAIDs must be provided; and
6. A failed trial at least 3 months in duration of hormonal contraceptives or a patient-specific, clinically significant reason why the member cannot use hormonal contraceptives must be provided; and
7. For Myfembree®, a patient-specific, clinically significant reason why the member cannot use leuprolide depot formulations available without prior authorization must be provided; and
8. For Myfembree®, a patient-specific, clinically significant reason (beyond convenience) why the member cannot use Oriahnn® must be provided; and
9. For Oriahnn®, prescriber must verify the member will not use Oriahnn® concomitantly with an organic anion transporting polypeptide (OATP) 1B1 inhibitor (e.g., cyclosporine, gemfibrozil); and
10. Quantity limits will apply based on FDA approved dosing:
    a. For Myfembree®, a quantity limit of 28 tablets per 28 days will apply; and
    b. For Oriahnn®, a quantity limit of 56 tablets per 28 days will apply; and
11. Lifetime approval duration will be limited to a maximum of 24 months. For members previously approved for Myfembree® or Oriahnn®, a combined cumulative maximum treatment duration of 24 months will apply.

Utilization Details of GnRH Medications: Fiscal Year 2021

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
GONADOTROPIN-RELEASING HORMONE (GnRH) AGONIST PRODUCTS						
TRIPTODUR SUS 22.5MG	72	49	$1,241,399.52	$17,241.66	1.47	64.99%
LUPRON DEP-PED INJ 30MG	29	18	$272,058.43	$9,381.33	1.61	14.24%
LUPRON DEP INJ 11.25MG	22	15	$91,994.36	$4,181.56	1.47	4.82%
LUPRON DEP INJ 3.75MG	17	9	$23,154.00	$1,362.00	1.89	1.21%
LUPRON DEP-PED INJ 11.25MG	16	7	$50,688.07	$3,168.00	2.29	2.65%
LUPRON DEP-PED INJ 15MG	15	2	$19,508.41	$1,300.56	7.5	1.02%
LUPRON DEP-PED INJ 11.25MG	7	5	$65,269.38	$9,324.20	1.4	3.42%
LUPRON DEP-PED INJ 7.5MG	5	3	$8,665.94	$1,733.19	1.67	0.45%
LUPRON DEP INJ 22.5MG	3	2	$15,477.27	$5,159.09	1.5	0.81%
LUPRON DEP INJ 7.5MG	2	2	$3,340.23	$1,670.12	1	0.17%
LUPRON DEP INJ 30MG	1	1	$6,664.47	$6,664.47	1	0.35%
SUBTOTAL	**189**	**113**	**$1,798,220.08**	**$9,514.39**	**1.67**	**94.14%**
GnRH ANTAGONIST PRODUCTS						
ORILISSA TAB 150MG	100	28	$89,927.12	$899.27	3.57	4.71%
ORILISSA TAB 200MG	24	11	$22,066.66	$919.44	2.18	1.16%
SUBTOTAL	**124**	**39**	**$111,993.78**	**$903.18**	**3.18**	**5.86%**
TOTAL	**313**	**137***	**$1,910,213.86**	**$6,102.92**	**2.28**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
DEP = depot; INJ = injection; PED= pediatric; SUS = suspension; TAB = tablet
Fiscal Year 2021 = 07/01/2020 to 06/30/2021

Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS⁺	TOTAL MEMBERS*	TOTAL COST	COST/ CLAIM
J9217 LEUPROLIDE DEPOT 7.5MG	149	56	$74,969.73	$503.15
J1950 LEUPROLIDE DEPOT 3.75MG	66	18	$112,348.34	$1,702.25
J9218 LEUPROLIDE INJ 1MG	16	16	$273.22	$17.08
TOTAL	**231**	**90**	**$187,591.29**	**$812.08**

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

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Appendix F

Fiscal Year 2021 Annual Review of Oxlumo™ (Lumasiran)

Oklahoma Health Care Authority
January 2022

Current Prior Authorization Criteria

Oxlumo™ (Lumasiran) Approval Criteria:

1. An FDA approved indication for the treatment of primary hyperoxaluria type 1 (PH1) to lower urinary oxalate levels. Diagnosis of PH1 must be confirmed by:
   a. Molecular genetic testing identifying biallelic pathogenic variants in the *AGXT* gene; or
   b. Liver biopsy confirming alanine-glyoxylate aminotransferase (AGT) catalytic deficiency if the results of genetic testing are not diagnostic; and
2. Oxlumo™ must be prescribed by a nephrologist, geneticist, or other specialist with expertise in the treatment of PH1 (or an advanced care practitioner with a supervising physician who is a nephrologist, geneticist, or other specialist with expertise in the treatment of PH1); and
3. Prescriber must verify the member has an estimated glomerular filtration rate (eGFR) of ≥30mL/min/1.73m^2 prior to starting Oxlumo™ and must agree to monitor renal function regularly during treatment with Oxlumo™; and
4. Member must not have a history of liver transplant; and
5. Member must not have evidence of systemic oxalosis; and
6. Prescriber must verify that Oxlumo™ will be administered by a health care professional; and
7. 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 the Oxlumo™ *Prescribing Information*; and
8. 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 urinary oxalate excretion.

Utilization of Oxlumo™ (Lumasiran): Fiscal Year 2021

There was no SoonerCare utilization of Oxlumo™ (lumasiran) during fiscal year 2021 (07/01/2020 to 06/30/2021).

Prior Authorization of Oxlumo™ (Lumasiran)

There were no prior authorization requests submitted for Oxlumo™ (lumasiran) during fiscal year 2021 (07/01/2020 to 06/30/2021).

Market News and Updates[1,2,3]

Anticipated Patent Expiration(s):

- Oxlumo™ (lumasiran): October 2035

Pipeline:

- **Lumasiran:** In November 2021, Alnylam, the manufacturer of Oxlumo™, announced positive topline results from the Phase 3 ILLUMINATE-C study of lumasiran in patients with advanced primary hyperoxaluria type 1 (PH1). Previous Phase 3 studies of lumasiran enrolled patients with PH1 with relatively preserved renal function. The ILLUMINATE-C study enrolled patients with PH1 with estimated glomerular filtration rate (eGFR) ≤45mL/min/1.73m^2, including patients on dialysis. The primary endpoint of the study was the percent change in plasma oxalate levels from baseline to month 6, averaged across months 3-6. The results from the 6-month analysis indicated the primary endpoint was met in PH1 patients regardless of dialysis status, with a reduction in plasma oxalate evident by month 1 and persisting through the end of the 6-month treatment period. Additional clinical outcomes related to systemic oxalosis are being evaluated in the extension period of the study. Alnylam is also currently enrolling patients into a Phase 2 study evaluating lumasiran for the treatment of patients with recurrent renal stones. Patient enrollment is expected to be completed in late 2022.

Recommendations

The College of Pharmacy does not recommend any changes to the current Oxlumo™ (lumasiran) prior authorization criteria at this time.

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[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm. Last revised 12/2021. Last accessed 12/15/2021.

[2] Alnylam Pharmaceuticals, Inc. Alnylam Presents Positive Results from ILLUMINATE-C Phase 3 Study of Lumasiran in Patients with Advanced Primary Hyperoxaluria Type 1. Available online at: https://investors.alnylam.com/press-release?id=26206. Issued 11/05/2021. Last accessed 12/15/2021.

[3] Alnylam Pharmaceuticals, Inc. Alnylam Announces 2022 Product and Pipeline Goals and Provides Program Updates at R&D Day. Available online at: https://investors.alnylam.com/press-release?id=26236. Issued 11/19/2021. Last accessed 12/15/2021.

Appendix G

Fiscal Year 2021 Annual Review of Dry Eye Disease (DED) Medications and 30-Day Notice to Prior Authorize Tyrvaya™ (Varenicline Nasal Spray)

Oklahoma Health Care Authority
January 2022

Current Prior Authorization Criteria

Cequa™ (Cyclosporine 0.09% Ophthalmic Solution) Approval Criteria:

1. An FDA approved indication to increase tear production in members with keratoconjunctivitis sicca (dry eye); and
2. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine 0.05% ophthalmic emulsion) single-use vials, which are available without a prior authorization, must be provided; and
3. A quantity limit of 60 single-use vials (1 box) per 30 days will apply.

Eysuvis® (Loteprednol Etabonate 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) single-use vials, which are 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 etabonate 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).

Restasis MultiDose® (Cyclosporine 0.05% Ophthalmic Emulsion) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use Restasis® in the individual dosage formulation (single-use vials), which is available without a prior authorization, must be provided.

Xiidra® (Lifitegrast 5% Ophthalmic Solution) Approval Criteria:

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

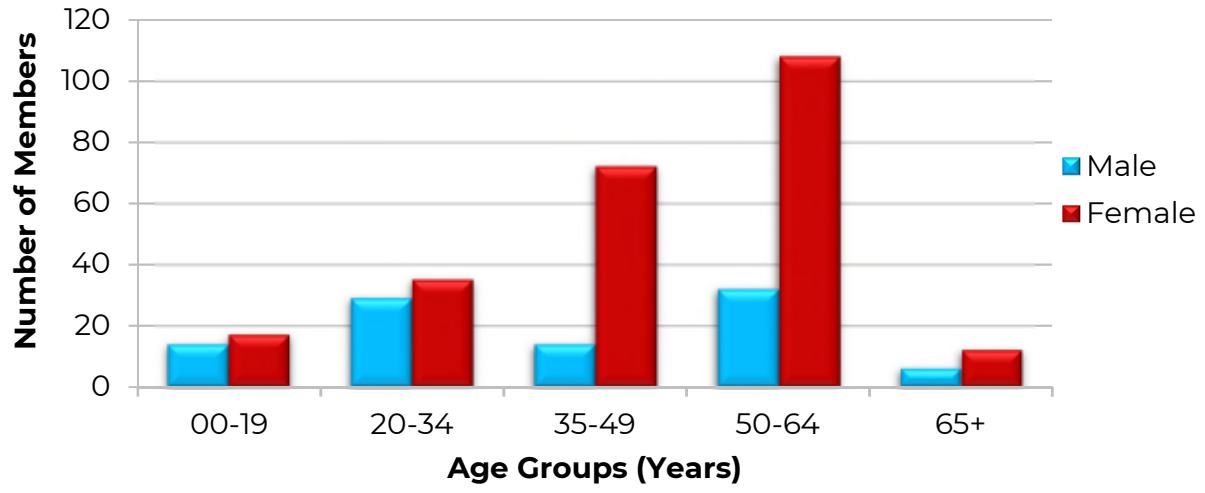
Utilization of DED Medications: Fiscal Year 2021

Comparison of Fiscal Years

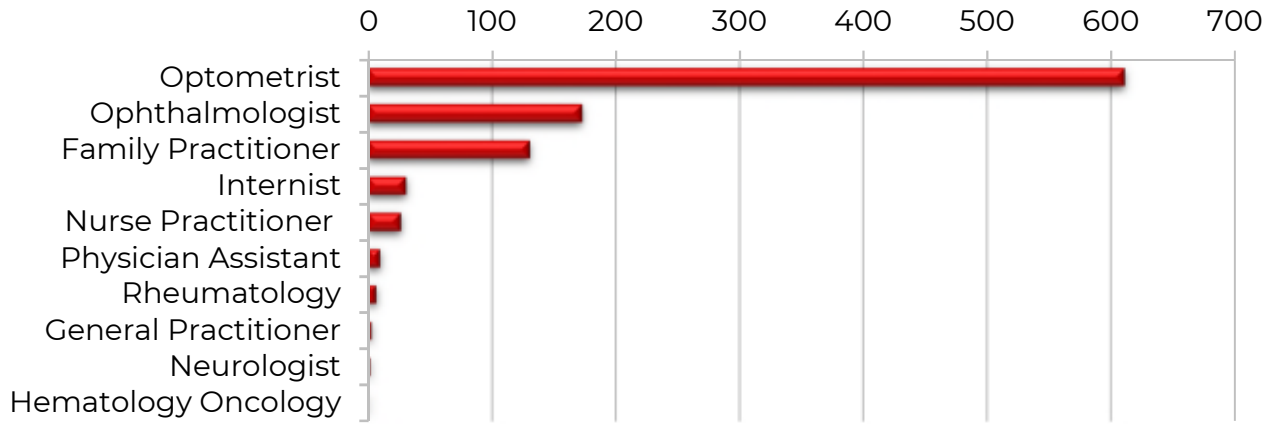
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2020	263	787	$396,885.15	$504.30	$17.59	43,260	22,560
2021	339	998	$542,560.00	$543.65	$18.75	56,040	28,935
% Change	**28.90%**	**26.80%**	**36.70%**	**7.80%**	**6.60%**	**29.50%**	**28.30%**
Change	**76**	**211**	**$145,674.85**	**$39.35**	**$1.16**	**12,780**	**6,375**

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

Demographics of Members Utilizing DED Medications



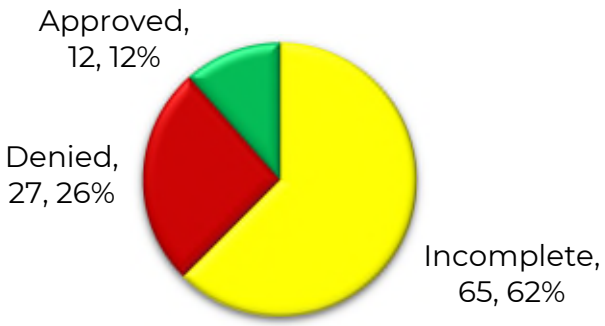
Top Prescriber Specialties of DED Medications by Number of Claims



Prior Authorization of DED Medications

There were 104 prior authorization requests submitted for DED 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]

Anticipated Patent Expiration(s):

- Eysuvis® (loteprednol etabonate 0.25% ophthalmic suspension): May 2033
- Xiidra® (lifitegrast 5% ophthalmic solution): December 2033
- Restasis MultiDose® (cyclosporine 0.05% ophthalmic emulsion): May 2034
- Tyrvaya™ (varenicline nasal spray): October 2035
- Cequa™ (cyclosporine 0.09% ophthalmic solution): February 2037

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

- **October 2021:** The FDA approved Tyrvaya™ (varenicline 0.03mg nasal spray) for the treatment of the signs and symptoms of DED. Tyrvaya™ is the first and only nasal spray approved for the treatment of DED. Tyrvaya™ is believed to bind to cholinergic receptors to activate the trigeminal parasympathetic pathway resulting in increased production of basal tear film as a treatment for DED.

Pipeline:

- **CyclASol:** CyclASol is a topical anti-inflammatory and immunomodulating ophthalmic solution, containing 0.1% cyclosporine A in EyeSol, developed for the treatment of DED. The unique water-free drug product is based on the EyeSol enhanced ocular bioavailability technology that allows for several-fold higher corneal penetration of cyclosporine A in comparison to water- or oil-based formulations. The previous Phase 2b/3 trial (ESSENCE-1) evaluated the efficacy, safety, and tolerability of CyclASol in patients with DED. CyclASol demonstrated statistically significant improvements in pre-specified endpoints for both signs and symptoms of DED when compared to the vehicle after 4 weeks. The ongoing ESSENCE-2 trial is a multicenter, randomized, double-masked, vehicle-controlled clinical trial assessing efficacy, safety, and tolerability of CyclASol for the treatment of signs and symptoms of DED. Positive results from ESSENCE-2 will allow for a New Drug Application (NDA) filing to the FDA in 2022, according to Novaliq, the company developing CyclASol.
- **NOV03:** Bausch and Lomb is developing NOV03, an investigational, proprietary, water-free and preservative-free solution, based on patented EyeSol technology from Novaliq. The GOBI trial is the first Phase 3 trial evaluating the investigational drug NOV03 (perfluorohexyloctane) as a first-in-class eye drop with a novel mechanism of action to treat the signs and symptoms of DED associated with meibomian gland dysfunction. The GOBI trial included results from 597 patients 18 years of age and older who were randomized to receive either treatment with NOV03 or administration of placebo 4 times daily. The multicenter, randomized, double-masked, saline-controlled Phase 3 trial was conducted at 26 locations in the United States. NOV03 was well-tolerated, with the incidence of instillation site reactions <0.5%. Treatment-emergent adverse events were reported by <2% of patients in either treatment group.
- **Reproxalap:** Aldeyra Therapeutics is developing reproxalap, a small-molecule reactive aldehyde species (RASP) inhibitor that covalently binds free aldehydes and diminishes excessive RASP levels. In a recent trial, reproxalap demonstrated rapid, broad, and clinically relevant symptomatic control of DED in patients over 12 weeks of therapy.

Additionally, there was statistically significant improvement compared to vehicle in signs of DED, as demonstrated by fluorescein staining. The results represent the first vehicle-controlled evidence for the therapeutic potential of RASP inhibition to ameliorate the signs and symptoms of DED.

- **RGN-259:** RegeneRx is developing RGN-259, a Tβ4-based sterile and preservative-free eye drop designed to be a novel treatment for DED and neurotrophic keratitis. Recently, the ARISE-3 Phase 3 clinical trial evaluating RGN-259 eye drops for the treatment of DED did not meet its primary outcome measures, according to the company. However, researchers noted statistically significant improvement in ocular grittiness at 1 and 2 weeks after treatment and post-exposure in a controlled adverse environment after 2 weeks of treatment with the drug, compared to placebo. Additionally, RGN-259 continued to demonstrate safety in the treatment of DED consistent with previous clinical trials.
- **Visomitin (SkQ1):** Mitotech is developing visomitin, an eye-drop formulation of the drug SkQ1 designed to target ophthalmic disorders like DED, uveitis, and macular degeneration. SkQ1 was designed to address DED through a novel mechanism of action that consists of acting on the mitochondria at a cellular level. It belongs to the class of cardiolipin peroxidation inhibitors developed for the treatment of several age-related disorders, including DED. In contrast to current standards of care, which act primarily as anti-inflammatory agents, SkQ1 has been shown to not only relieve inflammation but also to mitigate tissue degeneration and improve tear quality deficit by targeting oxidative stress within the eye. VISTA-1, a Phase 2b/3 clinical trial in the United States, found that SkQ1 showed evidence of efficacy in reducing both the signs and symptoms of DED. Mitotech and Essex Bio-Technology recently announced completion of enrollment in a pivotal Phase 3 VISTA-2 trial of SkQ1 ophthalmic solution in patients with moderate-to-severe DED. VISTA-2 is a multicenter, randomized, double-blind, placebo-controlled clinical trial with 2 treatment arms, 1 receiving SkQ1 and 1 receiving vehicle administered twice daily. The trial includes 610 patients in multiple centers across the United States who will receive treatment over a 2-month period. VISTA-2 was designed to confirm the outcome of VISTA-1.

Tyrvaya™ (Varenicline Nasal Spray) Product Summary[4,5]

Indication(s): Tyrvaya™ (varenicline nasal spray) is a cholinergic agonist indicated for the treatment of the signs and symptoms of DED.

How Supplied:

- Tyrvaya™ is available in a carton containing 2 amber glass bottles, each bottle with a nasal pump.
- Each bottle contains 4.2mL of varenicline solution and provides 1 spray in each nostril twice daily for 15 days.
- Each spray delivers 0.03mg varenicline per 0.05mL.

Dosing and Administration:

- The recommended dosing is 1 spray in each nostril twice daily (approximately 12 hours apart).
- Tyrvaya™ should be primed before initial use by pumping 7 actuations into the air away from the face. When Tyrvaya™ has not been used for >5 days, it should be re-primed with 1 spray into the air.

Mechanism of Action: The exact mechanism of action is unknown at this time. The efficacy of Tyrvaya™ in DED is believed to be the result of varenicline's activity at heteromeric sub-type(s) of the nicotinic acetylcholine (nACh) receptor where Tyrvaya™ binds and produces agonist activity. This activates the trigeminal parasympathetic pathway resulting in increased production of basal tear film as a treatment for DED.

Contraindication(s): None

Safety:

- Pregnancy: No data is available on the use of Tyrvaya™ in pregnant women to inform any drug associated risks. In animal reproduction studies, varenicline did not produce malformations at clinically relevant doses.
- Lactation: No data is available on the presence of Tyrvaya™ in human milk, the effects on the breastfed infant, or the effects on milk production. In animal studies Tyrvaya™ was present in milk of lactating rats. However, due to species-specific differences in lactation physiology, animal data may not reliably predict drug levels in human milk.
- Pediatric Use: Safety and efficacy of Tyrvaya™ in pediatric patients have not been established.
- Geriatric Use: No overall differences in safety or effectiveness of Tyrvaya™ have been observed between elderly and younger adult patients.

Adverse Reactions: The most common adverse reaction reported in 82% of Tyrvaya™ treated patients was sneezing. Other common adverse reactions that were reported in >5% of patients include cough (16%), throat irritation (13%), and instillation-site irritation (8%).

Efficacy: The efficacy of Tyrvaya™ for the treatment of DED was supported by 2 randomized, multi-center, double-masked, vehicle-controlled studies (ONSET-1 and ONSET-2). Use of artificial tears was allowed during the studies. Tear film production was measured by anesthetized Schirmer's score assessed using a Schirmer's strip (0-35mm). Of the patients treated with Tyrvaya™, a statistically significant (P<0.01) increase in Schirmer's score from baseline was achieved in both studies.

- The Schirmer Tear Test: This test can be performed with or without anesthesia. It evaluates tear adequacy and often aids in the diagnosis of dry eye syndrome. The Schirmer test performed with anesthesia measures basal tear secretion by eliminating the irritation that causes reflex tearing. To perform the test, the examiner places 1 end of the calibrated filter paper strip over the lateral third of the lower eyelid. After 5 minutes, the examiner removes the strips and measures the length of strip wetted by tears. With anesthesia, the interpretation is as follows: 0 to 5mm of wetting, severe dry eyes; 5 to 10mm of wetting, moderately dry eyes; 10 to 1mm of wetting, mildly dry eyes; and greater than 15mm of wetting, normal tear function.
- ONSET-1: In this study, 182 patients were randomized in a 1:1:1:1 ratio to receive 1 spray in each nostril twice daily of varenicline solution 0.006mg (N=47), varenicline solution (Tyrvaya™) 0.03mg (N=48), varenicline solution 0.06mg (N=44), or vehicle (N=43). The average baseline Schirmer's score was 5.0mm. Of the patients treated with varenicline solution (Tyrvaya™) 0.03mg, 52% achieved an increase of ≥10mm in Schirmer's score from baseline compared to 14% of the vehicle-treated patients at day 28.
- ONSET-2: In this study, 758 patients were randomized in a 1:1:1 ratio to receive 1 spray in each nostril twice daily of varenicline solution (Tyrvaya™) 0.03mg (N=260), varenicline solution 0.06mg (N=246), or vehicle (N=252). The average baseline Schirmer's score was 5.1mm. Of the patients treated with varenicline solution (Tyrvaya™) 0.03mg, 47% achieved ≥10mm increase in Schirmer's score from baseline, compared 28% of vehicle-treated patients at day 28.

Cost Comparison:

Product	Cost Per Unit	Cost Per Package*
Tyrvaya™ (varenicline nasal spray)	**$70.51**	**$592.28**
Restasis® (cyclosporine 0.05% ophthalmic emulsion)⁺	$9.85	$591.00
Restasis MultiDose® (cyclosporine 0.05% ophthalmic emulsion)	$107.33	$590.21
Xiidra® (lifitegrast 5% ophthalmic solution)	$9.47	$568.20
Cequa™ (cyclosporine 0.09% ophthalmic solution)	$8.43	$252.90

Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC).
*Cost per package based on largest package size available for product listed.
⁺Restasis® single-use vials were first FDA approved in 2002 and have a significant federal rebate and thus, do not require prior authorization.
Unit = milliliter (mL) or single-use vial

Recommendations

The College of Pharmacy recommends the prior authorization of Tyrvaya™ (varenicline nasal spray) with the following criteria (shown in red):

Tyrvaya™ (Varenicline Nasal Spray) Approval Criteria:

1. An FDA approved indication for the treatment of the signs and symptoms of dry eye disease (DED) in members 18 years of age or older; and
2. Prescriber must verify that environmental factors (e.g., humidity, fans) have been addressed; and
3. Member must have trials with at least 3 over-the-counter (OTC) products for at least 3 days in duration (per product) in the last 30 days that failed to relieve signs and symptoms of DED; and
4. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine 0.05% ophthalmic emulsion) single-use vials, which are available without a prior authorization, must be provided; and
5. A patient-specific, clinically significant reason why the member cannot use all available ophthalmic preparations for the treatment of DED must be provided; and
6. A quantity limit of 8.4mL (2 bottles) per 30 days will apply.

Additionally, the College of Pharmacy recommends updating the prior authorization criteria for Cequa™ (cyclosporine 0.09% ophthalmic solution) and Restasis MultiDose® (cyclosporine 0.05% ophthalmic emulsion) based on net costs (changes shown in red):

Cequa™ (Cyclosporine 0.09% Ophthalmic Solution) Approval Criteria:

1. An FDA approved indication to increase tear production in members with keratoconjunctivitis sicca (dry eye); and
2. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine 0.05% ophthalmic emulsion) single-use vials, which are available without a prior authorization, must be provided; and
3. A patient-specific, clinically significant reason why the member cannot use Xiidra® (lifitegrast 5% ophthalmic solution) must be provided; and
4. A quantity limit of 60 single-use vials (1 box) per 30 days will apply.

Restasis MultiDose® (Cyclosporine 0.05% Ophthalmic Emulsion) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use Restasis® in the individual dosage formulation (single-use vials), which is available without a prior authorization, must be provided; and
2. A patient-specific, clinically significant reason why the member cannot use Xiidra® (lifitegrast 5% ophthalmic solution) must be provided.

Utilization Details of DED Medications: Fiscal Year 2021

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM	% COST
CYCLOSPORINE PRODUCTS						
RESTASIS EMU 0.05%	908	316	$493,141.77	2.87	$543.11	90.89%
CEQUA SOL 0.09%	3	2	$1,485.75	1.5	$495.25	0.28%
SUBTOTAL	**911**	**318**	**$494,627.52**	**2.86**	**$542.95**	**91.17%**
LIFITEGRAST PRODUCTS						
XIIDRA DROP 5%	87	36	$47,932.48	2.42	$550.95	8.83%
SUBTOTAL	**87**	**36**	**$47,932.48**	**2.42**	**$550.95**	**8.83%**
TOTAL	**998**	**339***	**$542,560.00**	**2.94**	**$543.65**	**100.00%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
EMU = emulsion; SOL = solution
Fiscal Year 2021 = 07/01/2020 to 06/30/2021
Due to previous supplemental rebate participation, Xiidra® was available without prior authorization until 01/01/2021.

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/. Last revised 12/2021. Last accessed 12/17/2021.
[2] Oyster Point Pharma. Oyster Point Pharma Announces FDA Approval of Tyrvaya™ (Varenicline Solution) Nasal Spray for the Treatment of the Signs and Symptoms of Dry Eye Disease. Available online at: https://investors.oysterpointrx.com/news-releases/news-release-details/oyster-point-pharma-announces-fda-approval-tyrvayatm-varenicline. Issued 10/18/2021. Last accessed 12/17/2021.
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[5] Aaron M, Solley WA, Broocker G. General Eye Examination in Primary Care Ophthalmology (Second Edition). Available online at: https://www.sciencedirect.com/topics/medicine-and-dentistry/schirmer-test. Issued 2005. Last accessed 12/17/2021.

Appendix H

Fiscal Year 2021 Annual Review of Imcivree™ (Setmelanotide)

Oklahoma Health Care Authority
January 2022

Current Prior Authorization Criteria

Imcivree™ (Setmelanotide) Approval Criteria:

1. An FDA approved indication of chronic weight management in adult and pediatric members 6 years of age and older with obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency; and
2. Molecular genetic testing to confirm variants in the *POMC*, *PCSK1*, or *LEPR* genes that are interpreted as pathogenic, likely pathogenic, or of uncertain significance; and
3. Requests for Imcivree™ for obesity due to suspected POMC-, PCSK1-, or LEPR-deficiency with *POMC, PCSK1, or LEPR* variants classified as benign or likely benign, obesity associated with other genetic syndromes, or general obesity will not be approved; and
4. Member's baseline weight and body mass index (BMI) must be provided; and
5. Baseline BMI must be ≥30kg/m^2 for adults or ≥95th percentile on BMI-for-age growth chart assessment for children; and
6. Member must not be actively suicidal or have uncontrolled depression, and prescriber must verify member will be monitored for depression prior to starting Imcivree™ therapy and throughout treatment; and
7. Prescriber must verify member has been counseled on potential sexual adverse reactions and when to seek emergency medical care; and
8. Prescriber must verify member does not have moderate, severe, or end stage renal disease [estimated glomerular filtration rate (eGFR) <60mL/min/1.73m^2]; and
9. Prescriber must verify female member is not pregnant or breastfeeding; and
10. Prescriber must confirm member or caregiver has been trained on the proper storage and administration of Imcivree™ prior to the first dose; and
11. Initial approvals will be for the duration of 16 weeks. Reauthorization may be granted if the prescriber documents the member's current weight or BMI and member has achieved weight loss of ≥5% of baseline body weight or ≥5% of BMI; and
12. A quantity limit of 9mL per 30 days will apply.

Utilization of Imcivree™ (Setmelanotide): Fiscal Year 2021

There was no SoonerCare utilization of Imcivree™ (setmelanotide) during fiscal year 2021 (07/01/2020 to 06/30/2021).

Prior Authorization of Imcivree™ (Setmelanotide)

There were no prior authorization requests submitted for Imcivree™ (setmelanotide) during fiscal year 2021 (07/01/2020 to 06/30/2021).

Market News and Updates[1]

Anticipated Patent Expiration(s):

- Imcivree™ (setmelanotide): July 2034

Recommendations

The College of Pharmacy does not recommend any changes to the current Imcivree™ (setmelanotide) prior authorization criteria at this time.

[1] U.S. Food and Drug Administration (FDA). Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: https://www.accessdata.fda.gov/scripts/cder/ob/index.cfm. Last revised 12/2021. Last accessed 12/16/2021.

Appendix I

Fiscal Year 2021 Annual Review of Elzonris® (Tagraxofusp-erzs) and Inrebic® (Fedratinib)

Oklahoma Health Care Authority
January 2022

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

Blastic plasmacytoid dendritic cell neoplasm (BPDCN) is a rare, clinically aggressive hematologic malignancy arising from precursors of myeloid-derived plasmacytoid dendritic cells (type 2 dendritic cells). The nomenclature used to describe BPDCN has evolved over the years along with the understanding of the underlying biology. The exact incidence of BPDCN is unknown due to constantly changing nomenclature and lack of precise defining criteria prior to the 2008 World Health Organization (WHO) classification system. BPDCN represents 0.7% of primary cutaneous skin lymphomas; however, cutaneous lymphoma registries likely underestimate the true incidence of BPDCN because some patients present without skin lesions. BPDCN is most common in adults and the majority of patients are older adults, but it has been described in all age groups. There is a male to female ratio of approximately 2.5:1. Optimal management of BPDCN is not well defined; however, treatment suggestions are stratified by age because outcomes are generally more favorable in children than in adults. In December 2018, the U.S. Food and Drug Administration (FDA) approved Elzonris® (tagraxofusp-erzs) for the treatment of BPDCN in adults and pediatric patients 2 years of age and older. Prior to this approval, there were no FDA approved therapies for BPDCN, and treatment consisted of intensive chemotherapy followed by bone marrow transplantation.

Myelofibrosis is a type of chronic leukemia. It belongs to a group of related blood cancers known as myeloproliferative neoplasms (MPNs) in which bone marrow cells that produce blood cells function abnormally. The result is excessive fibrous tissue formation in the bone marrow, which can lead to severe anemia, weakness, fatigue, splenomegaly, and hepatomegaly. Myelofibrosis can occur on its own (primary myelofibrosis) or as a result of another bone marrow disorder, such as polycythemia vera (PV) or essential thrombocythemia (ET). Between 15 to 20% of myelofibrosis cases begin as either PV or ET. Myelofibrosis occurs in approximately 1.5 out of 100,000 individuals in the United States each year. The disease affects both men and women and is usually diagnosed in patients older than 60 years of age, but can occur at any age. In August 2019, the FDA approved Inrebic® (fedratinib) for the treatment of adult patients with certain types of myelofibrosis. Prior to

this approval, Jakafi® (ruxolitinib) was the only FDA approved treatment for myelofibrosis. Jakafi® entered the marketplace in 2011.

Current Prior Authorization Criteria

Elzonris® (Tagraxofusp-erzs) Approval Criteria [Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN) Diagnosis]:

1. Diagnosis of BPDCN; and
2. Member must be 2 years of age or older; and
3. As a single agent.

Inrebic® (Fedratinib) Approval Criteria [Myelofibrosis Diagnosis]:

1. Diagnosis of myelofibrosis in adult members; and
2. Intermediate-2 or high-risk primary or secondary disease (post-polycythemia vera or post-essential thrombocythemia).

Utilization of Elzonris® (Tagraxofusp-erzs) and Inrebic® (Fedratinib): Fiscal Year 2021

There was no pharmacy or medical SoonerCare utilization of Elzonris® (tagraxofusp-erzs) or Inrebic® (fedratinib) during fiscal year 2021 (07/01/2020 to 06/30/2021).

Prior Authorization of Elzonris® (Tagraxofusp-erzs) and Inrebic® (Fedratinib)

There were no prior authorization requests submitted for Elzonris® (tagraxofusp-erzs) or Inrebic® (fedratinib) during fiscal year 2021 (07/01/2020 to 06/30/2021).

Recommendations

The College of Pharmacy does not recommend any changes to the current Elzonris® (tagraxofusp-erzs) or Inrebic® (fedratinib) prior authorization criteria at this time.

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[1] Gurbuxani S. Blastic Plasmacytoid Dendritic Cell Neoplasm. *UpToDate*. Available online at: https://www.uptodate.com/contents/blastic-plasmacytoid-dendritic-cell-neoplasm. Last revised 09/30/2021. Last accessed 12/17/2021.
[2] Elzonris® (Tagraxofusp-erzs) – BPDCN Overview. Stemline Therapeutics, Inc. Available online at: https://www.elzonris.com/hcp/what-is-bpdcn. Last accessed 12/17/2021.
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[5] Nelson R. FDA Approves Fedratinib for the Treatment of Myelofibrosis. *Medscape*. Available online at: https://www.medscape.com/viewarticle/916928. Issued 08/16/2019. Last accessed 12/17/2021.

Appendix J

Fiscal Year 2021 Annual Review of Turalio® (Pexidartinib)

Oklahoma Health Care Authority
January 2022

Introduction[1]

Tenosynovial giant cell tumor (TGCT), also referred to as pigmented villonodular synovitis (PVNS) or giant cell tumor of the tendon sheath (GCT-TS), is a rare, non-malignant tumor that can be locally aggressive. TGCT affects the synovium-lined joints, bursae, and tendon sheaths, resulting in reduced mobility in the affected limb or joint. The exact incidence of TGCT is not known; however, it is estimated to be 11 to 50 cases per 1 million person-years, based on studies from 3 countries. TGCT is subcategorized into 2 types, localized and diffuse. Localized TGCT is more common and accounts for 80 to 90% of cases. TGCT affects all age groups. The localized type is more common between 30 and 50 years of age, and the diffuse type occurs most often in individuals younger than 40 years of age.

The current standard of care for TGCT is surgical resection. In patients with recurrent, difficult-to-treat, or diffuse forms of TGCT, the tumor may wrap around ligaments, tendons, bone, or other parts of the joint. In these cases, the tumor may not be amenable to improvement with surgery or may be difficult to remove with surgery. Multiple surgeries for more severe cases may lead to significant joint damage, debilitating functional impairments, reduced quality of life, and amputation. Following complete resection, recurrence rates for localized TGCT are estimated to be up to 15%. Diffuse TGCT recurrence rates are estimated to be approximately 20 to 50% following complete resection. In August 2019, the U.S. Food and Drug Administration (FDA) approved Turalio® (pexidartinib) as the first and only treatment for adult patients with symptomatic TGCT associated with severe morbidity or functional limitations not amenable to improvement with surgery. Prior to FDA approval in January 2019, the American Society of Clinical Oncology (ASCO) selected pexidartinib as 1 of 5 significant advances in rare disease treatment, calling it the first promising investigational therapy for TGCT.

Current Prior Authorization Criteria

Turalio® (Pexidartinib) Approval Criteria [Soft Tissue Sarcoma – Pigmented Villonodular Synovitis (PVNS)/Tenosynovial Giant Cell Tumor (TGCT) Diagnosis]:

1. Member must not be a candidate for surgery; and
2. As a single agent.

Utilization of Turalio® (Pexidartinib): Fiscal Year 2021

There was no SoonerCare utilization of Turalio® (pexidartinib) during fiscal year 2021 (07/01/2020 to 06/30/2021).

Prior Authorization of Turalio® (Pexidartinib)

There were no prior authorization requests submitted for Turalio® (pexidartinib) during fiscal year 2021 (07/01/2020 to 06/30/2021).

Recommendations

The College of Pharmacy does not recommend any changes to the current Turalio® (pexidartinib) prior authorization criteria at this time.

[1] Daiichi-Sankyo. Press Release: FDA Approves Daiichi Sankyo's Turalio® (Pexidartinib) for the Treatment of Select Patients with TGCT, a Rare and Debilitating Tumor. Available online at: https://dsi.com/press-releases/-/article/364091/10481984. Issued 08/02/2019. Last accessed 12/17/2021.

Appendix K

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: December 15, 2021

FDA Approves First Drug to Prevent Graft Versus Host Disease

The FDA approved Orencia (abatacept) for the prophylaxis of acute graft versus host disease (aGVHD), a condition that occurs when donor bone marrow or stem cells attack the graft recipient, in combination with certain immunosuppressants. Orencia may be used in adults and pediatric patients 2 years of age or older undergoing hematopoietic stem cell transplantation from an unrelated donor.

This is the first FDA drug approval for aGVHD prevention and incorporates real world evidence (RWE) as 1 component of the determination of clinical effectiveness. RWE is clinical evidence regarding the usage and potential benefits or risks of a medical product derived from analysis of real world data (i.e., data relating to patient health status and/or the delivery of health care routinely collected data from a variety of sources, including registry data). There are significant ongoing efforts at the FDA to incorporate use of high-quality RWE to support regulatory decision-making.

A potentially fatal complication, aGVHD, that can occur after stem cell transplantation when the donor's immune cells view the recipient's body as foreign, and the donated cells attack the body. The chances of developing aGVHD increase when the donor and recipient are not related or are not a perfect match.

The safety and efficacy of Orencia in combination with immunosuppressant therapy in patients 6 years of age and older who underwent stem cell transplantation from a matched or mismatched unrelated donor were evaluated in 2 separate studies.

One study, GVHD-1, was a double-blind, placebo-controlled trial of 186 patients who underwent stem cell transplantation from a matched unrelated donor and randomly received Orencia or a placebo in combination with the immunosuppressive drugs. The study measured severe (grade III-IV) aGVHD-free survival, overall survival, and moderate-severe (grade II-IV) aGVHD-free survival 6 months after transplantation. While severe aGVHD-survival was not significantly improved in patients who received Orencia (87%) compared to patients who received a placebo (75%), patients who received Orencia saw a 97% overall survival rate compared to 84% for patients who received a placebo. For moderate-severe aGVHD-free survival, patients who received Orencia saw a 50% rate compared to 32% for patients who received a placebo.

Additional evidence of effectiveness was provided by GVHD-2, a registry-based clinical study conducted using real world data from the Center for International Blood and Marrow Transplant Research in patients who underwent stem cell transplantation from a mismatched unrelated donor. This study analyzed outcomes of 54 patients treated with Orencia for the prevention of aGVHD, in combination with standard immunosuppressive drugs, versus 162 patients treated with standard immunosuppressive drugs alone. The study measured overall survival 6 months after transplantation. Patients who received Orencia saw a 98% overall survival rate compared to 75% for patients who received standard immunosuppression alone.

The most common side effects of Orencia for prevention of aGVHD include anemia, hypertension, cytomegalovirus (CMV) reactivation/CMV infection, fever, pneumonia, nosebleed, decreased CD4 lymphocytes, increased levels of magnesium in the blood, and acute kidney injury. Patients who receive Orencia should be monitored for Epstein-Barr virus reactivation in accordance with institutional practices and receive preventative medication for Epstein-Barr virus infection before starting treatment and for 6 months post-transplantation. Patients should also be monitored for CMV infection/reactivation for 6 months post-transplant.

Orencia received Breakthrough, Orphan Drug, and Priority Review designations for this indication. Development of this product was partially supported by the FDA's Orphan Products Grants Program, which provides grants for clinical studies on safety and efficacy of products for use in rare diseases or conditions.

Orencia was originally approved by the FDA in 2005 for the treatment of adult rheumatoid arthritis. Orencia is also approved for the treatment of polyarticular juvenile idiopathic arthritis and adult psoriatic arthritis. The FDA granted approval of Orencia to Bristol Myers Squibb.

FDA NEWS RELEASE

For Immediate Release: December 14, 2021

Coronavirus (COVID-19) Update: December 14, 2021

The FDA is announcing revisions to the Janssen COVID-19 Vaccine Fact Sheet for Heath Care Providers Administering Vaccine and the Fact Sheet for Recipients and Caregivers. The fact sheets will now include a contraindication to the administration of the Janssen COVID-19 vaccine to individuals with a history of thrombosis with thrombocytopenia following the Janssen COVID-19 vaccine or any other adenovirus-vectored COVID-19 vaccine, and to update the information about the risk of thrombosis with thrombocytopenia syndrome (TTS) following vaccination. Cases of TTS following administration of the Janssen COVID-19 vaccine have been reported in males and females 18 years of age and older, with the highest reporting rate of approximately 1 case per 100,000 doses administered in females 30-49 years of age; overall, approximately 1 out of 7 cases has been fatal. The FDA and Centers for Disease Control and Prevention (CDC) continue to investigate the level of potential excess risk. The FDA continues to find that the known and potential benefits of the Janssen COVID-19 vaccine outweigh its known and potential risks in individuals 18 years of age and older. Individuals should speak to their health care provider to determine which COVID-19 vaccine is most appropriate for their own situation.

Testing updates:

- As of today, 421 tests and sample collection devices are authorized by the FDA under Emergency Use Authorizations (EUAs). These include 291 molecular tests and sample collection devices, 89 antibody and other immune response tests, and 41 antigen tests. There are 67 molecular authorizations 1 antibody authorization that can be used with home-collected samples. There is 1 EUA for a molecular prescription at-home test, 3 EUAs for antigen prescription at-home tests, 11 EUAs for antigen over-the-counter (OTC) at-home tests, and 3 EUAs for molecular OTC at-home tests.
- The FDA has authorized 22 antigen tests and 9 molecular tests for serial screening programs. The FDA has also authorized 707 revisions to EUA authorizations.

FDA NEWS RELEASE

For Immediate Release: December 9, 2021

Coronavirus (COVID-19) Update: FDA Expands Eligibility for Pfizer-BioNTech COVID-19 Booster Dose to 16- and 17-Year-Olds

The FDA amended the EUA for the Pfizer-BioNTech COVID-19 vaccine, authorizing the use of a single booster dose for administration to individuals 16 and 17 years of age at least 6 months after completion of primary vaccination with the Pfizer-BioNTech COVID-19 vaccine.

On November 19, 2021, the FDA authorized the use of a single booster dose of the Pfizer-BioNTech COVID-19 vaccine for administration to all individuals 18 years of age and older after completion of primary vaccination with any FDA-authorized or approved COVID-19 vaccine. This action expands the use of a single booster dose of the Pfizer-BioNTech COVID-19 vaccine for administration at least 6 months after completion of a primary series of the Pfizer-BioNTech COVID-19 vaccine to individuals 16 and 17 years of age. The FDA-authorized Pfizer-BioNTech COVID-19 vaccine and the FDA-approved Comirnaty (COVID-19 vaccine, mRNA) are the only COVID-19 vaccines currently available for the 16- and 17-year-old age group. Individuals who are 16 and 17 years of age should only receive the Pfizer-BioNTech COVID-19 vaccine or Comirnaty as their booster dose.

Data Supporting Effectiveness

The EUA for a single booster dose of the Pfizer-BioNTech COVID-19 vaccine for individuals 16 and 17 years of age is based on the FDA's previous analysis of immune response data that supported use of a booster dose in individuals 18 years of age and older.

The FDA had analyzed the immune response data from approximately 200 participants, 18 through 55 years of age, who received a single booster dose approximately 6 months after their second dose. The antibody response against the SARS-CoV-2 virus 1 month after a booster dose of the vaccine, when compared to the response 1 month after the 2-dose primary series in the same individuals, demonstrated a booster response. The FDA's assessment of the effectiveness of a booster dose for individuals 16 and 17 years of age is based on this data. Based on the available data for individuals 18 and older regarding effectiveness, the FDA has concluded that the data supports extending the eligible booster age population.

FDA Evaluation of Benefits and Risks

In the time since Pfizer initially submitted safety and effectiveness data on a single booster dose following the 2-dose primary series to the FDA, additional real-world data has become available on the increasing number of cases of COVID-19 in the United States and on the risk of myocarditis and pericarditis following vaccination with the Pfizer-BioNTech COVID-19 vaccine. These additional data enabled the FDA to reassess the benefits and risks of the use of the vaccine in a wider population. The FDA has determined that the benefits of a single booster dose of the Pfizer-BioNTech COVID-19 vaccine or Comirnaty outweigh the risks of myocarditis and pericarditis in individuals 16 and 17 years of age to provide continued protection against COVID-19 and the associated serious consequences that can occur including hospitalization and death.

Pfizer is conducting post-authorization/post-marketing studies to assess known serious risks of myocarditis and pericarditis. In addition, the FDA and the CDC have several systems in place to continually monitor COVID-19 vaccine safety and allow for the rapid detection and investigation of potential safety concerns.

The fact sheets for recipients and caregivers and for health care providers contain information about the potential side effects, as well as the risk of myocarditis and

pericarditis. The most commonly reported side effects by individuals who received a booster dose were pain, redness and swelling at the injection site, as well as fatigue, headache, muscle or joint pain, and chills. Of note, swollen lymph nodes in the underarm were observed more frequently following the booster dose than after the second dose of a 2-dose primary series.

The FDA did not hold a meeting of the Vaccines and Related Biological Products Advisory Committee on this most recent action, as the agency previously convened the committee for extensive discussions regarding the use of booster doses of COVID-19 vaccines and, after review of Pfizer's EUA request, the FDA concluded that the request does not raise questions that would benefit from additional discussion by committee members. The FDA will be publicly posting documents regarding the agency's decision on its website following authorization. The amendment to the EUA was granted to Pfizer Inc.

FDA NEWS RELEASE

For Immediate Release: December 8, 2021

Coronavirus (COVID-19) Update: FDA Authorizes New Long-Acting Monoclonal Antibodies for Pre-exposure Prevention of COVID-19 in Certain Individuals

The FDA issued an EUA for AstraZeneca's Evusheld (tixagevimab co-packaged with cilgavimab and administered together) for the pre-exposure prophylaxis of COVID-19 in certain adults and pediatric individuals (12 years of age and older weighing ≥40kg).

The product is only authorized for those individuals who are not currently infected with the SARS-CoV-2 virus and who have not recently been exposed to an individual infected with SARS-CoV-2. The authorization also requires that individuals either have:

- Moderate-to-severely compromised immune systems due to a medical condition or due to taking immunosuppressive medications or treatments and may not mount an adequate immune response to COVID-19 vaccination (examples of such medical conditions or treatments can be found in the fact sheet for health care providers); or
- A history of severe adverse reactions to a COVID-19 vaccine and/or component(s) of those vaccines, therefore vaccination with an available COVID-19 vaccine, according to the approved or authorized schedule, is not recommended.

One dose of Evusheld, administered as 2 separate consecutive intramuscular injections (1 injection per monoclonal antibody, given in immediate succession), may be effective for pre-exposure prevention for 6 months. Evusheld is not authorized for individuals for the treatment of COVID-19 or for post-exposure prevention of COVID-19. Patients should talk with their health care provider to determine whether Evusheld is an appropriate pre-exposure prevention option for them.

Pre-exposure prevention with Evusheld is not a substitute for vaccination in individuals for whom COVID-19 vaccination is recommended. The FDA has approved 1 vaccine and authorized others to prevent COVID-19 and serious clinical outcomes associated with a COVID-19 infection, including hospitalization and death. The FDA urges the public to get vaccinated if eligible.

Monoclonal antibodies are laboratory-made proteins that mimic the immune system's ability to fight off harmful pathogens such as viruses. Tixagevimab and cilgavimab are long-acting monoclonal antibodies that are specifically directed against the spike protein of SARS-CoV-2, designed to block the virus' attachment and entry into

human cells. Tixagevimab and cilgavimab bind to different, non-overlapping sites on the spike protein of the virus.

The issuance of an EUA is different than an FDA approval. In determining whether to issue an EUA, the FDA evaluates the totality of available scientific evidence and carefully balances any known or potential risks with any known or potential benefits of the product. Based on the FDA's review of the totality of the scientific evidence available, the agency has determined that it is reasonable to believe that Evusheld may be effective for use as pre-exposure prevention in 12 years of age and older weighing ≥40kg. The agency has also determined that the known and potential benefits of Evusheld, when used consistent with the terms and conditions of the authorization, outweigh the known and potential risks of the product. There are no adequate, approved and available alternatives to Evusheld for the pre-exposure prevention of COVID-19 in the authorized population.

The primary data supporting this EUA for Evusheld are from PROVENT, a randomized, double-blind, placebo-controlled clinical trial in adults older than 59 years of age or with a prespecified chronic medical condition or at increased risk of SARS-CoV-2 infection for other reasons who had not received a COVID-19 vaccine and did not have a history of SARS-CoV-2 infection or test positive for SARS-CoV-2 infection at the start of the trial. The main outcome measured in the trial was whether a trial participant had a first case of COVID-19 after receiving Evusheld or placebo and before day 183 of the trial. In this trial, 3,441 people received Evusheld and 1,731 received a placebo. In the primary analysis, Evusheld recipients saw a 77% reduced risk of developing COVID-19 compared to those who received a placebo, a statistically significant difference. In additional analyses, the reduction in risk of developing COVID-19 was maintained for Evusheld recipients through 6 months. The safety and effectiveness of Evusheld for use in the pre-exposure prevention of COVID-19 continue to be evaluated.

Under the EUA, fact sheets that provide important information about using Evusheld in pre-exposure prevention of COVID-19 as authorized must be made available to health care providers and to patients and caregivers. These fact sheets include dosing instructions, potential side effects and drug interactions.

Possible side effects of Evusheld include: hypersensitivity reactions (including anaphylaxis), bleeding at the injection site, headache, fatigue, and cough.

Serious cardiac adverse events were infrequent in PROVENT. However, more trial participants had serious cardiac adverse events (such as myocardial infarction and heart failure) after receiving Evusheld compared to placebo. These participants all had risk factors for cardiac disease or a history of cardiovascular disease before participating in the clinical trial. It is not clear if Evusheld caused these cardiac adverse events.

The FDA is working with sponsors of all currently authorized therapeutics to assess the activity against any global SARS-CoV-2 variant(s) of interest and is committed to communicating with the public as we learn more. The EUA was issued to AstraZeneca.

FDA NEWS RELEASE

For Immediate Release: December 3, 2021

FDA Expands Authorization of 2 Monoclonal Antibodies for Treatment and Post-Exposure Prevention of COVID-19 to Younger Pediatric Patients, Including Newborns

The FDA revised the EUA of bamlanivimab and etesevimab (previously authorized for pediatric patients 12 years of age and older weighing ≥40kg), to additionally authorize bamlanivimab and etesevimab administered together for the treatment of mild-to-moderate COVID-19 in all younger pediatric patients, including newborns, who have a

positive COVID-19 test and are at high risk for progression to severe COVID-19, including hospitalization or death. This revision also authorizes bamlanivimab and etesevimab, to be administered together, for post-exposure prophylaxis for prevention of COVID-19 in all pediatric patients, including newborns, at high risk of progression to severe COVID-19, including hospitalization or death.

Bamlanivimab and etesevimab are monoclonal antibodies that are specifically directed against the spike protein of SARS-CoV-2, designed to block the virus' attachment and entry into human cells. Bamlanivimab and etesevimab bind to different but overlapping sites on the spike protein of the virus.

In February 2021, the FDA originally authorized bamlanivimab and etesevimab administered together to treat mild-to-moderate COVID-19 in adults and pediatric patients (12 years of age or older weighing ≥40kg) with positive results of direct SARS-CoV-2 viral testing, and who are at high-risk for progressing to severe COVID-19 and/or hospitalization. In September, the agency authorized its use for post-exposure prevention of COVID-19 in certain adults and pediatric individuals (12 years of age and older weighing ≥40kg) who are at high-risk for progression to severe COVID-19, including hospitalization or death.

To support the FDA's action, bamlanivimab and etesevimab, administered together, were studied in a clinical trial of 125 pediatric patients (14 adolescent patients received placebo), all with at least 1 risk factor for severe COVID-19, to evaluate the safety and pharmacokinetics of treatment in pediatric patients. Patients weighing <40kg received doses of bamlanivimab and etesevimab adjusted for their body weight, to achieve comparable exposures to adults and adolescents receiving the authorized dose. Given the similar course of COVID-19 disease, the authorization of bamlanivimab and etesevimab in younger pediatric patients, including neonates, is supported by safety and efficacy data in adolescents and adults, together with additional pharmacokinetic and safety data from the clinical trial in pediatric patients.

Serious adverse events including hypersensitivity, anaphylaxis, and infusion-related reactions have been observed with bamlanivimab with and without coadministration of etesevimab. Possible side effects of bamlanivimab and etesevimab administered together include nausea, dizziness, pruritus, and rash.

Under the EUA, fact sheets that provide important information about the emergency use of bamlanivimab and etesevimab, to be administered together, must be made available to health care providers and to patients, parents, and caregivers. The EUA was issued to Eli Lilly and Co.

FDA NEWS RELEASE

For Immediate Release: November 23, 2021

FDA Approves First Treatment for Common Type of Post-Transplant Infection that is Resistant to Other Drugs

The FDA approved Livtencity (maribavir) as the first drug for treating adults and pediatric patients (12 years of age and older and weighing ≥35kg) with post-transplant cytomegalovirus (CMV) infection/disease that does not respond (with or without genetic mutations that cause resistance) to available antiviral treatment for CMV. Livtencity works by preventing the activity of human cytomegalovirus enzyme pUL97, thus blocking virus replication.

CMV is a type of herpes virus that commonly causes infection in patients after a stem cell or organ transplant. CMV infection can lead to CMV disease and have a major

negative impact on transplant recipients, including loss of the transplanted organ and death.

Livtencity's safety and efficacy were evaluated in a Phase 3, multicenter, open-label, active-controlled trial that compared Livtencity with a treatment assigned by a researcher running the study, which could include 1 or 2 of the following antivirals used to treat CMV: ganciclovir, valganciclovir, foscarnet, or cidofovir. In the study, 352 transplant recipients with CMV infections who did not respond (with or without resistance) to treatment randomly received Livtencity or treatment assigned by a researcher for up to 8 weeks.

The study compared the 2 groups' plasma CMV DNA concentration levels at the end of the study's eighth week, with efficacy defined as having a level below what is measurable. Of the 235 patients who received Livtencity, 56% had levels of CMV DNA below what was measurable versus 24% of the 117 patients who received an investigator-assigned treatment.

The most common side effects of Livtencity include taste disturbance, nausea, diarrhea, vomiting, and fatigue. Livtencity may reduce the antiviral activity of ganciclovir and valganciclovir, so coadministration with these drugs is not recommended. Virologic failure due to resistance can occur during and after treatment with Livtencity; therefore, CMV DNA levels should be monitored and Livtencity resistance should be checked if the patient is not responding to treatment or relapses.

Livtencity received Breakthrough Therapy and Priority Review designations for this indication. The FDA granted the approval of Livtencity to Takeda Pharmaceuticals.

FDA NEWS RELEASE

For Immediate Release: November 19, 2021

FDA Approves First Drug to Improve Growth in Children with Most Common Form of Dwarfism

The FDA approved Voxzogo (vosoritide) injection to improve growth in children 5 years of age and older with achondroplasia and open epiphyses. Achondroplasia is the most common form of dwarfism and is a genetic condition that causes severely short stature and disproportionate growth. The average height of an adult with achondroplasia is approximately 4 feet. People with achondroplasia have a genetic mutation that causes a certain growth regulation gene called fibroblast growth factor receptor 3 to be overly active, which prevents normal bone growth. Voxzogo works by binding to a specific receptor called natriuretic peptide receptor-B that reduces the growth regulation gene's activity and stimulates bone growth.

Voxzogo's safety and efficacy in improving growth were evaluated in a 1-year, double-blind, placebo-controlled, Phase 3 study in participants 5 years and older with achondroplasia who have open epiphyses. In the study, 121 participants were randomly assigned to receive either Voxzogo subcutaneous injections or placebo. Researchers measured the participants' annualized growth velocity at the end of the year. Participants who received Voxzogo grew an average 1.57 centimeters taller compared to those who received placebo.

The most common side effects of Voxzogo include injection site reactions, vomiting, and decreased blood pressure. Voxzogo's labeling also lists decreased blood pressure as a warning and precaution.

The FDA approved Voxzogo under the accelerated approval pathway, which allows for earlier approval of drugs that treat serious conditions and fill an unmet medical need,

based on a surrogate or intermediate clinical endpoint. A condition of this accelerated approval is a post-marketing study that will assess final adult height. This application also received Priority Review designation. The FDA granted the approval of Voxzogo to BioMarin.

Current Drug Shortages Index (as of December 16, 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***
Amphetamine Oral Suspension, Extended Release	***Currently in Shortage***
Atropine Sulfate Injection	***Currently in Shortage***
Azacitidine for Injection	***Currently in Shortage***
Bacteriostatic 0.9% Sodium Chloride Injection	***Currently in Shortage***
Bacteriostatic Water for Injection	***Currently in Shortage***
Belatacept (Nulojix) Lyophilized Powder for Injection	***Currently in Shortage***
Bumetanide Injection	***Currently in Shortage***
Bupivacaine Hydrochloride and Epinephrine Injection	***Currently in Shortage***
Bupivacaine Hydrochloride Injection	***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***
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) Solutions	***Currently in Shortage***
Cortisone Acetate Tablets	***Currently in Shortage***
Cyclopentolate Ophthalmic Solution	***Currently in Shortage***
Cysteamine Hydrochloride Ophthalmic Solution	***Currently in Shortage***
Cytarabine Injection	***Currently in Shortage***
Dacarbazine Injection	***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) Ophthalmic Solution	***Currently in Shortage***
Enalaprilat Injection	***Currently in Shortage***
Epinephrine Injection, 0.1 mg/mL	***Currently in Shortage***
Epinephrine Injection, Auto-Injector	***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% Injection	***Currently in Shortage***
Hydrocortisone Tablets	***Currently in Shortage***
Hydromorphone Hydrochloride Injection	***Currently in Shortage***
Hydroxocobalamin Injection	***Currently in Shortage***
Hydroxypropyl (Lacrisert) Cellulose Ophthalmic Insert	***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 Injection	***Currently in Shortage***
Leuprolide Acetate Injection	***Currently in Shortage***
Lidocaine Hydrochloride (Xylocaine) and Dextrose Injection Solution-Premix Bags	***Currently in Shortage***
Lidocaine Hydrochloride (Xylocaine) Injection	***Currently in Shortage***
Lidocaine Hydrochloride (Xylocaine) Injection with Epinephrine	***Currently in Shortage***
Lipid Injection	***Currently in Shortage***
Lithium Oral Solution	***Currently in Shortage***
Lorazepam Injection	***Currently in Shortage***
Loxapine Capsules	***Currently in Shortage***
Mannitol Injection	***Currently in Shortage***
Mepivacaine Hydrochloride Injection	***Currently in Shortage***
Methyldopa Tablets	***Currently in Shortage***
Methylprednisolone Acetate Injection	***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***
Paclitaxel Injection (protein-bound particles)	***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***
Potassium Chloride Concentrate 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 Injection	***Currently in Shortage***
Sodium Acetate Injection	***Currently in Shortage***
Sodium Bicarbonate Injection	***Currently in Shortage***
Sodium Chloride 0.9% Injection Bags	***Currently in Shortage***
Sodium Chloride 23.4% Injection	***Currently in Shortage***
Sodium Chloride Injection USP, 0.9% Vials and Syringes	***Currently in Shortage***
Sodium Phosphates Injection	***Currently in Shortage***
Sterile Water for Injection	***Currently in Shortage***
Sulfasalazine Tablets	***Currently in Shortage***
Tacrolimus Capsules	***Currently in Shortage***
Technetium Tc 99m Sulfur Colloid Injection	***Currently in Shortage***
Technetium Tc99m Succimer Injection (DMSA)	***Currently in Shortage***
Teprotumumab-trbw	***Currently in Shortage***
Thiothixene Capsules	***Currently in Shortage***
Tocilizumab Injection	***Currently in Shortage***
Triamcinolone Acetonide Injectable Suspension	***Currently in Shortage***
Triamcinolone Hexacetonide Injectable suspension	***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***
Vitamin A Palmitate (Aquasol A) Injection	***Currently in Shortage***