OKLAHOMA
Health Care Authority

Drug Utilization Review Board

Wednesday,
October 12, 2022
4:00pm

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

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

MEMORANDUM

TO: Drug Utilization Review (DUR) Board Members

FROM: Michyla Adams, Pharm.D.

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

DATE: October 5, 2022

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

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

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After registering, you will receive a confirmation email containing information about joining the webinar.

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

Call to Order

Public Comment Forum

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

Update on the Medication Coverage Authorization Unit/Fall 2022 Pipeline Update – Appendix B

Action Item – Approval of September 2022 DUR Board Recommendations – Appendix C

Action Item – Vote to Prior Authorize Amvuttra™ (Vutrisiran) and Update the Approval Criteria for Amyloidosis Medications – Appendix D

Action Item – Vote to Prior Authorize Herceptin Hylecta™ (Trastuzumab/Hyaluronidase-oysk) and Update the Approval Criteria for the Breast Cancer Medications – Appendix E

Action Item – Annual Review of Bylvay® (Odevixibat) and Livmarli® (Maralixibat) – Appendix F

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

Annual Review of Myeloproliferative Neoplasm (MPN) Medications and 30-Day Notice to Prior Authorize Besremi® (Ropeginterferon Alfa-2b-njft) and Vonjo™ (Pacritinib) – Appendix H

Annual Review of Targeted Immunomodulator Agents and 30-Day Notice to Prior Authorize Sotyktu™ (Deucravacitinib), Spevigo® (Spesolimab-sbzo), and Tavneos® (Avacopan) – Appendix I

Annual Review of Anemia Medications and 30-Day Notice to Prior Authorize Enjaymo™ (Sutimlimab-jome), Pyrukynd® (Mitapivat), and Zynteglo® (Betibeglogene Autotemcel) – Appendix J

Annual Review of Hepatitis C Medications – Appendix K

30-Day Notice to Prior Authorize Xenpozyme® (Olipudase Alfa-rpcp) – Appendix L

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

Future Business

Adjournment

Oklahoma Health Care Authority

Drug Utilization Review Board
(DUR Board)
Meeting – October 12, 2022 @ 4:00pm
at the
Oklahoma Health Care Authority (OHCA)
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma 73105

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

AGENDA

Discussion and action on the following items:

Items to be presented by Dr. Muchmore, Chairman:

1. **Call to Order**

A. Roll Call – Dr. Wilcox

DUR Board Members:

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

Viewing Access Only via Zoom:

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https://zoom.us/webinar/register/WN_73z8ERX7Sv-KeQGP3GVqPg
After registering, you will receive a confirmation email containing information about joining the webinar.

Or join by phone:
Dial: +1-602-753-0140 or +1-669-219-2599
Webinar ID: 952 7560 1667
Passcode: 69395211

Public Comment for Meeting:

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

Items to be presented by Dr. Muchmore, Chairman:

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

Items to be presented by Dr. Muchmore, Chairman:

3. **Action Item – Approval of DUR Board Meeting Minutes – See Appendix A**
   A. July 13, 2022 DUR Board Meeting Minutes
   B. July 13, 2022 DUR Board Recommendations Memorandum
   C. August 10, 2022 DUR Board Recommendations Memorandum
   D. September 14, 2022 DUR Board Meeting Minutes
   E. September 14, 2022 DUR Board Recommendations Memorandum

Items to be presented by Dr. O'Halloran, Dr. Teel, Dr. Muchmore, Chairman:

4. **Update on Medication Coverage Authorization Unit/Fall 2022 Pipeline Update – See Appendix B**
   A. Pharmacy Helpdesk Activity for September 2022
   B. Medication Coverage Activity for September 2022
   C. Fall 2022 Pipeline Update

Items to be presented by Dr. O'Halloran, Dr. Muchmore, Chairman:

5. **Action Item – Approval of September 2022 DUR Board Recommendations – See Appendix C**
   A. Vote to Update the Approval Criteria for the Ophthalmic Anti-Inflammatory Products
      i. College of Pharmacy Recommendations
   B. Vote to Prior Authorize Recorlev® (Levoketoconazole) and Update the Approval Criteria for Isturisa® (Osilodrostat)

i. Market News and Updates
ii. Recorlev® (Levoketoconazole) Product Summary
iii. College of Pharmacy Recommendations

C. Vote to Prior Authorize Tlando® (Testosterone Undecanoate) and Update the Approval Criteria for the Testosterone Products
i. Market News and Updates
ii. Cost Comparison
iii. College of Pharmacy Recommendations

D. Vote to Update the Approval Criteria for the Opioid Analgesics and Medication-Assisted Treatment (MAT) Medications
i. Market News and Updates
ii. College of Pharmacy Recommendations

E. Vote to Prior Authorize Adlarity® (Donepezil Transdermal System) and Aduhelm® (Aducanumab-avwa)
i. Market News and Updates
ii. Aduhelm® (Aducanumab-avwa) Product Summary
iii. College of Pharmacy Recommendations

F. Vote to Update the Approval Criteria for the Topical Corticosteroids
i. College of Pharmacy Recommendations

G. Vote to Prior Authorize Camzyos™ (Mavacamten)
i. Market News and Updates
ii. Camzyos™ (Mavacamten) Product Summary
iii. College of Pharmacy Recommendations

H. Vote to Update the Approval Criteria for the Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) Modulators
i. Market News and Updates
ii. College of Pharmacy Recommendations

I. Vote to Prior Authorize Alymsys® (Bevacizumab-maly), Lonsurf® (Trifluridine/Tipiracil), and Stivarga® (Regorafenib) and Update the Approval Criteria for the Colorectal Cancer Medications
i. Market News and Updates
ii. Product Summaries
iii. College of Pharmacy Recommendations

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

6. **Action Item – Vote to Prior Authorize Amvuttra™ (Vutrisiran) and Update the Approval Criteria for Amyloidosis Medications – See Appendix D**

A. Market News and Updates
B. Amvuttra™ (Vutrisiran) Product Summary
C. College of Pharmacy Recommendations

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

7. **Action Item – Vote to Prior Authorize Herceptin Hylecta™ (Trastuzumab/Hyaluronidase-oysk) and Update the Approval Criteria for the Breast Cancer Medications – See Appendix E**

A. Market News and Updates
B. Herceptin Hylecta™ (Trastuzumab/Hyaluronidase-oysk) Product Summary
C. College of Pharmacy Recommendations

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

8. Action Item – Annual Review of Bylvay® (Odevixibat) and Livmarli® (Maralixibat) – See Appendix F

A. Current Prior Authorization Criteria
B. Utilization of Bylvay® (Odevixibat) and Livmarli® (Maralixibat)
C. Prior Authorization of Bylvay® (Odevixibat) and Livmarli® (Maralixibat)
D. Market News and Updates
E. College of Pharmacy Recommendations

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

9. Action Item – Annual Review of Spinal Muscular Atrophy (SMA) Medications – See Appendix G

A. Current Prior Authorization Criteria
B. Utilization of SMA Medications
C. Prior Authorization of SMA Medications
D. Market News and Updates
E. College of Pharmacy Recommendations
F. Utilization Details of SMA Medications

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

10. Annual Review of Myeloproliferative Neoplasm (MPN) Medications and 30-Day Notice to Prior Authorize Besremi® (Ropeginterferon Alfa-2b-njft) and Vonjo® (Pacritinib) – See Appendix H

A. Introduction
B. Current Prior Authorization Criteria
C. Utilization of MPN Medications
D. Prior Authorization of MPN Medications
E. Market News and Updates
F. Product Summaries
G. College of Pharmacy Recommendations
H. Utilization Details of MPN Medications

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

11. Annual Review of Targeted Immunomodulator Agents and 30-Day Notice to Prior Authorize Sotyktu™ (Deucravacitinib), Spevigo® (Spesolimab-sbzo), and Tavneos® (Avacopan) – See Appendix I

A. Current Prior Authorization Criteria
B. Utilization of Targeted Immunomodulator Agents
C. Prior Authorization of Targeted Immunomodulator Agents
D. Market News and Updates
E. Product Summaries

F. College of Pharmacy Recommendations
G. Utilization Details of Targeted Immunomodulator Agents

Items to be presented by Dr. O'Halloran, Dr. Muchmore, Chairman:

12. Annual Review of Anemia Medications and 30-Day Notice to Prior Authorize Enjaymo™ (Sutimlimab-jome), Pyrukynd® (Mitapivat), and Zynteglo® (Betibeglogene Autotemcel) – See Appendix J

A. Current Prior Authorization Criteria
B. Utilization of Anemia Medications
C. Prior Authorization of Anemia Medications
D. Market News and Updates
E. Product Summaries
F. College of Pharmacy Recommendations
G. Utilization Details of Anemia Medications

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

13. Annual Review of Hepatitis C Medications – See Appendix K

A. Current Prior Authorization Criteria
B. Utilization of Hepatitis C Medications
C. Prior Authorization of Hepatitis C Medications
D. Market News and Updates
E. College of Pharmacy Recommendations
F. Utilization Details of Hepatitis C Medications

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

14. 30-Day Notice to Prior Authorize Xenpozyme® (Olipudase Alfa-rpcp)– See Appendix L

A. Introduction
B. Xenpozyme® (Olipudase Alfa-rpcp) Product Summary
C. College of Pharmacy Recommendations

Items to be presented by Dr. O'Halloran, Dr. Muchmore, Chairman:

15. U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates – See Appendix M

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

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

A. Asthma and Chronic Obstructive Pulmonary Disease (COPD) Maintenance Medications
B. Atopic Dermatitis Medications
C. Multiple Myeloma Medications
D. Vesicular Monoamine Transporter 2 (VMAT2) Inhibitor Medications

*Future product and class reviews subject to change.

17. Adjournment

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

Appendix A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
MINUTES OF MEETING JULY 13, 2022

DUR BOARD MEMBERS:	PRESENT	ABSENT
Stephen Anderson, Pharm.D.		X
Jennifer de los Angeles, Pharm.D., BCOP	X	
Jennifer Boyett, MHS; PA-C	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
Thara Kottoor, Pharm.D.; Pharmacy Resident	X	
Morgan Masterson, Pharm.D; Clinical Pharmacist		X
Regan Moss, 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
Ashley Teel, Pharm.D.; Clinical Pharmacist		X
Jacquelyn Travers, Pharm.D.; Practice Facilitating Pharmacist	X	
Devin Wilcox, D.Ph.; Pharmacy Director	X	
Justin Wilson, Pharm.D.; Clinical Pharmacist		X
PA Oncology Pharmacists: Allison Baxley, Pharm.D., BCOP		X
Emily Borders, Pharm.D., BCOP	X	
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 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
Traylor Rains; State Medicaid Director		X
Jill Ratterman, D.Ph.; Clinical Pharmacist	X	
Paula Root, M.D.; Senior Medical Director, Interim Chief Medical Officer	X	
Shanna Simmons, Pharm.D.; Program Integrity Pharmacist	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:	
Kenneth Berry, Alkermes	Audrey Rattan, Alkermes
Robert Greely, Biogen	Christopher Ngai, Calliditas
Ed Eldridge, Gilead	Frank Alvarado, Johnson & Johnson
Ed Clasby, Medtronic	Christy Olson, Medtronic
Shellie Keast, Mercer	Brent Parker, Merck
Mark Kaiser, Otsuka	Marc Parker, Sunovion
Bob Atkins, Biogen	Heather Higgins, Jazz
Sheri Jepsen, Seagen	Steven Angelcyk, Embecta
Tom Seignious, Azurity	Robin Selsor, Aimmune
Evie Knisely, Novartis	Bettina Buob, Neurelis
Maggie Shaffer, Alzheimer's Association	Burl Beasley, OMES
Aaron Austin, Takeda	Rhonda Clark, Indivior
Gina Heinen, Novo Nordisk	Himanshu Patel, McDermott, Will, & Emery
Jeff Knappen, Spark	Craig Irwin, Acadia
Raquel Jordan, Takeda	Tracey Maravilla, Ascendis
Chrystal Mayes, Sanofi	

PRESENT FOR PUBLIC COMMENT:	
Kenneth Berry, Alkermes	Christopher Ngai, Calliditas Therapeutics
Robert Greely, Biogen	

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

1A: ROLL CALL

Dr. Muchmore called the meeting to order at 4:01pm. 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. 8 KENNETH BERRY
2B: AGENDA ITEM NO. 10 CHRISTOPHER NGAI
2C: AGENDA ITEM NO. 14 ROBERT GREELY
ACTION: NONE REQUIRED

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

3A: JUNE 8, 2022 DUR MINUTES – VOTE

Materials included in agenda packet; presented by Dr. Muchmore
Dr. Muñoz moved to approve; seconded by Ms. Boyett

ACTION: MOTION CARRIED

AGENDA ITEM NO. 4: **UPDATE ON MEDICATION COVERAGE AUTHORIZATION UNIT/CHRONIC MEDICATION ADHERENCE (CMA) PROGRAM UPDATE**

4A: PHARMACY HELPDESK ACTIVITY FOR JUNE 2022
4B: MEDICATION COVERAGE ACTIVITY FOR JUNE 2022
4C: CMA PROGRAM UPDATE

Materials included in agenda packet; presented by Dr. O'Halloran, Dr. Travers
ACTION: NONE REQUIRED

AGENDA ITEM NO. 5: **VOTE TO PRIOR AUTHORIZE XELSTRYM™ (DEXTROAMPHETAMINE TRANSDERMAL SYSTEM) AND UPDATE THE APPROVAL CRITERIA FOR THE ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AND NARCOLEPSY MEDICATIONS**

5A: MARKET NEWS AND UPDATES
5B: XELSTRYM™ (DEXTROAMPHETAMINE TRANDSERMAL SYSTEM) PRODUCT SUMMARY
5C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Travers
Dr. Muñoz moved to approve; seconded by Ms. Boyett
ACTION: MOTION CARRIED

AGENDA ITEM NO. 6: **VOTE TO PRIOR AUTHORIZE LIVTENCITY™ (MARIBAVIR)**

6A: MARKET NEWS AND UPDATES
6B: LIVTENCITY™ (MARIBAVIR) PRODUCT SUMMARY
6C: COLLEGE OF PHARMACY RECOMMENDATIONS

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

AGENDA ITEM NO. 7: **VOTE TO PRIOR AUTHORIZE QUVIVIQ™ (DARIDOREXANT) AND UPDATE THE APPROVAL CRITERIA FOR THE INSOMNIA MEDICATIONS**

7A: MARKET NEWS AND UPDATES
7B: QUVIVIQ™ (DARIDOREXANT) PRODUCT SUMMARY
7C: COLLEGE OF PHARMACY RECOMMENDATIONS

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

AGENDA ITEM NO. 8: **VOTE TO PRIOR AUTHORIZE INVEGA HAFYERA™ (PALIPERIDONE PALMITATE INJECTION) AND UPDATE THE APPROVAL CRITERIA FOR THE ATYPICAL ANTIPSYCHOTIC MEDICATIONS**

8A: MARKET NEWS AND UPDATES
8B: INVEGA HAFYERA™ (PALIPERIDONE PALMITATE) PRODUCT SUMMARY
8C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. O'Halloran
Dr. Muñoz moved to approve; seconded by Ms. Boyett
ACTION: MOTION CARRIED

AGENDA ITEM NO. 9: **VOTE TO PRIOR AUTHORIZE RYPLAZIM® (PLASMINOGEN, HUMAN-TVMH)**

9A: MARKET NEWS AND UPDATE
9B: RYPLAZIM® (PLASMINOGEN, HUMAN-TVMH) PRODUCT SUMMARY

9C: COLLEGE OF PHARMACY RECOMMENDATIONS
Materials included in agenda packet; presented by Dr. O'Halloran
Dr. Muñoz moved to approve; seconded by Ms. Boyett
ACTION: MOTION CARRIED

AGENDA ITEM NO. 10: VOTE TO PRIOR AUTHORIZE CITALOPRAM CAPSULE, DARTISLA ODT™ (GLYCOPYRROLATE ORALLY DISINTEGRATING TABLET), FLEQSUVY™ (BACLOFEN ORAL SUSPENSION), LOFENA™ (DICLOFENAC POTASSIUM TABLET), LOREEV XR™ (LORAZEPAM EXTENDED-RELEASE CAPSULE), NORLIQVA® (AMLODIPINE BESYLATE ORAL SOLUTION), SEGLENTIS® (CELECOXIB/TRAMADOL TABLET), SUTAB® (SODIUM SULFATE/MAGNESIUM SULFATE/POTASSIUM CHLORIDE TABLET), TARPEYO™ (BUDESONIDE DELAYED-RELEASE CAPSULE), VUITY™ (PILOCARPINE 1.25% OPHTHALMIC SOLUTION), AND XIPERE™ (TRIAMCINOLONE ACETONIDE INJECTION)
10A: INTRODUCTION
10B: PRODUCT SUMMARIES AND COLLEGE OF PHARMACY RECOMMENDATIONS
Materials included in agenda packet; presented by Dr. Chandler
Dr. Muñoz moved to approve; seconded by Ms. Boyett
ACTION: MOTION CARRIED

AGENDA ITEM NO. 11: VOTE TO PRIOR AUTHORIZE CAMCEVI™ (LEUPROLIDE), PLUVICTO® (LUTETIUM LU 177 VIPIVOTIDE TETRAXETAN), TIVDAK® (TISOTUMAB VEDOTIN-TFTV), AND WELIREG™ (BELZUTIFAN) AND UPDATE THE APPROVAL CRITERIA FOR THE GENITOURINARY AND CERVICAL/ENDOMETRIAL CANCER MEDICATIONS
11A: MARKET NEWS AND UPDATES
11B: PRODUCT SUMMARIES
11C: COLLEGE OF PHARMACY RECOMMENDATIONS
Materials included in agenda packet; presented by Dr. Borders
Dr. Muñoz moved to approve; seconded by Ms. Boyett
ACTION: MOTION CARRIED

AGENDA ITEM NO. 12: ANNUAL REVIEW OF COLORECTAL CANCER MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE ALYMSYS® (BEVACIZUMAB-MALY), LONSURF® (TRIFLURIDINE/TIPIRACIL), AND STIVARGA® (REGORAFENIB)
12A: INTRODUCTION
12B: CURRENT PRIOR AUTHORIZATION CRITERIA
12C: UTILIZATION OF COLORECTAL CANCER MEDICATIONS
12D: PRIOR AUTHORIZATION OF COLORECTAL CANCER MEDICATIONS
12E: MARKET NEWS AND UPDATES
12F: PRODUCT SUMMARIES
12G: COLLEGE OF PHARMACY RECOMMENDATIONS
12H: UTILIZATION DETAILS OF COLORECTAL CANCER MEDICATIONS
Materials included in agenda packet; presented by Dr. Borders
ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN SEPTEMBER

AGENDA ITEM NO. 13: ANNUAL REVIEW OF DANYELZA® (NAXITAMAB-GQGK), KOSELUGO® (SELUMETINIB), PEMAZYRE® (PEMIGATINIB), QINLOCK™ (RIPRETINIB), AND TRUSELTIQ™ (INFIGRATINIB)
13A: INTRODUCTION
13B: CURRENT PRIOR AUTHORIZATION CRITERIA

13C: UTILIZATION OF DANYELZA® (NAXITAMAB-GQGK), KOSELUGO® (SELUMETINIB), PEMAZYRE® (PEMIGATINIB), QINLOCK™ (RIPRETINIB), AND TRUSELTIQ™ (INFIGRATINIB)
13D: PRIOR AUTHORIZATION OF DANYELZA® (NAXITAMAB-GQGK), KOSELUGO® (SELUMETINIB), PEMAZYRE® (PEMIGATINIB), QINLOCK™ (RIPRETINIB), AND TRUSELTIQ™ (INFIGRATINIB)
13E: MARKET NEWS AND UPDATES
13F: COLLEGE OF PHARMACY RECOMMENDATIONS
13G: UTILIZATION DETAILS OF DANYELZA® (NAXITAMAB-GQGK), KOSELUGO® (SELUMETINIB), PEMAZYRE® (PEMIGATINIB), QINLOCK™ (RIPRETINIB), AND TRUSELTIQ™ (INFIGRATINIB)
Materials included in agenda packet; presented by Dr. Borders
ACTION: NONE REQUIRED

AGENDA ITEM NO. 14: ANNUAL REVIEW OF ALZHEIMER'S DISEASE MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE ADLARITY® (DONEPEZIL TRANSDERMAL SYSTEM) AND ADUHELM™ (ADUCANUMAB-AVWA)
14A: CURRENT PRIOR AUTHORIZATION CRITERIA
14B: UTILIZATION OF ALZHEIMER'S DISEASE MEDICATIONS
14C: PRIOR AUTHORIZATION OF ALZHEIMER'S DISEASE MEDICATIONS
14D: MARKET NEWS AND UPDATES
14E: ADUHELM™ (ADUCANUMAB-AVWA) PRODUCT SUMMARY
14F: COLLEGE OF PHARMACY RECOMMENDATIONS
14G: UTILIZATION DETAILS OF ALZHEIMER'S DISEASE MEDICATIONS
Materials included in agenda packet; presented by Dr. O'Halloran
ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN SEPTEMBER

AGENDA ITEM NO. 15: ANNUAL REVIEW OF TESTOSTERONE PRODUCTS AND 30-DAY NOTICE TO PRIOR AUTHORIZE TLANDO® (TESTOSTERONE UNDECANOATE)
15A: CURRENT PRIOR AUTHORIZATION CRITERIA
15B: UTILIZATION OF TESTOSTERONE PRODUCTS
15C: PRIOR AUTHORIZATION OF TESTOSTERONE PRODUCTS
15D: MARKET NEWS AND UPDATES
15E: COST COMPARISON
15F: COLLEGE OF PHARMACY RECOMMENDATIONS
15G: UTILIZATION DETAILS OF TESTOSTERONE PRODUCTS
Materials included in agenda packet; presented by Dr. Chandler
ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN SEPTEMBER

AGENDA ITEM NO. 16: ANNUAL REVIEW OF VARIOUS SYSTEMIC ANTIBIOTICS
16A: CURRENT PRIOR AUTHORIZATION CRITERIA
16B: UTILIZATION OF VARIOUS SYSTEMIC ANTIBIOTICS
16C: PRIOR AUTHORIZATION OF VARIOUS SYSTEMIC ANTIBIOTICS
16D: MARKET NEWS AND UPDATES
16E: COLLEGE OF PHARMACY RECOMMENDATIONS
16F: UTILIZATION DETAILS OF VARIOUS SYSTEMIC ANTIBIOTICS
Materials included in agenda packet; presented by Dr. Ha
ACTION: NONE REQUIRED

AGENDA ITEM NO. 17: ANNUAL REVIEW OF ISTURISA® (OSILODROSTAT) AND 30-DAY NOTICE TO PRIOR AUTHORIZE RECORLEV® (LEVOKETOCONAZOLE)
17A: CURRENT PRIOR AUTHORIZATION CRITERIA

17B: UTILIZATION OF ISTURISA® (OSILODROSTAT)
17C: PRIOR AUTHORIZATION OF ISTURISA® (OSILODROSTAT)
17D: MARKET NEWS AND UPDATES
17E: RECORLEV® (LEVOKETOCONAZOLE) PRODUCT SUMMARY
17F: COLLEGE OF PHARMACY RECOMMENDATIONS
Materials included in agenda packet; presented by Dr. Ha
ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN SEPTEMBER

AGENDA ITEM NO. 18: U.S. FOOD AND DRUG ADMINISTRATION (FDA) AND DRUG ENFORCEMENT ADMINISTATION (DEA) UPDATES
Materials included in agenda packet; presented by Dr. O'Halloran
ACTION: NONE REQUIRED

AGENDA ITEM NO. 19: FUTURE BUSINESS* (UPCOMING PRODUCT AND CLASS REVIEWS)
No live DUR Board meeting scheduled for August 2022. August 2022 will be a packet-only meeting.
19A: INTRAVENOUS (IV) IRON PRODUCTS
19B: OPHTHALMIC ANTI-INFLAMMATORY PRODUCTS
19C: OPIOID ANALGESICS AND MEDICATION-ASSISTED TREATMENT (MAT) MEDICATIONS
19D: TOPICAL CORTICOSTEROIDS
*Future product and class reviews subject to change.
Materials included in agenda packet; presented by Dr. Adams
ACTION: NONE REQUIRED

AGENDA ITEM NO. 20: ADJOURNMENT
The meeting was adjourned at 5:40pm.

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

Memorandum

Date: July 15, 2022

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 July 13, 2022

Recommendation 1: Chronic Medication Adherence (CMA) Program Update

NO ACTION REQUIRED.

Recommendation 2: Vote to Prior Authorize Xelstrym™ (Dextroamphetamine Transdermal System) and Update the Approval Criteria for Attention-Deficit/Hyperactivity Disorder (ADHD) and Narcolepsy Medications

MOTION CARRIED by unanimous approval.

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

1. Updating the approval criteria for Qelbree® (viloxazine) based on the recent FDA approved age expansion
2. Updating the approval criteria for Xywav® (calcium/magnesium/ potassium/sodium oxybates) based on the recent FDA approval for idiopathic hypersomnia
3. The prior authorization of Dyanavel XR® [amphetamine extended-release (ER) tablets] and placement into Tier-2 of the Long-Acting Stimulants category of the ADHD Medications PBPA Tier chart

4. The prior authorization of Xelstrym™ (dextroamphetamine transdermal system) and placement into the Special PA Tier of the ADHD Medications PBPA Tier chart with the following additional criteria

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

ADHD Medications			
Tier-1*	**Tier-2***	**Tier-3***	**Special PA**
Non-Stimulants			methylphenidate ER chew tab (QuilliChew ER®) viloxazine (Qelbree®)
atomoxetine (Strattera®) guanfacine ER (Intuniv®)	clonidine ER (Kapvay®)Δ		

*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC). Placement of products shown in blue is based on net cost after federal and/or supplemental rebates, and products may be moved to a higher tier if the net cost changes in comparison to other available products.

+Unique criteria applies for the diagnosis of binge eating disorder (BED).

ΔUnique criteria applies in addition to tier trial requirements.

ADHD = attention-deficit/hyperactivity disorder; cap = capsule; chew tab = chewable tablet; ER = extended-release; ODT = orally disintegrating tablet; PA = prior authorization; soln = solution; susp = suspension; tab = tablet

ADHD Medications Tier-2 Approval Criteria:

1. A covered diagnosis; and
2. A previously failed trial with at least 1 long-acting Tier-1 stimulant that resulted in an inadequate response:
   a. Trials should have been within the last 180 days; and
   b. Trials should have been dosed up to maximum recommended dose or documented adverse effects at higher doses should be included; and
   c. If trials are not in member's claim history, the pharmacy profile should be submitted or detailed information regarding dates and doses should be included along with the signature from the physician; and
3. For Dyanavel® XR oral suspension and Quillivant XR®, an age restriction of 10 years and younger will apply. Members older than 10 years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.
4. Kapvay® [Clonidine Extended-Release (ER) Tablet] Approval Criteria:
   a. An FDA approved diagnosis; and
   b. Previously failed trials (within the last 180 days) with a long-acting Tier-1 stimulant, Intuniv®, and Strattera®, unless contraindicated, that did not yield adequate results; and
   c. A patient-specific, clinically significant reason why the member cannot use clonidine immediate-release tablets must be provided.

ADHD Medications Tier-3 Approval Criteria:

1. A covered diagnosis; and
2. A previously failed trial with at least 1 long-acting Tier-1 stimulant that resulted in an inadequate response; and
3. A previously failed trial with at least 1 long-acting Tier-2 stimulant that resulted in an inadequate response:
   a. Trials should have been within the last 365 days; and

b. Trials should have been dosed up to maximum recommended dose or documented adverse effects at higher doses should be included; and
c. If trials are not in member's claim history, the pharmacy profile should be submitted or detailed information regarding dates and doses should be included along with the signature from the physician.

ADHD Medications Special Prior Authorization (PA) Approval Criteria:

1. Adzenys XR-ODT®, Adzenys ER™, Cotempla XR-ODT®, Evekeo ODT™, QuilliChew ER®, Vyvanse® Chewable Tablets, and Xelstrym™ Approval Criteria:
   a. A covered diagnosis; and
   b. A patient-specific, clinically significant reason why the member cannot use all other available formulations of stimulant medications that can be used for members who cannot swallow capsules or tablets must be provided; and
   c. An age restriction of 10 years and younger will apply. Members older than 10 years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.
2. Desoxyn®, Dexedrine®, Dexedrine Spansules®, Evekeo®, ProCentra®, and Zenzedi® Approval Criteria:
   a. A covered diagnosis; and
   b. A patient-specific, clinically significant reason why the member cannot use all other available stimulant medications must be provided.
3. Methylin® Chewable Tablets Approval Criteria:
   a. A covered diagnosis; and
   b. A patient-specific, clinically significant reason why the member cannot use methylphenidate immediate-release tablets or oral solution must be provided; and
   c. An age restriction of 10 years and younger will apply. Members older than 10 years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.
4. Mydayis® Approval Criteria:
   a. A covered diagnosis; and
   b. Member must be 13 years of age or older; and
   c. A patient-specific, clinically significant reason why the member cannot use all other available stimulant medications must be provided.
5. Qelbree® [Viloxazine Extended-Release (ER) Capsule] Approval Criteria:
   a. An FDA approved diagnosis; and
   b. Member must be 6 ~~to 17~~ years of age or older; and
   c. Previously failed trials (within the last 180 days) with any 2 Tier-1 or Tier-2 ADHD medications, unless contraindicated, that did not yield adequate results; and

i. Qelbree® will not require a prior authorization and claims will pay at the point of sale if the member has paid claims for 2 Tier-1 or Tier-2 ADHD medications within the past 180 days of claims history; and

d. Member must not be taking a monoamine oxidase inhibitor (MAOI) or have taken an MAOI within the last 14 days; and
e. Member must not be taking sensitive CYP1A2 substrates or CYP1A2 substrates with a narrow therapeutic range (e.g., alosetron, duloxetine, ramelteon, tasimelteon, tizanidine, theophylline) concomitantly with Qelbree®; and
f. A quantity limit of 30 capsules per 30 days will apply for the 100mg strengths and 60 capsules per 30 days will apply for the 150mg and 200mg strength.

ADHD Medications Additional Criteria:

1. Doses exceeding 1.5 times the FDA maximum dose are not covered.
2. Prior authorization is required for all tiers for members older than 20 years of age and for members younger than 5 years of age. All prior authorization requests for members younger than 5 years of age must be reviewed by an Oklahoma Health Care Authority (OHCA)-contracted psychiatrist.
3. For Daytrana® patches and Methylin® oral solution, an age restriction of 10 years and younger will apply. Members older than 10 years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.
4. Vyvanse® (Lisdexamfetamine) Approval Criteria [Binge Eating Disorder (BED) Diagnosis]:
   a. An FDA approved diagnosis of moderate-to-severe BED; and
   b. Member must be 18 years of age or older; and
   c. Vyvanse® for the diagnosis of BED must be prescribed by a psychiatrist; and
   d. Authorizations will not be granted for the purpose of weight loss without the diagnosis of BED or for the diagnosis of obesity alone. The safety and effectiveness of Vyvanse® for the treatment of obesity have not been established; and
   e. A quantity limit of 30 capsules or chewable tablets per 30 days will apply; and
   f. Initial approvals will be for the duration of 3 months. Continued authorization will require prescriber documentation of improved response/effectiveness of Vyvanse®.

Narcolepsy Medications Approval Criteria:

1. An FDA approved diagnosis; and
2. Use of Nuvigil® (armodafinil) requires a patient-specific, clinically significant reason why the member cannot use stimulant medications to improve wakefulness during the daytime; and

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

Idiopathic Hypersomnia (IH) Medications Approval Criteria:

1. Diagnosis of IH meeting the following ICSD-3 (International Classification of Sleep Disorders) criteria:
   a. Daily periods of irresistible need to sleep or daytime lapses into sleep for >3 months; and
   b. Absence of cataplexy; and
   c. Multiple sleep latency test (MSLT) results showing 1 of the following:
      i. <2 sleep-onset rapid eye movement (REM) periods (SOREMPs); or
      ii. No SOREMPs if the REM sleep latency on the preceding polysomnogram is ≤15 minutes; and
   d. At least 1 of the following:
      i. MSLT showing mean sleep latency ≤8 minutes; or
      ii. Total 24-hour sleep time ≥660 minutes on 24-hour polysomnography monitoring (performed after the correction of chronic sleep deprivation) or by wrist actigraphy in association with a sleep log (averaged over ≥7 days with unrestricted sleep); and
   e. Insufficient sleep syndrome has been ruled out; and

    f. Hypersomnolence or MSLT findings are not better explained by any other sleep disorder, medical or neurologic disorder, mental disorder, medication use, or substance abuse; and
2. Diagnosis must be confirmed by a sleep specialist; and
3. Use of Nuvigil® (armodafinil) requires a patient-specific, clinically significant reason why the member cannot use stimulant medications to improve wakefulness during the daytime; and
    a. Nuvigil® is brand name preferred due to net cost after rebates; however, brand name preferred status may be removed if the net cost changes and brand name is more costly than generic; and
4. Use of Provigil® (modafinil) requires a previously failed trial (within the last 180 days) with Nuvigil® and a patient-specific, clinically significant reason why the member cannot use stimulant medications to improve wakefulness during the daytime; and
5. Use of Xyrem® (sodium oxybate) or Xywav® (calcium/magnesium/potassium/sodium oxybates) requires previously failed trials (within the last 180 days) with at least 4 of the following, unless contraindicated, that did not yield adequate results:
    a. Tier-1 stimulant; or
    b. Tier-2 stimulant; or
    c. Nuvigil®; or
    d. Provigil®; or
    e. Clarithromycin; and
6. Xywav® (calcium/magnesium/potassium/sodium oxybates) additionally requires a patient-specific, clinically significant reason why the member cannot use Xyrem®; and
    a. For members requesting Xywav® due to lower sodium content in comparison to Xyrem®, a patient-specific, clinically significant reason why the member requires a low-sodium product must be provided.

Recommendation 3: Vote to Prior Authorize Livtencity™ (Maribavir)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Livtencity™ (maribavir) with the following criteria:

Livtencity™ (Maribavir) Approval Criteria:

1. An FDA approved indication of the treatment of post-transplant cytomegalovirus (CMV) infection and disease that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir, or foscarnet in adults and pediatric members (12 years of age and older weighing ≥35kg); and

2. A previously failed trial at least 14 days in duration with ganciclovir, valganciclovir, cidofovir, or foscarnet; and
3. Prescriber must verify the member does not have CMV disease involving the central nervous system including the retina (CMV retinitis); and
4. Prescriber must verify member will not receive concurrent treatment with ganciclovir and/or valganciclovir while taking Livtencity™; and
5. Prescriber must verify the member will be monitored for virologic failure during and after treatment with Livtencity™; and
6. Livtencity™ must be prescribed by an oncology, hematology, infectious disease, or transplant specialist (or advanced care practitioner with a supervising physician who is an oncology, hematology, infectious disease, or transplant specialist); and
7. Prescriber must verify Livtencity™ will not be used concomitantly with strong inducers of CYP3A4 (e.g., rifampin, rifabutin, St. John's wort) except carbamazepine, phenobarbital, or phenytoin. Use of carbamazepine, phenobarbital, or phenytoin concomitantly with Livtencity™ will require dose adjustment according to package labeling; and
8. Prescriber must agree to monitor drug concentrations of immunosuppressant drugs that are CYP3A4 and/or P-glycoprotein (P-gp) substrates (e.g., tacrolimus, cyclosporine, sirolimus, everolimus) throughout treatment with Livtencity™ and adjust the dose of immunosuppressant drug(s) as needed; and
9. Approvals will be for a maximum duration of 8 weeks, and a quantity limit of 112 tablets per 28 days will apply.

Recommendation 4: Vote to Prior Authorize Quviviq™ (Daridorexant) and Update the Approval Criteria for the Insomnia Medications

MOTION CARRIED by unanimous approval.

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

1. Updating the approval criteria for Hetlioz® (tasimelteon capsules) based on the new FDA approved indication
2. The prior authorization of Hetlioz LQ™ (tasimelteon oral suspension) and placement into the Special Prior Authorization (PA) Tier of the Insomnia Medications PBPA Tier chart with the following additional criteria
3. The prior authorization of Quviviq™ (daridorexant) and placement into the Special PA category of the Insomnia Medications PBPA category

Insomnia Medications			
Tier-1	**Tier-2**	**Tier-3**	**Special PA***
estazolam (ProSom®)	zolpidem CR (Ambien® CR)	lemborexant (Dayvigo®)	**daridorexant (Quviviq™)**
eszopiclone (Lunesta®)		suvorexant (Belsomra®)	doxepin (Silenor®)
flurazepam (Dalmane®)			tasimelteon (Hetlioz®, **Hetlioz LQ™**)+
ramelteon (Rozerem®) – **Brand Preferred**			temazepam (Restoril®) 7.5mg and 22.5mg
temazepam (Restoril®) 15mg and 30mg			zolpidem SL tablets (Edluar®)
triazolam (Halcion®)			zolpidem SL tablets (Intermezzo®)
zaleplon (Sonata®)			zolpidem oral spray (Zolpimist®)
zolpidem (Ambien®)			

CR = controlled release; PA = prior authorization; SL = sublingual
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).
*Medications in the Special PA Tier, including unique dosage formulations, require a special reason for use in place of ~~Tier-1 formulations~~ lower-tiered medications.
+Individual criteria specific to tasimelteon applies.

Hetlioz® (Tasimelteon Capsule) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
   a. ~~An FDA approved diagnosis of~~ Non-24-Hour Sleep-Wake Disorder (Non-24) confirmed by a sleep specialist; ~~and~~ or
   b. Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) confirmed by a sleep specialist; and
2. Member must be 18 years of age or older for a diagnosis of Non-24 or 16 years of age or older for a diagnosis of SMS; and
3. Member must have a failed trial of appropriately timed doses of melatonin; and
4. Initial approvals will be for the duration of 12 weeks. For continuation, the prescriber must include information regarding improved response/effectiveness of this medication; and
5. A quantity limit of 30 capsules for 30 days will apply.

Hetlioz LQ™ (Tasimelteon Oral Suspension) Approval Criteria:

1. An FDA approved diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) confirmed by a sleep specialist; and
2. Member must be 3 to 15 years of age; and
3. Member must have a failed trial of appropriately timed doses of melatonin; and

4. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to the Hetlioz LQ™ *Prescribing Information*; and
5. Initial approvals will be for the duration of 12 weeks. For continuation, the prescriber must include information regarding improved response/effectiveness of this medication.

Recommendation 5: Vote to Prior Authorize Invega Hafyera™ (Paliperidone Palmitate Injection) and Update the Approval Criteria for the Atypical Antipsychotic Medications

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the placement of Invega Hafyera™ (paliperidone palmitate IM injection) into Tier-1 of the Atypical Antipsychotic Medications Product Based Prior Authorization (PBPA) category based on net costs (changes noted in red):

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

Atypical Antipsychotic Medications*		
ziprasidone (Geodon®)		

*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC). Placement of products shown in blue is based on net cost after federal and/or supplemental rebates, and products may be moved to a higher tier if the net cost changes in comparison to other available products.
ER = extended-release; IM = intramuscular; inj = injection; ODT = orally disintegrating tablet; susp = suspension; sub-Q = subcutaneous
¥Aripiprazole (Abilify®) orally disintegrating tablet (ODT) is considered a special formulation and requires a patient-specific, clinically significant reason why a special formulation product is needed in place of the regular tablet formulation.
◊Clozapine does not count towards a Tier-1 trial.
^Use of Invega Hafyera™ requires members to have been adequately treated with the 1-month paliperidone palmitate injection (Invega Sustenna®) for at least 4 months or the 3-month paliperidone palmitate injection (Invega Trinza®) for at least one 3-month cycle.
**Use of Invega Trinza® requires members to have been adequately treated with the 1-month paliperidone palmitate injection (Invega Sustenna®) for at least 4 months.
~Unique criteria applies to Abilify MyCite® (aripiprazole tablets with sensor).
+Unique criteria applies in addition to tier trial requirements.

Additionally, the College of Pharmacy recommends adding the following criteria to Lybalvi™ (olanzapine/samidorphan):

Lybalvi™ (Olanzapine/Samidorphan) Approval Criteria:

1. An FDA approved diagnosis; and
2. Member must be 18 years of age or older; and
3. Member must be stable on olanzapine for at least 14 days and be experiencing significant weight gain (baseline and current weight must be provided); or
4. A patient specific, clinically significant reason why the member cannot use a lower-tiered product with a lower weight gain profile must be provided; and
5. Member must not be taking opioids or undergoing acute opioid withdrawal; and
6. Initial approvals will be for 3 months. For continuation consideration, documentation that the member is responding well to treatment and has had no excessive weight gain while on therapy must be provided.

Recommendation 6: Vote to Prior Authorize Ryplazim® (Plasminogen, Human-tvmh)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Ryplazim® (plasminogen, human-tvmh) with the following criteria:

Ryplazim® (Plasminogen, Human-tvmh) Approval Criteria:

1. An FDA approved indication of plasminogen deficiency type 1 (hypoplasminogenemia) as confirmed by at least 2 of the following:

a. Genetic testing confirming biallelic mutations in the plasminogen (*PLG*) gene; or
b. Plasminogen activity level ≤45%; or
c. Documentation of clinical symptoms and lesions consistent with plasminogen deficiency type 1 (e.g., ligneous conjunctivitis, ligneous gingivitis or gingival overgrowth, vision abnormalities, respiratory distress and/or obstruction, abnormal wound healing); and

2. Ryplazim® must be prescribed by, or in consultation with, a hematologist, pulmonologist, ophthalmologist, geneticist, or other specialist with expertise in the treatment of plasminogen deficiency (or an advanced care practitioner with a supervising physician who is a hematologist, pulmonologist, ophthalmologist, geneticist, or other specialist with expertise in the treatment of plasminogen deficiency); and
3. Prescriber must verify that members at high risk for bleeding and/or confirmed or suspected airway disease will be monitored by a health care provider for 4 hours after receiving the first dose; and
4. Documented vaccination history to hepatitis A and B must be provided or provider must verify member has received the first vaccine dose and is scheduled to receive the second vaccine dose; and
5. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
6. Initial approvals will be for 6 months, after which time the prescriber must document improvement in clinical symptoms, partial or complete lesion resolution, and increased plasminogen activity level; and
7. Subsequent approvals will be for the duration of 1 year and will require documentation from the prescriber that member has not developed new or recurrent lesions while on Ryplazim® and that adequate plasminogen activity trough levels are being maintained.

Recommendation 7: Vote to Prior Authorize Citalopram Capsule, Dartisla ODT™ [Glycopyrrolate Orally Disintegrating Tablet (ODT)], Fleqsuvy™ (Baclofen Oral Suspension), Lofena™ (Diclofenac Potassium Tablet), Loreev XR™ [Lorazepam Extended-Release (ER) Capsule], Norliqva® (Amlodipine Oral Solution), Seglentis® (Celecoxib/Tramadol Tablet), Sutab® (Sodium Sulfate/Magnesium Sulfate/Potassium Chloride Tablet), Tarpeyo™ [Budesonide Delayed-Release (DR) Capsule], Vuity™ (Pilocarpine 1.25% Ophthalmic Solution), and Xipere® (Triamcinolone Acetonide Injection)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the placement of citalopram capsules into the Special Prior Authorization (PA) Tier of the Antidepressants Product Based Prior Authorization (PBPA) category with the following additional criteria:

Citalopram Capsule Approval Criteria:

1. An FDA approved indication of major depressive disorder (MDD) in adults; and
2. Member must have initiated treatment with citalopram tablets for dose titration up to the 30mg dose; and
3. A patient-specific, clinically significant reason why the member cannot use citalopram tablets, which are available without prior authorization, in place of the capsule formulation must be provided; and
4. Citalopram capsules will not be approved for members 60 years of age or older; and
5. A quantity limit of 30 capsules per 30 days will apply.

The College of Pharmacy recommends the placement of Dartisla ODT™ (glycopyrrolate ODT) into the Special PA Tier of the Anti-Ulcer Medications PBPA category with the following additional criteria:

Dartisla ODT™ [Glycopyrrolate Orally Disintegrating Tablet (ODT)] Approval Criteria:

1. An FDA approved indication of adjunctive therapy in the treatment of peptic ulcer disease (PUD) in members 18 years of age and older; and
2. A patient-specific, clinically significant reason why the member cannot use glycopyrrolate 1mg and 2mg tablets, which are available without prior authorization, must be provided; and
3. A quantity limit of 120 ODTs per 30 days will apply.

The College of Pharmacy recommends adding Fleqsuvy™ (baclofen oral suspension) to the current Ozobax® (baclofen oral solution) prior authorization with the changes shown in red:

Fleqsuvy™ 25mg/5mL (Baclofen Oral Suspension) and Ozobax® 5mg/5mL (Baclofen Oral Solution) Approval Criteria:

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

The College of Pharmacy recommends the placement of Lofena™ (diclofenac potassium tablet) into the Special PA Tier of the NSAIDs PBPA category with the following additional criteria (changes shown in red):

NSAIDs Special Prior Authorization (PA) Approval Criteria:

1. A unique indication for which a Tier-1 or Tier-2 medication is not appropriate; or
2. Previous use of at least 2 Tier-1 NSAID products (from different product lines); and
3. A patient-specific, clinically significant reason why a special formulation is needed over a Tier-1 product.
4. Additionally, use of Tivorbex™ (indomethacin) will require a patient-specific, clinically significant reason why the member cannot use all other available generic indomethacin products.
5. Additionally, use of Celebrex® (celecoxib) 400mg capsules will require a diagnosis of Familial Adenomatous Polyposis (FAP) and a patient-specific, clinically significant reason why the member cannot use 2 celecoxib 200mg capsules to achieve a 400mg dose.
6. Additionally, use of Lofena™ (diclofenac potassium) will require a patient-specific, clinically significant reason why the member cannot use all other available generic diclofenac products.

The College of Pharmacy recommends the prior authorization of Loreev XR™ (lorazepam ER capsule) with the following criteria:

Loreev XR™ [Lorazepam Extended-Release (ER) Capsule] Approval Criteria:

1. An FDA approved indication for the treatment of anxiety disorders; and
2. Member must be 18 years of age or older; and
3. Member must be receiving a stable, evenly divided, 3 times daily dosing regimen of lorazepam tablets; and
4. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use the immediate-release formulation must be provided; and
5. A quantity limit of 30 capsules per 30 days will apply.

The College of Pharmacy recommends the placement of Norliqva® (amlodipine oral solution) into the Special PA Tier of the Calcium Channel Blockers (CCBs) PBPA category with criteria similar to Katerzia® (amlodipine oral suspension) as follows (changes shown in red):

Katerzia® (Amlodipine Oral Suspension) and Norliqva® (Amlodipine Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
   a. Hypertension in adults and pediatric members 6 years of age and older; or
   b. Coronary artery disease; or
   c. Chronic stable angina; or
   d. Vasospastic angina; and

2. A patient specific, clinically significant reason the member cannot use amlodipine oral tablets even when the tablets are crushed must be provided; and
3. A quantity limit of 300mL per 30 days will apply.

The College of Pharmacy recommends the placement of Seglentis® (celecoxib/tramadol) into the Special PA Tier of the Opioid Analgesics PBPA category with the following additional criteria:

Seglentis® (Celecoxib 56mg/Tramadol 44mg) Approval Criteria:

1. An FDA approved indication of acute pain in adults that is severe enough to require an opioid analgesic; and
2. A patient-specific, clinically significant reason why the member cannot use any other opioid medication for treatment of acute pain must be provided; and
3. A patient-specific, clinically significant reason why the member cannot use celecoxib and tramadol individual products in place of Seglentis® must be provided; and
4. An age restriction will apply for members younger than 12 years of age. For members younger than 12 years of age, the provider must submit patient-specific, clinically significant information supporting the use of tramadol despite the medication being contraindicated for the member's age; and
5. A quantity limit of 28 tablets for a 7-day supply will apply.

The College of Pharmacy recommends the prior authorization of Sutab® (sodium sulfate/magnesium sulfate/potassium chloride tablet) with the following criteria:

Clenpiq®, ColPrep Kit®, OsmoPrep®, Plenvu®, Prepopik®, SUPREP®, and Sutab® Approval Criteria:

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

The College of Pharmacy recommends the prior authorization of Tarpeyo™ (budesonide DR capsule) with the following criteria [changes shown in red indicate updates made based on guideline recommendations and Drug Utilization Review (DUR) Board recommendations]:

Tarpeyo™ [Budesonide Delayed Release (DR) Capsule] Approval Criteria:

1. An FDA approved indication to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression; and
2. The diagnosis of primary IgAN must be confirmed by the following:
    a. Kidney biopsy; and
    b. Secondary causes of IgAN have been ruled out (i.e., IgA vasculitis; IgAN secondary to virus, inflammatory bowel disease, autoimmune disease, or liver cirrhosis; IgA-dominant infection-related glomerulonephritis); and
3. Member must be 18 years of age or older; and
4. Must be prescribed by a nephrologist (or advanced care practitioner with a supervising physician who is a nephrologist); and
5. Member must ~~have a~~ be at risk of rapid disease progression as demonstrated by ≥1 of the following, despite maximal supportive care:
    a. Urine protein-to-creatinine ratio (UPCR) ≥1.5 g/g; or
    b. Proteinuria >0.75g/day; and
6. Member must be on a stable dose of a maximally-tolerated angiotensin converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB), unless contraindicated or intolerant; and
7. A patient-specific, clinically significant reason why ~~the member cannot use~~ a 6-month trial of an alternative formulation of budesonide DR oral capsules (e.g., Entocort® EC) or alternative oral corticosteroids ~~available without prior authorization~~ is not appropriate for the member must be provided; and
8. Approval duration will be for 9 months; and
9. A quantity limit of 120 capsules per 30 days will apply.

The College of Pharmacy recommends the prior authorization of Vuity™ (pilocarpine 1.25% ophthalmic solution) with the following criteria:

Vuity™ (Pilocarpine 1.25% Ophthalmic Solution) Approval Criteria:

1. An FDA approved indication of the treatment of presbyopia in adults; and
2. Must be prescribed by an ophthalmologist or optometrist; and
3. Prescriber must verify the member does not have iritis; and
4. Prescriber must verify the member has been counseled on the risk of retinal detachment with use of Vuity™ and when to seek immediate medical care; and
5. Prescriber must verify the member has been advised to use caution with night driving and hazardous occupations in poor illumination as vision may not be clear in these conditions while using Vuity™; and
6. A patient-specific, clinically significant reason the member cannot use corrective lenses must be provided; and

7. A patient-specific, clinically significant reason the member cannot use generic pilocarpine ophthalmic solution (Isopto® Carpine) must be provided.

The College of Pharmacy recommends the prior authorization of Xipere® (triamcinolone acetonide injection) with the following criteria:

Xipere® (Triamcinolone Acetonide Injection) Approval Criteria:

1. An FDA approved indication for the treatment of macular edema associated with non-infectious uveitis; and
2. Member must be 18 years of age or older; and
3. Xipere® must be administered by an ophthalmologist; and
4. Prescriber must confirm that the member does not have an active ocular or periocular infection; and
5. Prescriber must confirm member does not have untreated ocular hypertension or uncontrolled glaucoma; and
6. A patient-specific, clinically significant reason why the member cannot use corticosteroid ophthalmic preparations, such as solution or suspension, must be provided; and
7. A patient-specific, clinically significant reason the member cannot use Triesence® (triamcinolone acetonide injection) must be provided; and
8. Initial authorization will be for 12 weeks, with an additional dose approved at or after 12 weeks if the prescriber documents improvement from baseline in visual acuity.

Recommendation 8: Vote to Prior Authorize Camcevi™ (Leuprolide), Pluvicto™ (Lutetium Lu 177 Vipivotide Tetraxetan), Tivdak® (Tisotumab Vedotin-tftv), and Welireg™ (Belzutifan) and Update the Approval Criteria for the Genitourinary and Cervical/Endometrial Cancer Medications

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the prior authorization of Camcevi™ (leuprolide), Pluvicto™ (lutetium Lu 177 vipivotide tetraxetan), Tivdak® (tisotumab vedotin-tftv), and Welireg™ (belzutifan) with the following criteria listed in red:

Camcevi™ (Leuprolide) Approval Criteria [Prostate Cancer Diagnosis]:

1. Diagnosis of advanced prostate cancer; and
2. A patient-specific, clinically significant reason why the member cannot use Eligard® (leuprolide acetate), Firmagon® (degarelix), and Lupron Depot® (leuprolide acetate) must be provided [reason(s) must address each medication].

Pluvicto® (Lutetium Lu 177 Vipivotide Tetraxetan) Approval Criteria [Prostate Cancer Diagnosis]:

1. Diagnosis of prostate-specific membrane antigen (PSMA)-positive metastatic castration-resistant prostate cancer (mCRPC); and
2. Member must have been treated with androgen receptor pathway inhibition and taxane-based chemotherapy.

Tivdak® (Tisotumab Vedotin-tftv) Approval Criteria [Cervical Cancer Diagnosis]:

1. Diagnosis of recurrent or metastatic cervical cancer; and
2. Disease has progressed on or after chemotherapy.

Welireg™ (Belzutifan) Approval Criteria:

1. Diagnosis of von Hippel-Landau (VHL) disease; and
2. Diagnosis of either renal cell carcinoma, central nervous system hemangioblastomas, or pancreatic neuroendocrine tumor; and
3. Does not require immediate surgery.

Additionally, the College of Pharmacy recommends updating the Cabometyx® (cabozantinib) prior authorization criteria based on the recent FDA approval (changes noted in red):

Cabometyx® (Cabozantinib) Approval Criteria:

1. For cabozantinib monotherapy:
    a. Diagnosis of advanced renal cell carcinoma (RCC); or
    b. Diagnosis of advanced hepatocellular carcinoma (HCC); and
        i. Member has previously received sorafenib; or
    c. Diagnosis of locally advanced or metastatic differentiated thyroid cancer (DTC) in adults and pediatric members 12 years of age and older; and
        i. Disease has progressed following prior vascular endothelial growth factor (VEGF)-targeted therapy; and
        ii. Disease is radioactive iodine-refractory or member is ineligible for radioactive iodine; or
2. For cabozantinib in combination with nivolumab:
    a. Diagnosis of relapsed or surgically unresectable stage 4 disease in the initial treatment of members with advanced RCC; and
    b. Nivolumab, when used in combination with cabozantinib for RCC, will be approved for a maximum duration of 2 years.

Recommendation 9: Annual Review of Colorectal Cancer Medications and 30-Day Notice to Prior Authorize Alymsys® (Bevacizumab-maly), Lonsurf® (Trifluridine/Tipiracil), and Stivarga® (Regorafenib)

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

Recommendation 10: Annual Review of Danyelza® (Naxitamab-gqgk), Koselugo® (Selumetinib), Pemazyre® (Pemigatinib), Qinlock® (Ripretinib), and Truseltiq® (Infigratinib)

NO ACTION REQUIRED.

Recommendation 11: Annual Review of Alzheimer's Disease Medications and 30-Day Notice to Prior Authorize Adlarity® (Donepezil Transdermal System) and Aduhelm® (Aducanumab-avwa)

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

Recommendation 12: Annual Review of Testosterone Products and 30-Day Notice to Prior Authorize Tlando® (Testosterone Undecanoate)

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

Recommendation 13: Annual Review of Various Systemic Antibiotics

NO ACTION REQUIRED.

Recommendation 14: Annual Review of Isturisa® (Osilodrostat) and 30-Day Notice to Prior Authorize Recorlev® (Levoketoconazole)

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

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

NO ACTION REQUIRED.

Recommendation 16: Future Business

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

NO ACTION REQUIRED.

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

Memorandum

Date: August 12, 2022

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 Packet Meeting on August 10, 2022

Recommendation 1: Use of Statins in Members with Diabetes Mellitus (DM)

NO ACTION REQUIRED.

Recommendation 2: 30-Day Notice to Prior Authorize Camzyos™ (Mavacamten)

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

Recommendation 3: Annual Review of Intravenous (IV) Iron Products

NO ACTION REQUIRED.

Recommendation 4: Annual Review of Ophthalmic Anti-Inflammatory Products

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

Recommendation 5: Annual Review of Opioid Analgesics and Opioid Medication Assisted Treatment (MAT) Medications

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

Recommendation 6: Annual Review of Topical Corticosteroids

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

Recommendation 7: U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration (DEA) Updates

NO ACTION REQUIRED.

Recommendation 8: Future Business

NO ACTION REQUIRED.

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
MINUTES OF MEETING SEPTEMBER 14, 2022

DUR BOARD MEMBERS:	PRESENT	ABSENT
Stephen Anderson, Pharm.D.		X
Jennifer de los Angeles, Pharm.D., BCOP	X	
Jennifer Boyett, MHS; PA-C		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
Thara Kottoor, Pharm.D.; Pharmacy Resident	X	
Morgan Masterson, Pharm.D; Clinical Pharmacist		X
Regan Moss, 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
Ashley Teel, Pharm.D.; Clinical Pharmacist		X
Jacquelyn Travers, Pharm.D.; Practice Facilitating Pharmacist	X	
Devin Wilcox, D.Ph.; Pharmacy Director	X	
Justin Wilson, Pharm.D.; Clinical Pharmacist	X	
PA Oncology Pharmacists: Tad Autry Pharm.D., BCPS, BCOP		X
Allison Baxley, Pharm.D., BCOP		X
Emily Borders, Pharm.D., 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
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	

Brandon Keppner; Chief Operating Officer	X	
Debra Montgomery, D.O.; Medical Director		X
Traylor Rains; State Medicaid Director		X
Jill Ratterman, D.Ph.; Clinical Pharmacist	X	
Paula Root, M.D.; Senior Medical Director, Interim Chief Medical Officer	X	
Shanna Simmons, Pharm.D.; Program Integrity Pharmacist	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:	
Steve Angelcyk, Embecta	Carole Eisner, Novartis
Lisa Davis, Organon	Burl Beasley, OMES
Matt Harju, Mirum Pharma	Eric Berthelot, Sobi
Phillip Lohec, Viatris	Sara Gao, AstraZeneca
Dena Sessions, Immunogen	Kenneth Berry, Alkermes
Jennifer Davis, Gilead	Caitlyn Scharn, Alnylam
Rick Dabner, Alnylam	Doug Pierce, Genentech
Rodney Brown, Genentech	Brent Parker, Merck
Robert Greely, Biogen	Bob Atkins, Biogen
Frank Alvarado, Johnson & Johnson	Marc Parker, Sunovion
Shellie Keast, Mercer	David Prather, Novo Nordisk

PRESENT FOR PUBLIC COMMENT:	
Robert Greely, Biogen	Caitlyn Scharn, Alnylam

AGENDA ITEM NO. 1: **CALL TO ORDER**
1A: ROLL CALL
Dr. Muchmore called the meeting to order at 4:02pm. Roll call by Dr. Wilcox did not establish the presence of a quorum.
ACTION: NONE REQUIRED

AGENDA ITEM NO. 2: **PUBLIC COMMENT FORUM**
2A: AGENDA ITEM NO. 9 ROBERT GREELY
2B: AGENDA ITEM NO. 15 CAITLYN SCHARN
ACTION: NONE REQUIRED

AGENDA ITEM NO. 3: **APPROVAL OF DUR BOARD MEETING MINUTES**
3A: JULY 13, 2022 DUR MINUTES
Materials included in agenda packet; presented by Dr. Muchmore
ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 4: **UPDATE ON MEDICATION COVERAGE AUTHORIZATION UNIT/NONALCOHOLIC FATTY LIVER DISEASE (NAFLD) OVERVIEW**
4A: PHARMACY HELPDESK ACTIVITY FOR AUGUST 2022
4B: MEDICATION COVERAGE ACTIVITY FOR AUGUST 2022
4C: NAFLD OVERVIEW
Materials included in agenda packet; presented by Dr. Moss, Dr. Wilson
ACTION: NONE REQUIRED

AGENDA ITEM NO. 5: **VOTE TO UPDATE THE APPROVAL CRITERIA FOR THE OPHTHALMIC ANTI-INFLAMMATORY PRODUCTS**

5A: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Moss

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 6: **VOTE TO PRIOR AUTHORIZE RECORLEV® (LEVOKETOCONAZOLE) AND UPDATE THE APPROVAL CRITERIA FOR ISTURISA® (OSILODROSTAT)**

6A: MARKET NEWS AND UPDATES

6B: RECORLEV® (LEVOKETOCONAZOLE) PRODUCT SUMMARY

6C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Moss

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 7: **VOTE TO PRIOR AUTHORIZE TLANDO® (TESTOSTERONE UNDECANOATE) AND UPDATE THE APPROVAL CRITERIA FOR THE TESTOSTERONE PRODUCTS**

7A: MARKET NEWS AND UPDATES

7B: COST COMPARISON

7C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Wilson

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 8: **VOTE TO UPDATE THE APPROVAL CRITERIA FOR THE OPIOID ANALGESICS AND MEDICATION-ASSISTED TREATMENT (MAT) MEDICATIONS**

8A: MARKET NEWS AND UPDATES

8B: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Chandler

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 9: **VOTE TO PRIOR AUTHORIZE ADLARITY® (DONEPEZIL TRANSDERMAL SYSTEM) AND ADUHELM® (ADUCANUMAB-AVWA)**

9A: MARKET NEWS AND UPDATES

9B: ADUHELM® (ADUCANUMAB-AVWA) PRODUCT SUMMARY

9C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. O'Halloran

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 10: **VOTE TO UPDATE THE APPROVAL CRITERIA FOR THE TOPICAL CORTICOSTEROIDS**

10A: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. O'Halloran

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 11: **VOTE TO PRIOR AUTHORIZE CAMZYOS™ (MAVACAMTEN)**

11A: MARKET NEWS AND UPDATES

11B: CAMZYOS™ (MAVACAMTEN) PRODUCT SUMMARY

11C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. O'Halloran

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 12: **VOTE TO PRIOR AUTHORIZE ALYMSYS® (BEVACIZUMAB-MALY), LONSURF® (TRIFLURIDINE/TIPIRACIL), AND STIVARGA® (REGORAFENIB) AND UPDATE THE APPROVAL CRITERIA FOR THE COLORECTAL CANCER MEDICATIONS**

12A: MARKET NEWS AND UPDATES
12B: PRODUCT SUMMARIES
12C: COLLEGE OF PHARMACY RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Borders

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 13: **ANNUAL REVIEW OF CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) MODULATORS**

13A: CURRENT PRIOR AUTHORIZATION CRITERIA
13B: UTILIZATION OF CFTR MODULATORS
13C: PRIOR AUTHORIZATION OF CFTR MODULATORS
13D: MARKET NEWS AND UPDATES
13E: COLLEGE OF PHARMACY RECOMMENDATIONS
13F: UTILIZATION DETAILS OF CFTR MODULATORS

Materials included in agenda packet; presented by Dr. O'Halloran

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 14: **ANNUAL REVIEW OF BREAST CANCER MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE HERCEPTIN HYLECTA™ (TRASTUZUMAB/HYALURONIDASE-OYSK)**

14A: INTRODUCTION
14B: CURRENT PRIOR AUTHORIZATION CRITERIA
14C: UTILIZATION OF BREAST CANCER MEDICATIONS
14D: PRIOR AUTHORIZATION OF BREAST CANCER MEDICATIONS
14E: MARKET NEWS AND UPDATES
14F: HERCEPTIN HYLECTA™ (TRASTUZUMAB/HYALURONIDASE-OYSK) PRODUCT SUMMARY
14G: COLLEGE OF PHARMACY RECOMMENDATIONS
14H: UTILIZATION DETAILS OF BREAST CANCER MEDICATIONS

Materials included in agenda packet; presented by Dr. Borders

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 15: **ANNUAL REVIEW OF AMYLOIDOSIS MEDICATIONS AND 30-DAY NOTICE TO PRIOR AUTHORIZE AMVUTTRA™ (VUTRISIRAN)**

15A: CURRENT PRIOR AUTHORIZATION CRITERIA
15B: UTILIZATION OF AMYLOIDOSIS MEDICATIONS
15C: PRIOR AUTHORIZATION OF AMYLOIDOSIS MEDICATIONS
15D: MARKET NEWS AND UPDATES
15E: AMVUTTRA™ (VUTRISIRAN) PRODUCT SUMMARY
15F: COLLEGE OF PHARMACY RECOMMENDATIONS
15G: UTILIZATION DETAILS OF AMYLOIDOSIS MEDICATIONS

Materials included in agenda packet; presented by Dr. Chandler

ACTION: NONE REQUIRED; WILL BE AN ACTION ITEM IN OCTOBER

AGENDA ITEM NO. 16: **ANNUAL REVIEW OF SYNAGIS® (PALIVIZUMAB)**

16A: CURRENT PRIOR AUTHORIZATION CRITERIA
16B: UTILIZATION OF SYNAGIS® (PALIVIZUMAB)
16C: PRIOR AUTHORIZATION OF SYNAGIS® (PALIVIZUMAB)
16D: RESPIRATORY SYNCYTIAL VIRUS (RSV) SEASON COMPARISON

16E: MARKET NEWS AND UPDATES
16F: COLLEGE OF PHARMACY RECOMMENDATIONS
Materials included in agenda packet; presented by Dr. Wilson
ACTION: NONE REQUIRED

AGENDA ITEM NO. 17: ANNUAL REVIEW OF NULIBRY® (FOSDENOPTERIN)
17A: CURRENT PRIOR AUTHORIZATION CRITERIA
17B: UTILIZATION OF NULIBRY® (FOSDENOPTERIN)
17C: PRIOR AUTHORIZATION OF NULIBRY® (FOSDENOPTERIN)
17D: MARKET NEWS AND UPDATES
17E: COLLEGE OF PHARMACY RECOMMENDATIONS
Materials included in agenda packet; presented by Dr. Moss
ACTION: NONE REQUIRED

AGENDA ITEM NO. 18: U.S. FOOD AND DRUG ADMINISTRATION (FDA) AND DRUG ENFORCEMENT ADMINISTATION (DEA) UPDATES
Materials included in agenda packet; presented by Dr. Moss
ACTION: NONE REQUIRED

AGENDA ITEM NO. 19: FUTURE BUSINESS* (UPCOMING PRODUCT AND CLASS REVIEWS)
19A: ANEMEIA MEDICATIONS
19B: HEPATITIS C MEDICATIONS
19C: SPINAL MUSCULAR ATROPHY (SMA) MEDICATIONS
19D: TARGETED IMMUNOMODULATOR AGENTS
*Future product and class reviews subject to change.
Materials included in agenda packet; presented by Dr. Adams
ACTION: NONE REQUIRED

AGENDA ITEM NO. 20: ADJOURNMENT
The meeting was adjourned at 5:20pm.

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

Memorandum

Date: September 16, 2022

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

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

Subject: DUR Board Recommendations from Meeting on September 14, 2022

Recommendation 1: Nonalcoholic Fatty Liver Disease (NAFLD) Overview

NO ACTION REQUIRED.

Recommendation 2: Vote to Update the Approval Criteria for the Ophthalmic Anti-Inflammatory Products

VOTE ITEM AT OCTOBER MEETING

The College of Pharmacy recommends making Durezol® (difluprednate 0.05%) brand preferred based on net costs (changes are shown in red in the following Tier chart):

Ophthalmic Corticosteroids	
Tier-1	**Tier-2**
dexamethasone 0.1% sus (Maxidex®)	fluorometholone 0.25% sus (FML Forte®)
dexamethasone sodium phosphate 0.1% sol	fluorometholone 0.1% oint (FML S.O.P®)
difluprednate 0.05% emu (Durezol®) – **Brand Preferred**	loteprednol 1% sus (Inveltys®)
fluorometholone 0.1% sus (Flarex®)	loteprednol 0.38% gel (Lotemax® SM)
fluorometholone 0.1% sus (FML Liquifilm®)	prednisolone acetate 1% sus (Pred Forte®)

Ophthalmic Corticosteroids	
Tier-1	**Tier-2**
loteprednol 0.5% gel, oint, sus (Lotemax®) – **Brand Preferred**	
prednisolone acetate 1% sus (Omnipred®)	
prednisolone acetate 0.12% sus (Pred Mild®)	
prednisolone sodium phosphate 1% sol	

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).
emu = emulsion; oint = ointment; sol = solution; sus = suspension

Ophthalmic Corticosteroids Tier-2 Approval Criteria:

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

Recommendation 3: Vote Prior Authorize Recorlev® (Levoketoconazole) and Update the Approval Criteria for Isturisa® (Osilodrostat)

VOTE ITEM AT OCTOBER MEETING

The College of Pharmacy recommends the prior authorization of Recorlev® (levoketoconazole) with the following criteria [changes shown in red indicate updates made based on Drug Utilization Review (DUR) Board recommendations and consistent with current treatment guidelines]:

Recorlev® (Levoketoconazole) Approval Criteria:

1. An FDA approved indication for the treatment of adult members with Cushing's disease for whom pituitary or adrenal surgery is not an option or has not been curative; and
2. Member must be 18 years of age or older; and
3. Recorlev® must be prescribed by, or in consultation with, an endocrinologist (or an advanced care practitioner with a supervising physician who is an endocrinologist); and
4. Prescriber must document that the member has had an inadequate response to pituitary or adrenal surgery or is not a candidate for pituitary or adrenal surgery; and
5. Prescriber agrees to obtain baseline liver test and electrocardiogram (ECG) prior to initiating treatment; and
6. Prescriber agrees to monitor liver enzymes and bilirubin weekly for at least 6 weeks after initiating treatment, every 2 weeks for the next 6 weeks, monthly for the next 3 months, and then as clinically indicated; and
7. Prescriber must verify that hypokalemia and hypomagnesemia are corrected prior to starting Recorlev®; and

8. Member must not be taking medications that cause QT prolongation associated with ventricular arrhythmias, including torsades de pointes (e.g., dofetilide, dronedarone, methadone, quinidine, ranolazine); and
9. Member must not be taking medications that are sensitive substrates of CYP3A4 and/or P-gp (e.g., digoxin, lovastatin, simvastatin, tacrolimus, triazolam); and
10. If the member is taking medications that are strong CYP3A4 inhibitors (e.g., ritonavir, mifepristone) or strong CYP3A4 inducers (e.g., isoniazid, carbamazepine, rifampicin, phenytoin), the prescriber must verify the medication will be stopped 2 weeks before and during treatment with Recorlev® per package labeling; and
11. For female members, prescriber must verify that the member is not breastfeeding; and
12. A patient-specific, clinically significant reason why the member cannot use ketoconazole tablets and metyrapone capsules must be provided; and
13. Initial authorizations will be for the duration of 3 months. Continued authorization at that time will require the prescriber to provide a recent 24-hour urine free cortisol (UFC) level within the normal range to demonstrate the effectiveness of this medication, and compliance will also be checked at that time. Subsequent approvals will be for the duration of 1 year and will require the prescriber to verify the member is still not a candidate for pituitary or adrenal surgery.

Additionally, the College of Pharmacy recommends updating the approval criteria for Isturisa® based on Drug Utilization Review (DUR) Board recommendations and consistent with current treatment guidelines (updates shown in red):

Isturisa® (Osilodrostat) Approval Criteria:

1. An FDA approved indication for the treatment of adult members with Cushing's disease for whom pituitary or adrenal surgery is not an option or has not been curative; and
2. Member must be 18 years of age or older; and
3. Prescriber must document that the member has had an inadequate response to pituitary or adrenal surgery or is not a candidate for pituitary or adrenal surgery; and
4. Prescriber must verify that hypokalemia and hypomagnesemia are corrected prior to starting Isturisa®; and
5. Prescriber must agree to perform and monitor electrocardiogram (ECG) at baseline, 1 week after treatment initiation, and as clinically indicated thereafter; and
6. Prescriber must verify that dose titration will be followed according to package labeling; and
7. If the member is taking strong CYP3A4 inhibitors (e.g., itraconazole, clarithromycin) or strong CYP3A4 and/or CYP2B6 inducers (e.g.,

carbamazepine, rifampin, phenobarbital), the prescriber must verify that the Isturisa® dose will be adjusted according to the package labeling; and

8. For female members, prescriber must verify that the member is not breastfeeding; and
9. Isturisa® must be prescribed by, or in consultation with, an endocrinologist (or an advanced care practitioner with a supervising physician who is an endocrinologist); and
10. A patient-specific, clinically significant reason why the member cannot use ketoconazole tablets and metyrapone capsules must be provided; and
11. Initial authorizations will be for the duration of 3 months after which time, compliance and 24-hour urine free cortisol levels within the normal range (to demonstrate the effectiveness of this medication) will be required for continued approval. Subsequent approvals will be for the duration of 1 year and will require the prescriber to verify the member is still not a candidate for pituitary or adrenal surgery.

Recommendation 4: Vote to Prior Authorize Tlando® (Testosterone Undecanoate) and Update the Approval Criteria for the Testosterone Products

VOTE ITEM AT OCTOBER MEETING

The College of Pharmacy recommends the following changes to the testosterone products Product Based Prior Authorization (PBPA) category based on new FDA approvals, product discontinuations, net costs, and recommendations from the Drug Utilization Review (DUR) Board (changes shown in red in the following Tier chart and approval criteria):

1. Placement of Tlando® (testosterone undecanoate) into the Special Prior Authorization (PA) Tier; and
2. Moving Androgel® (testosterone topical gel 1% packet and 1.62% packet) from Tier-1 to Tier-2; and
3. Moving Testim® (testosterone topical gel 1% tube) and Vogelxo® (testosterone topical gel 1% packet, 1% pump, and 1% tube) from Tier-2 to Tier-1; and
4. Updating the initial approval criteria for all testosterone products to verify evaluation of the member for a pituitary tumor as the potential cause of low testosterone prior to starting treatment with a testosterone product.

Testosterone Products		
Tier-1	**Tier-2**	**Special PA**
methyltestosterone powder	testosterone enanthate sub-Q auto-injector (Xyosted®)	fluoxymesterone oral tab (Androxy®)
testosterone cypionate IM inj (Depo-Testosterone®)	testosterone nasal gel (Natesto®)	methyltestosterone oral tab/cap (Android®, Methitest®, Testred®)
testosterone enanthate IM inj (Delatestryl®)	testosterone patch (Androderm®)	testosterone buccal tab (Striant®)
testosterone topical gel 1% (Testim®, Vogelxo®)	**testosterone topical gel 1%, 1.62% packet (Androgel®)**	testosterone pellets (Testopel®)
testosterone topical gel **1.62% pump** (Androgel® ~~**1%, 1.62%**~~) – **Brand Preferred**	testosterone topical gel **2% pump** (Fortesta®~~**, Testim®, Vogelxo®**~~)	testosterone undecanoate oral cap (Jatenzo®, **Tlando®)**
	testosterone topical solution (Axiron®)	
	testosterone undecanoate IM inj (Aveed®)	

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; IM = intramuscular; inj = injection; PA = prior authorization; sub-Q = subcutaneous; tab = tablet

Initial Approval Criteria for All Testosterone Products:

1. An FDA approved diagnosis of 1 of the following:
   a. Testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, or orchiectomy; or
   b. Idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency, or pituitary hypothalamic injury from tumors, trauma, or radiation; or
   c. Delayed puberty; or
   d. Advanced inoperable metastatic mammary cancer in females 1 to 5 years postmenopausal, or premenopausal females with breast cancer benefitting from oophorectomy and have been determined to have a hormone-responsive tumor; and
2. The prescriber must verify the member has been evaluated for the presence of a pituitary tumor as the potential cause of low testosterone and the member will receive appropriate follow-up and/or treatment as necessary; and
3. Must include 2 labs showing pre-medication, morning testosterone (total testosterone) levels <300ng/dL; and
4. Must include 1 lab showing abnormal gonadotropins and/or other information necessary to demonstrate diagnosis; or
5. Testosterone and gonadotropin labs are not required for authorization of testosterone therapy if documentation is provided for established hypothalamic pituitary or gonadal disease, if the pituitary gland or testes has/have been removed, or for postmenopausal females with advanced inoperable metastatic mammary cancer or premenopausal females with breast cancer benefitting from oophorectomy and that have been determined to have a hormone-responsive tumor.

Testosterone Products Tier-2 Approval Criteria:

1. All diagnoses and laboratory requirements listed in the initial approval criteria for all testosterone products must be met; and
2. Member must have a trial of at least 2 Tier-1 products (must include at least 1 injectable and 1 topical formulation) at least 12 weeks in duration; or
3. A patient-specific, clinically significant reason why member cannot use all available Tier-1 products must be provided; or
4. Prior stabilization on a Tier-2 product (within the past 180 days); and
5. Approvals will be for the duration of 1 year; and
6. For Xyosted® [testosterone enanthate subcutaneous (sub-Q) auto-injector]:
    a. Member must be trained by a health care professional on sub-Q administration and storage of Xyosted® sub-Q auto-injector.

Testosterone Products Special Prior Authorization (PA) Approval Criteria:

1. All diagnoses and laboratory requirements listed in the initial approval criteria for all testosterone products must be met; and
2. A patient-specific, clinically significant reason why member cannot use all other available formulations of testosterone must be provided; and
3. Approvals will be for the duration of 1 year.

Recommendation 5: Vote to Update the Approval Criteria for the Opioid Analgesics and Medication-Assisted Treatment (MAT) Medications

VOTE ITEM AT OCTOBER MEETING

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

1. Moving hydrocodone/ibuprofen 10/200mg tablet (Ibudone®, Reprexain™) from Tier-1 to Tier-2 of the Short-Acting Opioid Analgesics category based on net cost

Opioid Analgesics*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
Long-Acting			
buprenorphine patch (Butrans®) – **Brand Preferred**	fentanyl patch (Duragesic®)	buprenorphine ER buccal film (Belbuca®)	oxycodone/APAP ER tab (Xartemis® XR)
oxycodone ER tab 10mg, 15mg, 20mg only (OxyContin®) – **Brand Preferred**	morphine ER tab (MS Contin®)	hydrocodone ER cap (Zohydro® ER)	oxymorphone ER tab

Opioid Analgesics*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
Long-Acting			
	oxycodone ER tab 30mg, 40mg, 60mg, 80mg (OxyContin®) – **Brand Preferred**	hydrocodone ER tab (Hysingla® ER)	tramadol ER cap (ConZip®)
	tramadol ER tab (Ultram ER®, Ryzolt®)	hydromorphone ER tab (Exalgo®)	
		methadone tab and oral soln (Dolophine®)	
		morphine ER cap (Avinza®, Kadian®)	
		morphine ER tab (Arymo™ ER)	
		morphine ER tab (MorphaBond™)	
		oxycodone ER cap (Xtampza® ER)	
		oxycodone/ naltrexone ER cap (Troxyca® ER)	
Short-Acting			
APAP/butalbital/ caff/codeine cap (Fioricet® with Codeine)	**hydrocodone/IBU tab 10/200mg (Ibudone®, Reprexain™)**	benzhydrocodone/ APAP tab (Apadaz®)	levorphanol tab
ASA/butalbital/caff/ codeine cap (Fiorinal® with Codeine)	oxymorphone IR tab (Opana®)	dihydrocodeine/ APAP/caff cap (Trezix®)	tramadol 100mg tab
codeine tab	tapentadol IR tab (Nucynta®)	hydrocodone/ APAP oral soln (Zamicet®, Liquicet®)	tramadol oral soln (Qdolo™)

Opioid Analgesics*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
Short-Acting			
codeine/APAP tab (Tylenol® with Codeine)		hydrocodone/ APAP tab (Xodol®)	
dihydrocodeine/ ASA/caff cap (Synalgos-DC®)		oxycodone tab (Oxaydo®)	
hydrocodone/ APAP tab (Norco®)		oxycodone tab (RoxyBond™)	
hydrocodone/IBU tab **5/200mg, 7.5/200mg only** (Vicoprofen®, Ibudone®, Reprexain™)			
hydromorphone tab (Dilaudid®)			
morphine IR tab (MSIR®)			***Oncology Only:***
oxycodone/APAP tab (Percocet®)			fentanyl buccal film (Onsolis®)
oxycodone/ASA tab (Percodan®)			fentanyl buccal tab (Fentora®)
oxycodone IR cap (Oxy IR®)			fentanyl nasal spray (Lazanda®)
oxycodone IR tab (Roxicodone®)			fentanyl SL spray (Subsys®)
tramadol 50mg tab (Ultram®)			fentanyl SL tab (Abstral®)
tramadol/APAP tab (Ultracet®)			fentanyl transmucosal lozenge (Actiq®)

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

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

1. Removal of Bunavail® (buprenorphine/naloxone buccal film) based on product discontinuation

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

1. Generic buprenorphine/naloxone SL tablet is the preferred product. Authorization consideration of ~~Bunavail®,~~ Suboxone® films (brand and generic)~~,~~ and Zubsolv® requires a patient-specific, clinically significant reason why generic buprenorphine/naloxone SL tablets are not appropriate.
2. Subutex® (buprenorphine) 2mg and 8mg SL tablets will only be approved if the member is pregnant or has a documented serious allergy or adverse reaction to naloxone; and
3. Buprenorphine products FDA approved for a diagnosis of opioid abuse/dependence must be prescribed by a licensed practitioner who qualifies for a waiver under the Drug Addiction Treatment Act (DATA) and has notified the Center for Substance Abuse Treatment of the intention to treat addiction patients and has been assigned a Drug Enforcement Agency (DEA) X number; and
4. Member must have an FDA approved diagnosis of opioid abuse/dependence; and
5. Concomitant treatment with opioid analgesics (including tramadol) will be denied; and
6. Approvals will be for the duration of 90 days to allow for concurrent medication monitoring; and
7. The following limitations will apply:
    a. Suboxone® 2mg/0.5mg and 4mg/1mg SL tablets and films: A quantity limit of 90 SL units per 30 days will apply.
    b. Suboxone® 8mg/2mg SL tablets and films: A quantity limit of 60 SL units per 30 days will apply.
    c. Suboxone® 12mg/3mg SL films: A quantity limit of 30 SL films per 30 days will apply.
    d. Subutex® 2mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    e. Subutex® 8mg SL tablets: A quantity limit of 60 SL tablets per 30 days will apply.
    f. Zubsolv® 0.7mg/0.18mg, 1.4mg/0.36mg, and 2.9mg/0.71mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    g. Zubsolv® 5.7mg/1.4mg SL tablets: A quantity limit of 60 SL tablets per 30 days will apply.

h. Zubsolv® 8.6mg/2.1mg and 11.4mg/2.9mg SL tablets: A quantity limit of 30 SL tablets per 30 days will apply.
~~i. Bunavail® 2.1mg/0.3mg buccal films: A quantity limit of 90 buccal films per 30 days will apply.~~
~~j. Bunavail® 4.2mg/0.7mg buccal films: A quantity limit of 60 buccal films per 30 days will apply.~~
~~k. Bunavail® 6.3mg/1mg buccal films: A quantity limit of 30 buccal films per 30 days will apply.~~

Recommendation 6: Vote to Prior Authorize Adlarity® (Donepezil Transdermal System) and Aduhelm® (Aducanumab-avwa)

VOTE ITEM AT OCTOBER MEETING

The College of Pharmacy recommends the prior authorization of Adlarity® (donepezil transdermal system) as a special formulation product. The following criteria will apply:

Alzheimer's Disease Medications Approval Criteria:

1. Special formulation products including oral solutions, transdermal patches, and other convenience formulations require prior authorization with the following approval criteria:
   a. A patient-specific, clinically significant reason why the special formulation is necessary in place of the standard formulation.

Additionally, the College of Pharmacy recommends the prior authorization of Aduhelm® (aducanumab-avwa) with the following criteria:

Aduhelm® (Aducanumab-avwa) Approval Criteria:

1. An FDA approved diagnosis of mild cognitive impairment or mild dementia stage of Alzheimer's disease [stage 3 or stage 4 Alzheimer's disease based on the Global Deterioration Scale (GDS)]. Diagnosis must be confirmed by at least 2 of the following:
   a. Mini-Mental State Exam (MMSE) score between 24 and 30; or
   b. Clinical Dementia Rating Global Score (CDR-GS) equal to 0.5; or
   c. Montreal Cognitive Assessment (MoCA) score ≥19; or
   d. Quick Dementia Rating System (QDRS) score ≤5; and
2. Member must have presence of amyloid pathology confirmed by a positive amyloid positron emission tomography (PET) scan or cerebral spinal fluid (CSF) test; and
3. Aduhelm® must be prescribed by, or in consultation with, a neurologist (or an advanced care practitioner with a supervising physician who is a neurologist); and
4. Other known medical or neurological causes of dementia have been ruled out (i.e., vascular dementia, dementia with Lewy bodies, frontotemporal dementia, Parkinson's disease dementia); and

5. Member must not have brain hemorrhage, bleeding disorder, or cerebrovascular abnormalities that increase the risk of hemorrhage; and
6. Member must not be taking anticoagulant or antiplatelet agents except for aspirin 325mg per day or less; and
7. Member must not have had a stroke or transient ischemic attack (TIA) or unexplained loss of consciousness in the past year; and
8. Member must not have any contraindications to brain magnetic resonance imaging (MRI) or PET scans; and
9. Member must not have any pre-treatment localized superficial siderosis, ≥10 brain microhemorrhages, or a brain hemorrhage >1cm within 1 year of treatment initiation as safety with Aduhelm® has not been established in patients with these conditions; and
10. Member must have a recent (within 1 year) brain MRI prior to initiating treatment with Aduhelm® and prior to the 7th infusion (1st dose of 10mg/kg) and 12th infusion (6th dose of 10mg/kg); and
11. The prescriber must confirm that the member will be monitored for amyloid-related imaging abnormalities (ARIA) during the first 8 doses of treatment with Aduhelm®, particularly during titration, and also throughout treatment; and
12. If ≥10 new incident microhemorrhages or >2 focal areas of superficial siderosis [radiographic severe amyloid related imaging abnormalities-hemosiderin deposition (ARIA-H)] are observed on MRI, prescriber must confirm that treatment will be continued with caution and only after a clinical evaluation and a follow-up MRI demonstrating radiographic stabilization (i.e., no increase in size or number of ARIA-H); and
13. Aduhelm® must be administered by a health care provider; and
14. Aduhelm® must be shipped via cold chain supply shipping and stored in a refrigerator; and
15. Member's weight must be provided and have been taken within the last 4 weeks to ensure accurate weight-based dosing; and
16. Initial approvals will be for 6 months. Confirmation that MRI has been completed and is acceptable to the provider prior to 7th infusion is required for continuation; and
17. Subsequent approvals will be for 6 months and prescriber must document that the member has responded well to therapy compared to pretreatment baseline status as evidenced by improvement, stability, or slowing in cognitive and/or functional impairment using the same baseline test(s) performed at initiation of therapy; and
18. Approval quantities will be dependent on the member's weight and dosing based on the Aduhelm® *Prescribing Information*; and
19. The maximum dose approvable is 10mg/kg per 28 days.

Recommendation 7: Vote to Update the Approval Criteria for the Topical Corticosteroids

VOTE ITEM AT OCTOBER MEETING

The College of Pharmacy recommends the following changes to the topical corticosteroids Product Based Prior Authorization (PBPA) Tier chart based on net costs (changes shown in red in the following Tier chart):

1. Ultra-High to High Potency:
    a. Augmented betamethasone 0.05% gel from Tier-1 to Tier-2; and
    b. Augmented betamethasone 0.05% ointment from Tier-2 to Tier-1; and
    c. Betamethasone dipropionate 0.05% cream and ointment from Tier-2 to Tier-1; and
    d. Clobetasol propionate 0.05% lotion from Tier-1 to Tier-2; and
    e. Desoximetasone 0.25% cream and ointment from Tier-3 to Tier-1; and
    f. Fluocinonide 0.1% cream from Tier-2 to Tier-1; and
    g. Halobetasol 0.05% ointment from Tier-2 to Tier-1.
2. Medium-High to Medium Potency:
    a. Betamethasone valerate 0.1% lotion from Tier-1 to Tier-2; and
    b. Desoximetasone 0.05% cream and ointment from Tier-2 to Tier-3.
3. Low Potency:
    a. Alclometasone 0.05% ointment from Tier-2 to Tier-3.
    b. Desonate® (desonide 0.05%) gel from Tier-1 to Tier-3; and
    c. Desonide emollient 0.05% cream and ointment from Tier-3 to Tier-1; and
    d. Fluocinolone 0.01% solution from Tier-2 to Tier-1; and
    e. Fluocinolone 0.01% oil from Tier-3 to Tier-2.

Topical Corticosteroids					
Tier-1		**Tier-2**		**Tier-3**	
Ultra-High to High Potency					
augmented betamethasone dipropionate 0.05% (**Diprolene®,** Diprolene AF®)	C,~~**G,O**~~	amcinonide 0.1%	C,L	clobetasol propionate 0.05% (Clobex®)	Sh,Spr
betamethasone dipropionate 0.05% (Diprosone®)	**C,O**	augmented betamethasone dipropionate 0.05% (Diprolene®, **Diprolene AF®**)	**G**,L,~~**O**~~	clobetasol propionate 0.05% (Olux®, Olux-E®, Tovet®)	F
~~**clobetasol propionate 0.05% (Clobex®)**~~	~~**L**~~	~~**betamethasone dipropionate 0.05% (Diprosone®)**~~	~~**C,O**~~	clobetasol propionate 0.05% (Impeklo™)	L

Topical Corticosteroids					
Tier-1		**Tier-2**		**Tier-3**	
clobetasol propionate 0.05% (Temovate®)	C,O,So	**clobetasol propionate 0.05% (Clobex®)**	**L**	desoximetasone 0.25% (Topicort®)	~~C,O~~,Spr
desoximetasone 0.25% (Topicort®)	**C,O**	clobetasol propionate 0.05% (Temovate®)	G	diflorasone diacetate 0.05% (Apexicon®)	C,O
fluocinonide 0.05%	C,O,So	desoximetasone 0.05% (Topicort®)	G	diflorasone diacetate 0.05% (Apexicon E®)	C
fluocinonide 0.1% (Vanos®)	**C**	fluocinonide 0.05%	G	halobetasol propionate 0.01% (Bryhali®)	L
halobetasol propionate 0.05% (Ultravate®)	C,**O**	~~**fluocinonide 0.1% (Vanos®)**~~	~~**C**~~	halobetasol propionate 0.05% (Lexette®)	F
		flurandrenolide tape 0.05% (Cordran®)	Tape		
		halcinonide 0.1% (Halog®)	C,O,So		
		halobetasol propionate 0.05% (Ultravate®)	L,~~O~~		
Medium-High to Medium Potency					
betamethasone dipropionate 0.05%	L	betamethasone dipropionate/ calcipotriene 0.064%/ 0.005% (Taclonex®)	O,Spr, Sus	**desoximetasone 0.05% (Topicort LP®)**	**C,O**
betamethasone valerate 0.1% (Beta-Val®)	C,~~L~~,O	betamethasone valerate 0.12% (Luxiq®)	F	hydrocortisone valerate 0.2% (Westcort®)	C,O
fluticasone propionate 0.005% (Cutivate®)	O	**betamethasone valerate 0.1% (Beta-Val®)**	**L**		
fluticasone propionate 0.05% (Cutivate®)	C	calcipotriene/ betamethasone dipropionate 0.064%/0.005% (Enstilar®)	F		
mometasone furoate 0.1% (Elocon®)	C,L,O, So	clocortolone pivalate 0.1% (Cloderm®)	C		
triamcinolone acetonide 0.025%	O	~~**desoximetasone 0.05% (Topicort LP®)**~~	~~**C,O**~~		
triamcinolone acetonide 0.1%	C,L,O	fluocinolone acetonide 0.025% (Synalar®)	C,O		
triamcinolone acetonide 0.5%	C,O	fluocinonide emollient 0.05% (Lidex E®)	C		

Topical Corticosteroids					
Tier-1		**Tier-2**		**Tier-3**	
		flurandrenolide 0.05%	C,LO		
		fluticasone propionate 0.05% (Cutivate®)	L		
		hydrocortisone butyrate 0.1%	C,L,O, So		
		hydrocortisone probutate 0.1% (Pandel®)	C		
		prednicarbate 0.1% (Dermatop®)	C,O		
		triamcinolone acetonide 0.147mg/g (Kenalog®)	Spr		
Low Potency					
~~desonide 0.05% (Desonate®)~~	**~~G~~**	alclometasone dipropionate 0.05% (Aclovate®)	C,**~~O~~**	**alclometasone dipropionate 0.05% (Aclovate®)**	**O**
desonide emollient 0.05%	**C,O**	fluocinolone acetonide 0.01% (Synalar®)	C,**~~So~~**	**~~fluocinolone acetonide 0.01% (Derma-Smoothe®; Derma-Smoothe FS®)~~**	**~~Oil~~**
fluocinolone acetonide 0.01% (Capex®)	Sh	**fluocinolone acetonide 0.01% (Derma-Smoothe®; Derma-Smoothe FS®)**	**Oil**	desonide 0.05%	L
fluocinolone acetonide 0.01% (Synalar®)	**So**	hydrocortisone 2.5% (Texacort®)	So	**~~desonide emollient 0.05%~~**	**~~C~~,~~O~~**
hydrocortisone acetate 1%	C,O	hydrocortisone/ pramoxine 1%/1% (Pramosone®)	C,L	**desonide 0.05% (Desonate®)**	**G**
hydrocortisone acetate 2.5%	C,L,O				

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

Topical Corticosteroids Tier-2 Approval Criteria:

1. Documented trials of all Tier-1 topical corticosteroids of similar potency in the past 30 days that did not yield adequate relief; and
2. If Tier-1 trials are completed and do not yield adequate relief, the member must also provide a patient-specific, clinically significant reason for requesting a Tier-2 in the same potency instead of trying a higher potency; and

3. When the same medication is available in Tier-1, a patient-specific, clinically significant reason must be provided for using a special dosage formulation of that medication in Tier-2 (foams, shampoos, sprays, kits, etc.); and
4. Topical corticosteroid kits require tier trials and a patient-specific, clinically significant reason for use of the kit over standard formulations.

Topical Corticosteroids Tier-3 Approval Criteria:

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

Recommendation 8: Vote to Prior Authorize Camzyos™ (Mavacamten)

VOTE ITEM AT OCTOBER MEETING

The College of Pharmacy recommends the prior authorization of Camzyos™ (mavacamten) with the following criteria:

Camzyos™ (Mavacamten) Approval Criteria:

1. An FDA approved diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and
2. Member must be 18 years of age or older; and
3. Member must have New York Heart Association (NYHA) class II to III heart failure; and
4. Camzyos™ must be prescribed by, or in consultation with, a cardiologist (or an advanced care practitioner with a supervising physician who is a cardiologist); and
5. Member must have left ventricular ejection fraction (LVEF) ≥55%; and
6. Member must be on current treatment with or have a documented failure, contraindication, or intolerance to beta blockers or nondihydropyridine calcium channel blockers; and
7. Member must not be taking concurrent moderate to strong CYP2C19 inhibitors (e.g., proton pump inhibitors, clopidogrel, voriconazole, fluvoxamine), strong CYP3A4 inhibitors (e.g., itraconazole, ketoconazole,

ritonavir), moderate to strong CYP2C19 inducers (e.g., rifampicin, carbamazepine), or moderate to strong CYP3A4 inducers (e.g., rifampin, carbamazepine, phenytoin); and
8. Member must not be taking or planning to take disopyramide, ranolazine, or a combination of a beta blocker and a calcium channel blocker concomitantly with Camzyos™; and
9. Female members of reproductive potential must have a negative pregnancy test prior to initiation of therapy and must agree to use effective contraception during treatment and for 4 months after the final dose of Camzyos™; and
10. Prescriber, pharmacy, and member must be enrolled in the Camzyos™ Risk Evaluation and Mitigation Strategy (REMS) program and maintain enrollment throughout therapy; and
11. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment; and
12. Subsequent approvals will be for the duration of 1 year.

Recommendation 9: Vote to Prior Authorize Alymsys® (Bevacizumab-maly), Lonsurf® (Trifluridine/Tipiracil), and Stivarga® (Regorafenib) and Update the Approval Criteria for the Colorectal Cancer Medications

VOTE ITEM AT OCTOBER MEETING

The College of Pharmacy recommends the prior authorization of Alymsys® (bevacizumab-maly), Lonsurf® (trifluridine/tipiracil), and Stivarga® (regorafenib) with the following criteria (new criteria and updates listed in red):

Alymsys® (Bevacizumab-maly) and Mvasi® (Bevacizumab-awwb) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use Avastin® (bevacizumab) or Zirabev® (bevacizumab-bvzr), which are available without prior authorization, must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Lonsurf® (Trifluridine/Tipiracil) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of metastatic, recurrent, or unresectable CRC; and
2. Previously treated with a fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy; and

3. Previously treated with an anti-vascular endothelial growth factor (VEGF) therapy; and
    a. If RAS wild-type disease, previously treated with an anti-epidermal growth factor receptor (EGFR) therapy; and
4. Used as monotherapy or in combination with bevacizumab.

Lonsurf® (Trifluridine/Tipiracil) Approval Criteria [Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of metastatic gastric or GEJ adenocarcinoma; and
2. Previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, paclitaxel, docetaxel, or irinotecan; and
3. If human epidermal receptor type 2 (HER2) positive disease, prior treatment should have included HER2 targeted therapy.

Stivarga® (Regorafenib) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of metastatic, recurrent, or unresectable CRC; and
2. Previous treatment with a fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy; and
3. Previous treatment with an anti-vascular endothelial growth factor (VEGF) therapy; and
    a. If RAS wild-type disease, previously treated with an anti-epidermal growth factor receptor (EGFR) therapy.

Stivarga® (Regorafenib) Approval Criteria [Gastrointestinal Stromal Tumor (GIST) Diagnosis]:

1. Diagnosis of locally advanced unresectable or metastatic GIST; and
2. Previously treated with imatinib and sunitinib.

Stivarga® (Regorafenib) Approval Criteria [Hepatocellular Carcinoma (HCC) Diagnosis]:

1. Diagnosis of HCC; and
2. Previous treatment with sorafenib.

Additionally, the College of Pharmacy recommends updating the Enhertu® (fam-trastuzumab deruxtecan-nxki), Herceptin® (trastuzumab), Herzuma® (trastuzumab-pkrb), Kanjinti® (trastuzumab-anns), Ogivri® (trastuzumab-dkst), Ontruzant® (trastuzumab-dttb), Trazimera® (trastuzumab-qyyp), Keytruda® (pembrolizumab), Opdivo® (nivolumab), Perjeta® (pertuzumab), and Yervoy® (ipilimumab) prior authorization criteria based on FDA approvals, NCCN guideline recommendations, and net costs (changes noted in red):

Enhertu® (Fam-Trastuzumab Deruxtecan-nxki) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of advanced or metastatic disease; and
2. Disease has progressed on prior therapy; and
3. Human epidermal receptor type 2 (HER2) amplified disease; and

4. RAS and BRAF mutation negative; and
5. Used as a single agent.

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

1. Diagnosis of human epidermal receptor type 2 (HER2)-positive CRC; and
2. RAS and BRAF mutation negative; and
3. Used in combination with ~~trastuzumab~~ pertuzumab or lapatinib; and
4. Used in 1 of the following settings:
   a. If first-line therapy, member should not be a candidate for intensive therapy; or
   b. For the treatment of advanced or metastatic disease following disease progression; and
5. Authorization of Herceptin® (trastuzumab), Herzuma® (trastuzumab-pkrb), ~~or~~ Kanjinti® (trastuzumab-anns), or Ogivri® (trastuzumab-dkst) will also require a patient-specific, clinically significant reason why the member cannot use ~~Ogivri® (trastuzumab-dkst),~~ Ontruzant® (trastuzumab-dttb)~~,~~ or Trazimera® (trastuzumab-qyyp). Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

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

1. Diagnosis of unresectable or metastatic CRC; and
2. ~~First-line treatment; and~~
3. Tumor is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR).

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

1. Diagnosis of unresectable advanced or metastatic ESCC; and
   a. Used in the first-line setting; and
   b. Used in combination with 1 of the following:
      i. Fluoropyrimidine- and platinum-based chemotherapy; or
      ii. Ipilimumab; 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. Used in first-line setting; and
            1. Used in combination with oxaliplatin and fluorouracil or capecitabine; and
            2. Adenocarcinoma pathology; or
        ii. Used in the second-line or greater setting; and
            1. As a single agent; and
            2. Squamous cell pathology.

Opdivo® (Nivolumab) Approval Criteria [~~Metastatic~~ Colorectal Cancer (~~m~~CRC) Diagnosis]:

1. Diagnosis of unresectable or metastatic CRC; and
2. ~~Disease has progressed on treatment with 5-fluorouracil (5-FU), oxaliplatin, and irinotecan; and~~
3. Tumor is microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR).~~; and~~
4. ~~Used as a single agent or in combination with ipilimumab.~~

~~**Opdivo® (Nivolumab) Approval Criteria [Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) Metastatic Colorectal Cancer (mCRC) Diagnosis]:**~~

1. ~~A diagnosis of MSI-H or dMMR mCRC; and~~
2. ~~Member has not previously failed other PD-1 inhibitors [e.g., Keytruda® (pembrolizumab)]; and~~
3. ~~Progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan.~~

Perjeta® (Pertuzumab) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of human epidermal receptor type 2 (HER2)-positive CRC; and
2. RAS and BRAF mutation negative; and
3. Used in combination with trastuzumab; and
4. Used in 1 of the following settings:
    a. If first-line therapy, member should not be a candidate for intensive therapy; or
    b. For the treatment of advanced or metastatic disease following disease progression.

Yervoy® (Ipilimumab) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of unresectable or metastatic CRC; and
2. ~~Disease has progressed on treatment with 5-fluorouracil (5-FU), oxaliplatin, and irinotecan; and~~

3. Tumor is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and
4. Used in combination with nivolumab.

Yervoy® (Ipilimumab) Approval Criteria [Esophageal Squamous Cell Carcinoma (ESCC) Diagnosis]:

1. Diagnosis of unresectable advanced or metastatic ESCC; and
   a. Used in the first-line setting; and
   b. Used in combination with nivolumab.

Recommendation 10: Annual Review of Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) Modulators

VOTE ITEM AT OCTOBER MEETING

The College of Pharmacy recommends updating the current prior authorization criteria for the CFTR modulators to be consistent with clinical practice and updating the age restriction for Orkambi® based on the newly FDA approved age expansion (changes shown in red):

Kalydeco® (Ivacaftor) Approval Criteria:

1. An FDA approved diagnosis of cystic fibrosis (CF) with a mutation in the CF transmembrane conductance regulator *(CFTR)* gene detected by genetic testing that is responsive to ivacaftor based on clinical and/or *in vitro* assay data; and
2. Documentation must be submitted with results of *CFTR* genetic testing; and
3. Member must be 4 months of age or older; and
4. A quantity limit of 2 tablets or 2 granule packets per day or 56 tablets or granule packets per 28 days will apply; and
5. An age restriction of 4 months to younger than 6 years of age will apply to Kalydeco® oral granule packets. Members 6 years of age or older will require a patient-specific, clinically significant reason why the member cannot use the oral tablet formulation; and
6. Approvals will be based on the recommended dosing per package labeling based on the member's age and recent weight, if applicable. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
7. Initial approvals will be for the duration of 6 ~~3~~ months~~, after which time compliance will be required for continued approval~~. After 6 months of utilization, compliance and information regarding efficacy, such as improvement in forced expiratory volume in 1 second (FEV_1), will be required for continued approval; and
8. Subsequent approvals will be for the duration of 1 year.

Orkambi® (Lumacaftor/Ivacaftor) Approval Criteria:

1. An FDA approved diagnosis of cystic fibrosis (CF) in members who are homozygous for the *F508del* mutation in the CF transmembrane conductance regulator *(CFTR)* gene detected by genetic testing; and
2. If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the *F508del* mutation on both alleles of the *CFTR* gene; and
3. Orkambi® will not be approved for members with CF other than those homozygous for the *F508del* mutation; and
4. Member must be 12 months ~~2 years~~ of age or older; and
5. Members using Orkambi® must be supervised by a pulmonary disease specialist; and
6. Prescriber must verify that ALT, AST, and bilirubin will be assessed prior to initiating Orkambi®, every 3 months during the first year of treatment, and annually thereafter; and
7. Member must not be taking any of the following medications concomitantly with Orkambi®: rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John's wort; and
8. A quantity limit of 4 tablets per day or 112 tablets per 28 days will apply or a quantity limit of 2 granule packets per day or 56 packets per 28 days will apply; and
9. An age restriction of 12 months ~~2 years~~ to younger than 6 years of age will apply to Orkambi® oral granule packets. Members 6 years of age or older will require a patient-specific, clinically significant reason why the member cannot use the oral tablet formulation; and
10. Approvals will be based on the recommended dosing per package labeling based on the member's age and recent weight, if applicable. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
11. Initial approvals will be for the duration of 6 ~~3~~ months~~, after which time compliance will be required for continued approval~~. After 6 months of utilization, compliance and information regarding efficacy, such as improvement in forced expiratory volume in 1 second (FEV_1), will be required for continued approval; and
12. Subsequent approvals will be for the duration of 1 year.

Symdeko® (Tezacaftor/Ivacaftor and Ivacaftor) Approval Criteria:

1. An FDA approved diagnosis of cystic fibrosis (CF) in members who are homozygous for the *F508del* mutation or who have at least 1 mutation in the CF transmembrane conductance regulator *(CFTR)* gene detected by genetic testing that is responsive to tezacaftor/ivacaftor based on *in vitro* data and/or clinical evidence; and
2. If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a *CFTR* mutation followed by verification with bi-directional sequencing when recommended by the mutation test's instructions for use; and

3. Member must be 6 years of age or older; and
4. Members using Symdeko® must be supervised by a pulmonary disease specialist; and
5. If the member is currently stabilized on Orkambi® (lumacaftor/ivacaftor) and experiencing adverse effects associated with Orkambi® use, the prescriber must indicate that information on the prior authorization request; and
6. Prescriber must verify the member has been counseled on proper administration of Symdeko® including taking with a fat-containing food; and
7. Prescriber must verify that ALT, AST, and bilirubin will be assessed prior to initiating Symdeko®, every 3 months during the first year of treatment, and annually thereafter; and
8. Member must not be taking any of the following medications concomitantly with Symdeko®: rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John's wort; and
9. A quantity limit of 2 tablets per day or 56 tablets per 28 days will apply; and
10. Approvals will be based on the recommended dosing per package labeling based on the member's age and recent weight, if applicable. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
11. Initial approvals will be for the duration of 6 ~~3~~ months~~, after which time compliance will be required for continued approval~~. After 6 months of utilization, compliance and information regarding efficacy, such as improvement in forced expiratory volume in 1 second (FEV_1), will be required for continued approval. Additionally, after 6 months of utilization, information regarding efficacy as previously mentioned or fewer adverse events must be provided for members who switched from Orkambi® to Symdeko®; and
12. Subsequent approvals will be for the duration of 1 year.

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

1. An FDA approved diagnosis of cystic fibrosis (CF) in members who have at least 1 *F508del* mutation in the CF transmembrane conductance regulator *(CFTR)* gene or a mutation in the *CFTR* gene that is responsive based on *in vitro* data; and
2. If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a *CFTR* mutation followed by verification with bi-directional sequencing when recommended by the mutation test's instructions for use; and
3. Member must be 6 years of age or older; and
4. Members using Trikafta® must be supervised by a pulmonary disease specialist; and

5. If the member is currently stabilized on Orkambi® (lumacaftor/ivacaftor) or Symdeko® (tezacaftor/ivacaftor and ivacaftor) and experiencing adverse effects associated with Orkambi® or Symdeko® use, the prescriber must indicate that information on the prior authorization request; and
6. Prescriber must verify the member has been counseled on proper administration of Trikafta® including taking with a fat-containing food; and
7. Prescriber must verify that ALT, AST, and bilirubin will be assessed prior to initiating Trikafta®, every 3 months during the first year of treatment, and annually thereafter; and
8. Prescriber must verify the member does not have severe hepatic impairment; and
9. Prescriber must verify that pediatric members will receive baseline and follow-up ophthalmological examinations as recommended in the Trikafta® *Prescribing Information*; and
10. Member must not be taking any of the following medications concomitantly with Trikafta®: rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John's wort; and
11. ~~For members 6 to 11 years of age, the member's recent weight must be provided on the prior authorization request in order to authorize the appropriate dose according to package labeling, as follows:~~
    a. ~~Members 6 to 11 years of age weighing <30kg will be approved for Trikafta® (elexacaftor 50mg/tezacaftor 25mg/ivacaftor 37.5mg and ivacaftor 75mg) upon meeting approval criteria; or~~
    b. ~~Members 6 to 11 years of age weighing ≥30kg and members 12 years of age and older will be approved for Trikafta® (elexacaftor 100mg/tezacaftor 50mg/ivacaftor 75mg and ivacaftor 150mg) upon meeting approval criteria; and~~
12. A quantity limit of 3 tablets per day or 84 tablets per 28 days will apply; and
13. Approvals will be based on the recommended dosing per package labeling based on the member's age and recent weight, if applicable. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
14. Initial approvals will be for the duration of 6 ~~3~~ months~~, after which time compliance will be required for continued approval~~. After 6 months of utilization, compliance and information regarding efficacy, such as improvement in forced expiratory volume in 1 second (FEV_1), will be required for continued approval. Additionally, after 6 months of utilization, information regarding efficacy as previously mentioned or fewer adverse events than with a previous CFTR therapy must be provided for members who switched from Orkambi® or Symdeko® to Trikafta®; and
15. Subsequent approvals will be for the duration of 1 year.

Recommendation 11: Annual Review of Breast Cancer Medications and 30-Day Notice to Prior Authorize Herceptin Hylecta™ (Trastuzumab/Hyaluronidase-oysk)

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

Recommendation 12: Annual Review of Amyloidosis Medications and 30-Day Notice to Prior Authorize Amvuttra™ (Vutrisiran)

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

Recommendation 13: Annual Review of Synagis® (Palivizumab)

NO ACTION REQUIRED.

Recommendation 14: Annual Review of Nulibry® (Fosdenopterin)

NO ACTION REQUIRED.

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

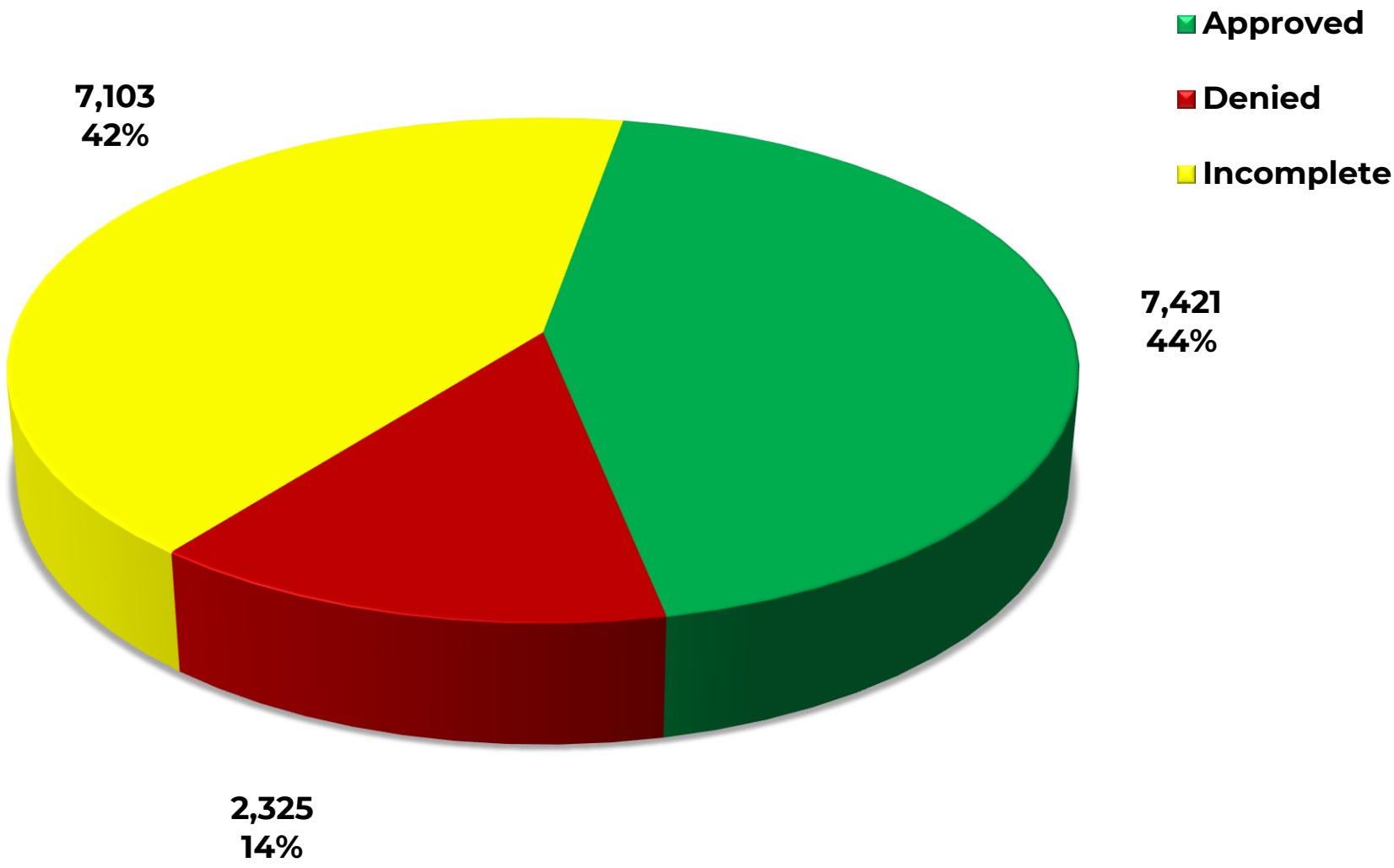
NO ACTION REQUIRED.

Recommendation 16: Future Business

NO ACTION REQUIRED.

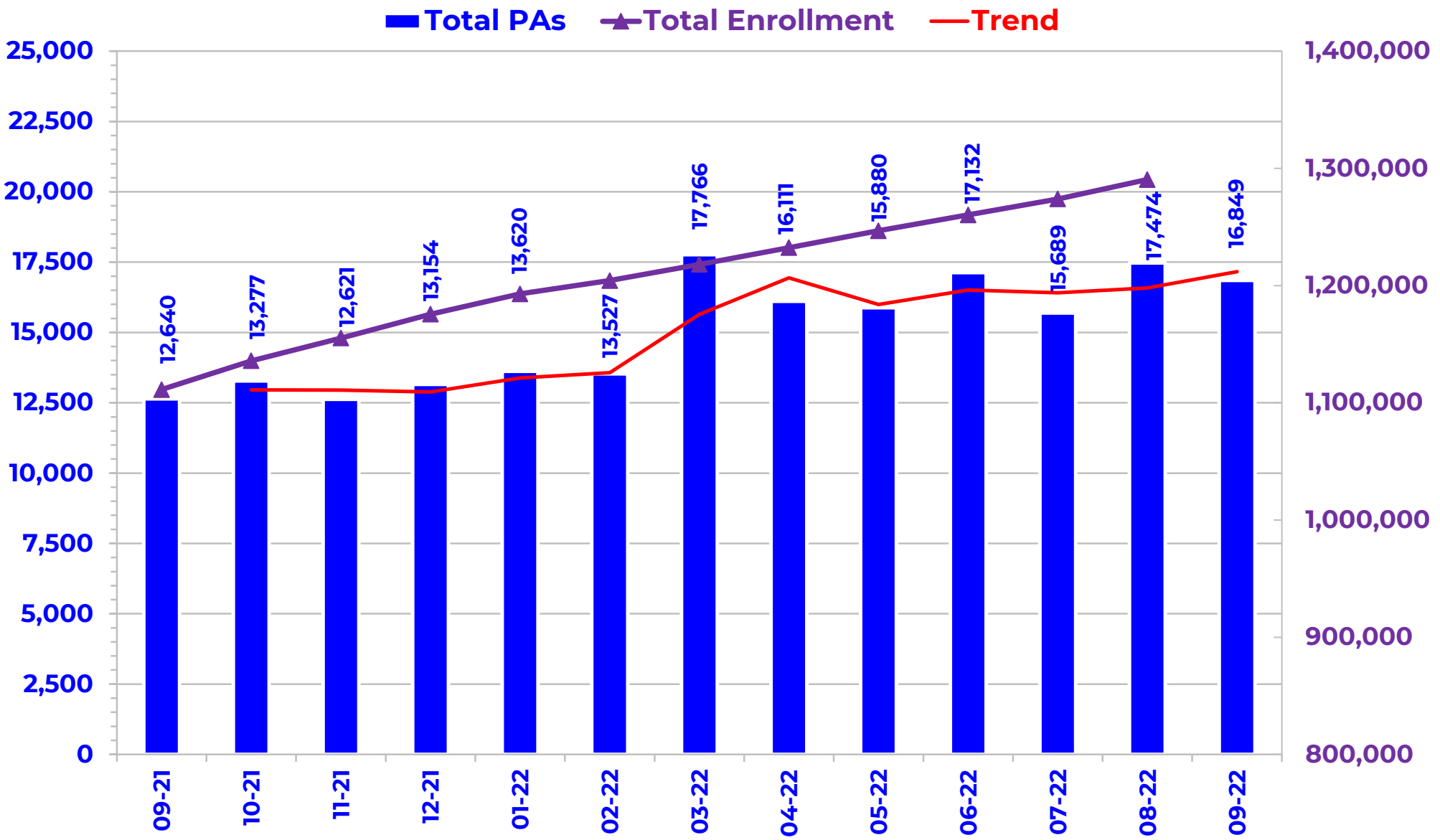
Appendix B

PRIOR AUTHORIZATION (PA) ACTIVITY REPORT: SEPTEMBER 2022



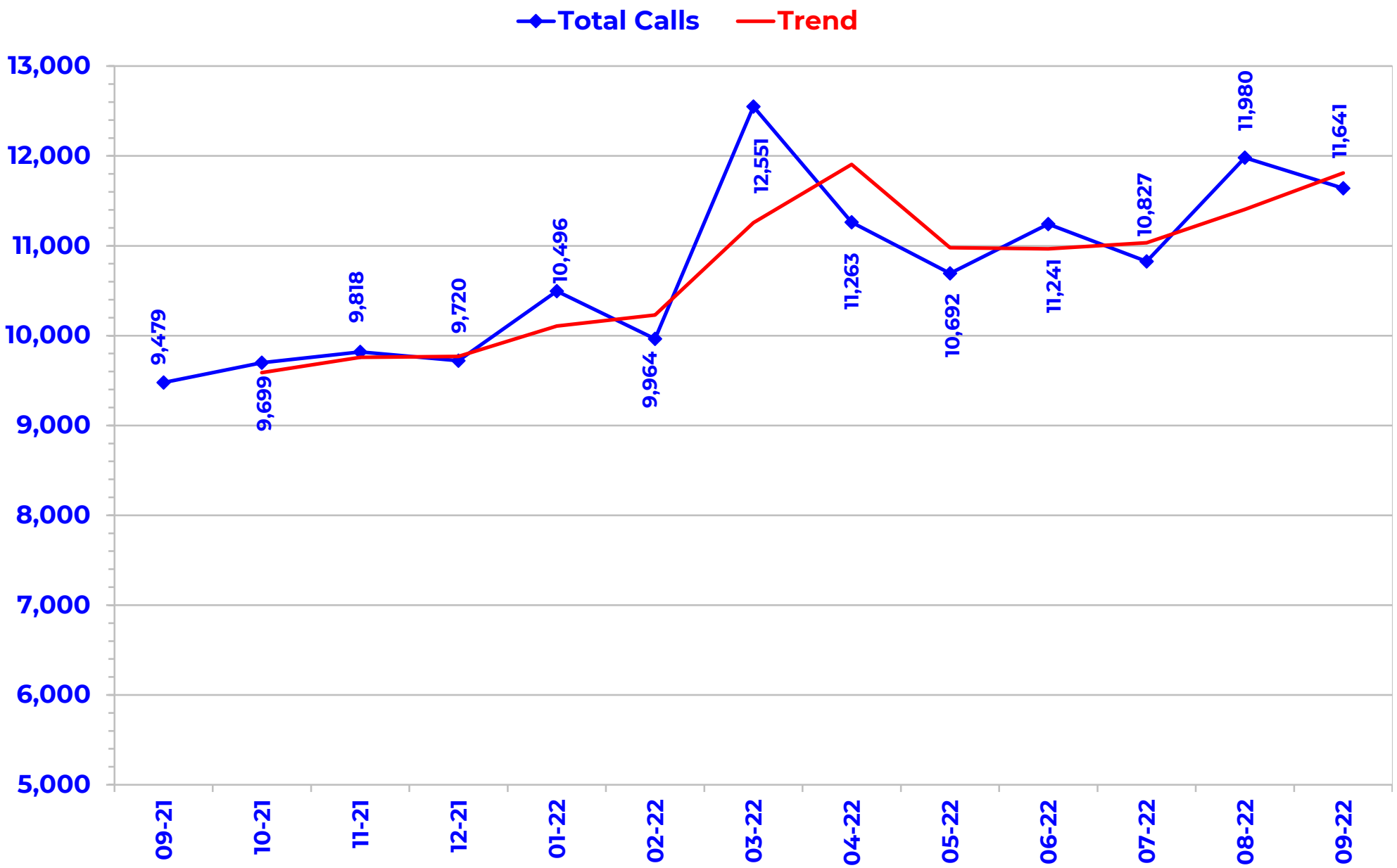
PA totals include approved/denied/incomplete/overrides

PRIOR AUTHORIZATION (PA) REPORT: SEPTEMBER 2021 – SEPTEMBER 2022



PA totals include approved/denied/incomplete/overrides

CALL VOLUME MONTHLY REPORT: SEPTEMBER 2021 – SEPTEMBER 2022



Prior Authorization Activity

9/1/2022 Through 9/30/2022

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort/Dulera	93	24	9	60	360
Analgesic - NonNarcotic	27	0	7	20	0
Analgesic, Narcotic	411	166	45	200	144
Angiotensin Receptor Antagonist	13	1	6	6	360
Antiasthma	101	27	29	45	246
Antibiotic	60	26	4	30	229
Anticonvulsant	233	107	15	111	299
Antidepressant	392	91	54	247	341
Antidiabetic	1,647	523	352	772	354
Antifungal	16	0	5	11	0
Antigout	16	5	3	8	318
Antihemophilic Factor	10	10	0	0	317
Antihistamine	69	15	18	36	324
Antimalarial Agent	155	118	4	33	340
Antimigraine	608	91	208	309	238
Antineoplastic	305	225	7	73	170
Antiobesity	33	3	24	6	298
Antiparasitic	36	12	2	22	41
Antiparkinsons	10	1	3	6	358
Antiulcers	41	6	13	22	112
Anxiolytic	36	4	3	29	291
Atypical Antipsychotics	563	247	43	273	345
Benign Prostatic Hypertrophy	22	1	11	10	360
Biologics	418	213	51	154	284
Bladder Control	108	9	41	58	291
Blood Thinners	749	432	35	282	340
Botox	90	48	27	15	351
Buprenorphine Medications	128	55	18	55	95
Calcium Channel Blockers	24	1	5	18	360
Cardiovascular	143	58	20	65	330
Chronic Obstructive Pulmonary Disease	294	62	59	173	332
Constipation/Diarrhea Medications	324	45	112	167	205
Contraceptive	44	16	10	18	359
Corticosteroid	32	6	14	12	253
Dermatological	531	164	155	212	215
Diabetic Supplies	948	317	172	459	243
Diuretic	15	6	2	7	305
Endocrine & Metabolic Drugs	125	54	10	61	196
Erythropoietin Stimulating Agents	25	13	1	11	121

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

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Estrogen Derivative	13	1	2	10	360
Fibric Acid Derivatives	11	1	1	9	360
Fibromyalgia	18	5	4	9	225
Fish Oils	21	5	9	7	359
Gastrointestinal Agents	221	41	44	136	224
Genitourinary Agents	20	4	3	13	193
Glaucoma	40	10	9	21	185
Growth Hormones	87	67	4	16	149
Hematopoietic Agents	28	13	2	13	247
Hepatitis C	111	75	11	25	8
HFA Rescue Inhalers	554	131	5	418	341
Insomnia	144	7	40	97	202
Insulin	337	135	28	174	349
Miscellaneous Antibiotics	27	6	6	15	17
Multiple Sclerosis	101	58	10	33	240
Muscle Relaxant	77	4	18	55	238
Nasal Allergy	43	4	10	29	107
Neurological Agents	169	47	34	88	203
Neuromuscular Agents	10	6	0	4	236
NSAIDs	41	1	9	31	85
Ocular Allergy	32	8	9	15	123
Ophthalmic	17	3	2	12	359
Ophthalmic Anti-infectives	36	14	2	20	16
Ophthalmic Corticosteroid	16	3	2	11	358
Osteoporosis	48	16	7	25	359
Other*	389	91	57	241	285
Otic Antibiotic	23	1	5	17	7
Pediculicide	10	2	1	7	28
Respiratory Agents	50	28	3	19	223
Smoking Cess.	10	0	2	8	0
Statins	65	9	11	45	147
Stimulant	2,007	1,339	98	570	349
Synagis	10	0	10	0	0
Testosterone	162	40	35	87	329
Thyroid	35	14	3	18	321
Topical Antifungal	66	7	17	42	138
Topical Corticosteroids	74	21	21	32	88
Vitamin	159	23	99	37	108
Pharmacotherapy	90	79	1	10	282
Emergency PAs	0	0	0	0	
Total	**14,267**	**5,521**	**2,231**	**6,515**	

* 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	30	17	0	13	284
Compound	13	10	0	3	14
Cumulative Early Refill	3	3	0	0	127
Diabetic Supplies	1	1	0	0	30
Dosage Change	446	415	4	27	17
High Dose	6	2	1	3	221
Ingredient Duplication	4	2	0	2	7
Lost/Broken Rx	188	164	6	18	19
MAT Override	321	249	5	67	74
NDC vs Age	367	235	37	95	272
NDC vs Sex	8	6	0	2	121
Nursing Home Issue	99	95	0	4	15
Opioid MME Limit	110	41	4	65	127
Opioid Quantity	46	37	1	8	155
Other	94	77	2	15	21
Quantity vs Days Supply	742	473	29	240	269
STBS/STBSM	20	16	0	4	86
Step Therapy Exception	21	8	2	11	347
Stolen	12	12	0	0	25
Third Brand Request	50	36	3	11	24
Wrong D.S. on Previous Rx	1	1	0	0	10
Overrides Total	**2,582**	**1,900**	**94**	**588**	
Total Regular PAs + Overrides	**16,849**	**7,421**	**2,325**	**7,103**	

Denial Reasons	
Unable to verify required trials.	5,860
Does not meet established criteria.	2,360
Lack required information to process request.	1,200
Other PA Activity	
Duplicate Requests	1,494
Letters	33,660
No Process	5
Changes to existing PAs	1,259
Helpdesk Initiated Prior Authorizations	1,145
PAs Missing Information	3

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

Fall 2022 Pipeline Update

Oklahoma Health Care Authority
October 2022

Introduction

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

Omecamtiv Mecarbil[1,2,3]

Anticipated Indication(s): Heart failure with reduced ejection fraction (HFrEF)

Clinical Trial(s): In February 2022, the FDA accepted a New Drug Application (NDA) for omecamtiv mecarbil, a novel, selective cardiac myosin activator for the treatment of HFrEF. Omecamtiv mecarbil works by stimulating cardiac myosin, a protein that allows the heart to contract and is designed to improve cardiac muscle performance, potentially helping patients preserve cardiac function and avoid hospitalization. A Phase 3 randomized, placebo-controlled trial enrolled 8,256 patients with symptomatic chronic heart failure (HF) with an ejection fraction (EF) ≤35%. In this trial, GALACTIC-HF, after a median duration of 21.8 months, the study demonstrated a statistically significant effect of treatment with omecamtiv mecarbil to reduce the risk of the primary endpoint of cardiovascular (CV) death or HF events when compared to placebo [hazard ratio (HR): 0.92; 95% confidence interval (CI): 0.89, 0.99; P=0.0252]. No reduction in the secondary endpoint of time to CV death was observed.

Place in Therapy: HFrEF is characterized by decreased systolic function leading to reduced cardiac output and increased filling pressure. An angiotensin receptor neprilysin inhibitor (ARNI) is the treatment of choice in HFrEF to reduce morbidity and mortality. Angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) may also be used for patients with New York Heart Association (NYHA) Class II or III HF. Other

agents used to treat HF include beta blockers, mineralocorticoid receptor antagonists, sodium-glucose cotransporter 2 (SGLT2) inhibitors, diuretics, ivabradine, vericiguat, digoxin, and isosorbide dinitrate. Currently, there are no medications that directly enhance systolic function that have improved outcomes. If FDA approved, omecamtiv mecarbil will be the first cardiac myosin activator to treat HFrEF.

Projected FDA Decision: February 2023

SoonerCare Impact: During fiscal year 2022 (07/01/2021 to 06/30/2022), there were 163,107 paid pharmacy claims for HF medications for 45,905 unique members, which accounted for a total cost of $2,677,364.64 and an average cost per claim of $16.41. These costs do not reflect rebated cost or net costs. During fiscal year 2022, there were 1,832 unique members with a diagnosis of unspecified (congestive) HF.

Zavegepant[4,5,6]

Anticipated Indication(s): Acute treatment of migraines in adults

Clinical Trial(s): In May 2022, the FDA accepted an NDA for zavegepant, a calcitonin gene-related peptide (CGRP) receptor antagonist administered as a single intranasal dose to treat an acute migraine attack. The data was supported from 2 double-blind, randomized, placebo-controlled trials: a Phase 2/3 dose-ranging trial and a Phase 3 single-dose trial. In the Phase 3 clinical trial, patients who used zavegepant nasal spray for acute migraine treatment had relief within 15 minutes after use. Pain was relieved in 15.9% vs. 8.0% ($P<0.001$) of patients whose migraine attacks were treated with zavegepant vs. placebo, respectively, and increased to 43.3% vs. 37.3% of patients with pain relief ($P=0.029$) at 1 hour. A proportion of patients treated with zavegepant compared to placebo had sustained pain relief for 48 hours (36.1% vs. 29.6%; $P=0.013$). No serious adverse events occurred, and the most common mild adverse effects were dysgeusia (20.5% vs. 4.7%), nasal discomfort (3.7% vs. 0.8%), and nausea (3.2% vs. 1.1%) between zavegepant and placebo, respectively.

Place in Therapy: Triptans are the drug of choice for acute treatment of migraine episodes. Oral CGRP inhibitors approved to treat acute migraine episodes include rimegepant (Nurtec® ODT) and ubrogepant (Ubrelvy®). If FDA approved, zavegepant will be the first intranasal CGRP inhibitor for the acute treatment of migraines.

Projected FDA Decision: January to March 2023

SoonerCare Impact: During fiscal year 2022 (07/01/2021 to 06/30/2022), there were 406 paid pharmacy claims for CGRP receptor antagonists for treatment

of acute migraine episodes for 136 unique members, which accounted for a total cost of $400,118.05 and an average cost per claim of $985.51. These costs do not reflect rebated cost or net costs.

Exagamglogene Autotemcel (Exa-cel)[7,8,9]

Anticipated Indication(s): Sickle cell disease (SCD) and beta thalassemia

Clinical Trial(s): In the Phase 2/3 CLIMB-SCD-121 trial, the safety and effectiveness of a single dose of exa-cel, an experimental gene-editing cell therapy, were evaluated in patients 12 to 35 years of age with severe SCD. Severe SCD was defined as having at least 2 severe vaso-occlusive crises (VOCs) per year in the 2 years before enrollment. The primary outcome was the proportion of patients who did not have any severe VOCs for at least a year after dosing. Thirty-one patients were followed between 5 to 32.3 months, and the results showed that exa-cel was safe and led to increased beta hemoglobin levels as well as a reduction in VOCs. After exa-cel infusions, all 31 patients were free of VOCs for the duration of follow-up and no serious adverse effects were reported.

Similar responses were seen in the 44 patients with beta thalassemia enrolled in the CLIMB-Thal-111 trial. Exa-cel led to a sustained increase in beta hemoglobin, and 42 patients remained transfusion free. The remaining 2 patients who were not yet transfusion free also showed significant progress, with 75% and 89% reductions in transfusion volume and an increase in fetal hemoglobin and total hemoglobin levels. Two patients reported adverse effects related to exa-cel treatment. One patient had a severe life-threatening immune reaction, and another patient had low blood platelets and delayed neutrophil engraftment. Both cases of serious adverse effects have been resolved.

Currently 2 Phase 3 trials are underway for children 2 to 11 years of age with severe SCD and in children with transfusion-dependent beta thalassemia.

Place in Therapy: SCD is a blood disorder in which the red blood cells are misshaped and can cause blocked blood vessels, which can lead to severe VOCs. Beta thalassemia is an inherited disorder in which the hemoglobin is produced by the body in less than normal amounts. After harvesting stem cells from a patient with SCD or beta thalassemia, exa-cel modifies the patient's DNA using CRISPR gene editing technology to reactivate a form of hemoglobin that is typically formed in infancy; the modified cells are then put back inside the patient's body to boost the production of healthy blood cells.

In August 2022, the FDA approved Zynteglo® (betibeglogene autotemcel), a cell-based gene therapy for the treatment of adult and pediatric patients with beta thalassemia who require regular blood transfusions. If exa-cel is

FDA approved, it will target the same population as Zynteglo®, but will also target patients with SCD, and it would become the first marketed therapy based on the CRISPR gene editing technology.

Projected FDA Decision: Q3 2023

SoonerCare Impact: During fiscal year 2022 (07/01/2021 to 06/30/2022), there were 68 unique SoonerCare members with a diagnosis of beta thalassemia and 338 unique members with a diagnosis of SCD.

Pipeline Table[10,11]

Medication Name*	Manufacturer	Therapeutic Use	Route of Admin	Approval Status	Anticipated FDA Response
Aflibercept	Viatris/Janssen	DME; DM retinopathy	Intra-vitreal	BLA	10/2022
Adalimumab 50mg/mL	Fresenius	RA; AS; PSO; PsA; JIA; CD; UC	SC	BLA	10/2022
Apomorphine Infusion Pump	Supernus	PD	SC	NDA	10/2022
Furosemide	scPharma-ceuticals	Decompensated HF	SC	NDA	10/2022
Cipaglucosidase Alfa	Amicus	Pompe disease	IV	BLA; Brk Thru; OD	10/2022
Etranacogene Dezaparvovec	CSL Behring	Hemophilia B	IV	BLA; Brk Thru; OD	11/2022
Omidenepag Isopropyl	Santen	Glaucoma and ocular HTN	OPH	NDA	11/2022
Sparsentan	Travere/Bristol-Myers Squibb	Berger's disease	PO	NDA; Brk Thru; OD	11/2022
Teplizumab	Provention Bio	T1DM	IV	BLA; Brk Thru; OD	11/2022
Omaveloxolone	Reata/AbbVie	Friedreich's ataxia	PO	NDA; Fst Trk; OD	11/2022
Adalimumab 100mg/mL	Alvotech	RA; AS; PSO; PsA; JIA; CD; UC	SC	BLA	12/2022
Ublituximab	TG Therapeutics	Relapsing MS	IV	BLA	12/2022
Palovarotene	Ipsen	Fibro dysplasia ossificans progressive	PO	NDA; Brk Thru; OD	12/2022
Sodium Phenylbutyrate	Acer	Urea cycle disorders	PO	NDA	01/2023
Budesonide/ Albuterol	AstraZeneca	Asthma	INH	NDA	01/2023-02/2023
Zavegepant	Biohaven/Bristol-Myers Squibb	Migraine Treatment	IN	NDA	01/2023-03/2023

Medication Name*	Manufacturer	Therapeutic Use	Route of Admin	Approval Status	Anticipated FDA Response
Lecanemab	Eisai/Biogen	Alzheimer's Disease (early)	IV	BLA; Brk Thru; Fst Trk	01/2023
Daprodustat	GlaxoSmithKline	Anemia of CKD	PO	NDA	02/2023
Omecamtiv Mecarbil	Cytokinetics	HFrEF	PO	NDA; Fst Trk	02/2023
Tixagevimab/ Cilgavimab	AstraZeneca	COVID-19	IM, IV	BLA	03/2023
Trofinetide	Acadia	Rett syndrome	PO	NDA; Fst Trk; OD	03/2023
Anthrax Vaccine, Adsorbed	Emergent	Anthrax infection	IM	BLA; Fst Trk	04/2023
Mirikizumab	Eli Lilly	UC	IV, SC	BLA	04/2023
Foscarbidopa/ Foslevodopa	AbbVie	PD motor fluctuations	SC	NDA	05/2023
Sotagliflozin	Lexicon	HF in patients with T2DM	PO	NDA	05/2023
Efanesoctocog Alfa	Sanofi	Hemophilia A	IV	BLA; Brk Thru; Fst Trk; OD	06/2023
Landiolol	Eagle	Supraventricular tachycardia	IV	NDA	06/2023
Beremagene Geperpavec	Krystal	Epidermolysis bullosa	Topical	BLA; Brk Thru; Fst Trk; OD	06/2023
Fezolinetant	Astellas	Menopause vasomotor symptoms	PO	NDA	06/2023
Nirmatrelvir/ritonavir (Paxlovid)	Pfizer	COVID-19	PO	NDA	06/2023
Exa-cel (Exagamglogene Autotemcel)	Vertex/CRISPR Therapeutics	SCD and TDT	IV, IM	BLA expected Q4 2022	Q3 2023

*Most biosimilars and oncology medications are excluded from the table. Medications known to have received a Complete Response Letter (CRL) from the FDA that have not resubmitted were also excluded.
AS = ankylosing spondylitis; BLA = Biologic License Application; Brk Thru = breakthrough; CD = Crohn's disease; CKD = chronic kidney disease; DM = diabetes mellitus; DME = diabetic macular edema; Fst Trk = fast track; HF = heart failure; HFrEF = heart failure with reduced ejection fraction; HTN = hypertension; IM = intramuscular; IN = intranasal; INH = inhaled; IV = intravenous; JIA = juvenile idiopathic arthritis; MS = multiple sclerosis; NDA = New Drug Application; OD = orphan drug; OPH = ophthalmic; PD = Parkinson's disease; PO = by mouth; PsA = psoriatic arthritis; PSO = plaque psoriasis, RA = rheumatoid arthritis, SC = subcutaneous; SCD = sickle cell disease; T1DM = type 1 diabetes mellitus; T2DM = type 2 diabetes mellitus; TDT = transfusion-dependent beta thalassemia; UC = ulcerative colitis

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Appendix C

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

Oklahoma Health Care Authority
October 2022

Recommendations

The College of Pharmacy recommends making Durezol® (difluprednate 0.05%) brand preferred based on net costs (changes are shown in red in the following Tier chart):

Ophthalmic Corticosteroids	
Tier-1	**Tier-2**
dexamethasone 0.1% sus (Maxidex®)	fluorometholone 0.25% sus (FML Forte®)
dexamethasone sodium phosphate 0.1% sol	fluorometholone 0.1% oint (FML S.O.P®)
difluprednate 0.05% emu (Durezol®) – **Brand Preferred**	loteprednol 1% sus (Inveltys®)
fluorometholone 0.1% sus (Flarex®)	loteprednol 0.38% gel (Lotemax® SM)
fluorometholone 0.1% sus (FML Liquifilm®)	prednisolone acetate 1% sus (Pred Forte®)
loteprednol 0.5% gel, oint, sus (Lotemax®) – **Brand Preferred**	
prednisolone acetate 1% sus (Omnipred®)	
prednisolone acetate 0.12% sus (Pred Mild®)	
prednisolone sodium phosphate 1% sol	

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).
emu = emulsion; oint = ointment; sol = solution; sus = suspension

Ophthalmic Corticosteroids Tier-2 Approval Criteria:

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

Vote to Prior Authorize Recorlev® (Levoketoconazole) and Update the Approval Criteria for Isturisa® (Osilodrostat)

Oklahoma Health Care Authority
October 2022

Market News and Updates[1]

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

- **December 2021:** The FDA approved Recorlev® (levoketoconazole) for the treatment of endogenous hypercortisolemia in adult patients with Cushing's syndrome (CS) for whom surgery is not an option or has not been curative. CS is a rare and serious endocrine disease caused by elevated cortisol level exposure often due to a benign tumor of the pituitary gland. This disease is most common in adults 30-50 years of age and affects women 3 times more than men. Metabolic changes such as diabetes, high blood pressure, high cholesterol, and psychological disturbances such as depression can occur in patients with CS. If untreated, the 5-year survival rate is approximately 50%. Recorlev® is a pure 2S, 4R enantiomer of ketoconazole and works by inhibiting cortisol synthesis. The approval of Recorlev® was based on 2 Phase 3 studies in 166 patients with CS. Both studies met their primary and key secondary endpoints which included reducing and normalizing mean urinary free cortisol concentrations without a dose increase and normalizing and maintaining therapeutic response compared to placebo.

Recorlev® (Levoketoconazole) Product Summary[2]

Indication(s): Treatment of endogenous hypercortisolemia in adult patients with CS for whom surgery is not an option or has not been curative

How Supplied: 150mg oral tablet

Dosing:

- The initial dosage is 150mg orally twice daily. Dosage may be titrated by 150mg daily, no more frequently than every 2-3 weeks.
- The maximum recommended dosage is 1,200mg daily, administered as 600mg [(4) 150mg tablets] twice daily.

Boxed Warning: Hepatotoxicity and QT Prolongation

- Hepatotoxicity:
  - Cases of hepatotoxicity with a fatal outcome or requiring liver transplantation have been reported with use of oral ketoconazole.
  - Liver enzymes should be evaluated prior to and during treatment.
- QT Prolongation:
  - Recorlev® is associated with a dose-related QT interval prolongation and may lead to life-threatening ventricular dysrhythmias.
  - A baseline electrocardiogram should be obtained prior to initiating therapy.
  - Hypokalemia and hypomagnesemia should be corrected prior to initiating therapy.

Warnings/Precautions:

- Hypocortisolism: Dosage reduction or interruption may be necessary if urine free cortisol or morning serum or plasma cortisol levels fall below the target range. Exogenous glucocorticoid replacement therapy should be administered if cortisol levels are below target range and signs and/or symptoms of adrenal insufficiency or hypocortisolism are present.
- Risks Related to Decreased Testosterone: Decreased testosterone may be seen in both men and women. Potential clinical manifestations of decreased testosterone concentrations in men may include gynecomastia, impotence, and oligospermia. Potential clinical manifestations of decreased testosterone in women include decreased libido and mood changes.

Mechanism of Action: Levoketoconazole inhibits key steps in the synthesis of cortisol and testosterone, principally mediated by CYP11B1, CYP11A1, and CYP17A1.

Contraindication(s):

- Cirrhosis, acute liver disease, or poorly controlled chronic liver disease, baseline AST or ALT >3 times the upper limit of normal (ULN), recurrent symptomatic cholelithiasis, a prior history of drug induced liver injury due to any azole antifungal therapy that required discontinuation of treatment, or extensive metastatic liver disease
- Taking drugs that cause QT prolongation associated with ventricular arrhythmias, including torsades de pointes
- Prolonged QTcF interval >470msec at baseline, history of torsades de pointes, ventricular tachycardia, ventricular fibrillation, or prolonged QT syndrome

- Taking certain drugs that are sensitive substrates of CYP3A4 and/or P-gp (e.g., ritonavir, mifepristone, isoniazid, carbamazepine, phenytoin)

Use in Specific Populations:

- Pregnancy: There is insufficient data to evaluate the drug associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. In animal reproduction studies, embryotoxic effects were observed in pregnant mice, rats, and rabbits, and fetal malformations were observed in rats.
- Pediatric Use: The safety and efficacy of levoketoconazole have not been established in pediatric patients younger than 18 years of age.
- Geriatric Use: Of the 166 patients in the clinical studies, 12 patients (7%) were 65 years of age and older. There was an insufficient number of patients 65 years of age and older to determine whether they responded differently from younger adult patients.

Adverse Reactions: The most common adverse reactions reported in clinical studies (incidence >20%) were nausea/vomiting, hypokalemia, hemorrhage/ contusion, systemic hypertension, headache, hepatic injury, abnormal uterine bleeding, erythema, fatigue, abdominal pain/dyspepsia, arthritis, upper respiratory infection, myalgia, arrhythmia, back pain, insomnia/sleep disturbances, and peripheral edema.

Cost Comparison:

Medication	Cost Per Unit	Cost Per Year*
Recorlev® (levoketoconazole) 150mg tablet	**$270.00**	**$777,600.00**
Isturisa® (osilodrostat) 10mg tablet	$529.12	$1,142,899.20
Metopirone® (metyrapone) 250mg capsule	$40.26	$347,846.40
ketoconazole 200mg tablet	$0.78	$1,684.80

Costs do not reflect rebated prices or net costs.
Cost of therapy calculated based on wholesale acquisition cost (WAC).
Unit = tablet or capsule
*Cost per year based on maximum recommended dosage of 1,200mg per day for levoketoconazole and ketoconazole, 60mg per day for osilodrostat, and 6g per day for metyrapone.

Recommendations[3]

The College of Pharmacy recommends the prior authorization of Recorlev® (levoketoconazole) with the following criteria [changes shown in red indicate updates made based on Drug Utilization Review (DUR) Board recommendations and consistent with current treatment guidelines]:

Recorlev® (Levoketoconazole) Approval Criteria:

1. An FDA approved indication for the treatment of adult members with Cushing's disease for whom pituitary or adrenal surgery is not an option or has not been curative; and
2. Member must be 18 years of age or older; and
3. Recorlev® must be prescribed by, or in consultation with, an endocrinologist (or an advanced care practitioner with a supervising physician who is an endocrinologist); and
4. Prescriber must document that the member has had an inadequate response to pituitary or adrenal surgery or is not a candidate for pituitary or adrenal surgery; and
5. Prescriber agrees to obtain baseline liver test and electrocardiogram (ECG) prior to initiating treatment; and
6. Prescriber agrees to monitor liver enzymes and bilirubin weekly for at least 6 weeks after initiating treatment, every 2 weeks for the next 6 weeks, monthly for the next 3 months, and then as clinically indicated; and
7. Prescriber must verify that hypokalemia and hypomagnesemia are corrected prior to starting Recorlev®; and
8. Member must not be taking medications that cause QT prolongation associated with ventricular arrhythmias, including torsades de pointes (e.g., dofetilide, dronedarone, methadone, quinidine, ranolazine); and
9. Member must not be taking medications that are sensitive substrates of CYP3A4 and/or P-gp (e.g., digoxin, lovastatin, simvastatin, tacrolimus, triazolam); and
10. If the member is taking medications that are strong CYP3A4 inhibitors (e.g., ritonavir, mifepristone) or strong CYP3A4 inducers (e.g. isoniazid, carbamazepine, rifampicin, phenytoin), the prescriber must verify the medication will be stopped 2 weeks before and during treatment with Recorlev® per package labeling; and
11. For female members, prescriber must verify that the member is not breastfeeding; and
12. A patient-specific, clinically significant reason why the member cannot use ketoconazole tablets and metyrapone capsules must be provided; and
13. Initial authorizations will be for the duration of 3 months. Continued authorization at that time will require the prescriber to provide a recent 24-hour urine free cortisol (UFC) level within the normal range to demonstrate the effectiveness of this medication, and compliance will also be checked at that time. Subsequent approvals will be for the duration of 1 year and will require the prescriber to verify the member is still not a candidate for pituitary or adrenal surgery.

Additionally, the College of Pharmacy recommends updating the approval criteria for Isturisa® based on Drug Utilization Review (DUR) Board recommendations and consistent with current treatment guidelines (updates shown in red):

Isturisa® (Osilodrostat) Approval Criteria:

1. An FDA approved indication for the treatment of adult members with Cushing's disease for whom pituitary or adrenal surgery is not an option or has not been curative;
2. Member must be 18 years of age or older; and
3. Prescriber must document that the member has had an inadequate response to pituitary or adrenal surgery or is not a candidate for pituitary or adrenal surgery; and
4. Prescriber must verify that hypokalemia and hypomagnesemia are corrected prior to starting Isturisa®; and
5. Prescriber must agree to perform and monitor electrocardiogram (ECG) at baseline, 1 week after treatment initiation, and as clinically indicated thereafter; and
6. Prescriber must verify that dose titration will be followed according to package labeling; and
7. If the member is taking strong CYP3A4 inhibitors (e.g., itraconazole, clarithromycin) or strong CYP3A4 and/or CYP2B6 inducers (e.g., carbamazepine, rifampin, phenobarbital), the prescriber must verify that the Isturisa® dose will be adjusted according to the package labeling; and
8. For female members, prescriber must verify that the member is not breastfeeding; and
9. Isturisa® must be prescribed by, or in consultation with, an endocrinologist (or an advanced care practitioner with a supervising physician who is an endocrinologist); and
10. A patient-specific, clinically significant reason why the member cannot use ketoconazole tablets and metyrapone capsules must be provided; and
11. Initial authorizations will be for the duration of 3 months after which time, compliance and 24-hour urine free cortisol levels within the normal range (to demonstrate the effectiveness of this medication) will be required for continued approval. Subsequent approvals will be for the duration of 1 year and will require the prescriber to verify the member is still not a candidate for pituitary or adrenal surgery.

[1] Xeris Biopharma Holdings, Inc. Xeris Biopharma Announces U.S. FDA Approval of Recorlev® (Levoketoconazole) for the Treatment of Endogenous Hypercortisolemia in Adult Patients with Cushing's Syndrome. *Business Wire*. Available online at: https://www.businesswire.com/news/home/20211230005308/en/Xeris-Biopharma-Announces-U.S.-FDA-Approval-of-Recorlev%C2%AE-levoketoconazole-for-the-Treatment-of-Endogenous-Hypercortisolemia-in-Adult-Patients-With-Cushing%E2%80%99s-Syndrome. Issued 12/30/2021. Last accessed 08/29/2022.

[2] Recorlev® (Levoketoconazole) Prescribing Information. Xeris Pharmaceuticals. Available online at: https://www.recorlev.com/full-prescribing-information.pdf. Last revised 12/2021. Last accessed 08/29/2022.

[3] Nieman LK, Biller BMK, Findling JW, et al. Treatment of Cushing's Syndrome: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab* 2015; 100(8):2807-2831. doi: 10.1210/jc.2015-1818.

Vote to Prior Authorize Tlando® (Testosterone Undecanoate) and Update the Approval Criteria for the Testosterone Products

Oklahoma Health Care Authority
October 2022

Market News and Updates[1,2,3]

Product Discontinuation(s):

- Androgel® (testosterone topical gel 1.62% packet)
- Androgel® (testosterone topical gel 1% packet)

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

- **March 2022:** The FDA approved Tlando® (testosterone undecanoate), an oral testosterone replacement therapy, for conditions associated with a deficiency or absence of endogenous testosterone or hypogonadism in adult males. Tlando® is supplied as 112.5mg testosterone undecanoate oral capsules and is not substitutable with other oral testosterone undecanoate products. The recommended dosing is 225mg twice daily with food. The approval of Tlando® was based on data from a multicenter, open-label, single-arm Phase 3 study, which evaluated the efficacy and safety of Tlando® in 95 adult hypogonadal male patients. Patients received 225mg orally twice daily with food for approximately 24 days; no titration was performed to adjust the dosage. Results demonstrated that the trial met the primary endpoint with 80% (95% confidence interval: 72, 88) of patients achieving a 24-hour average serum testosterone concentration (Cavg0-24h) within the normal range of 300-1080ng/dL on the final visit of the study. The safety and efficacy of Tlando® in males younger than 18 years of age have not been established.

Cost Comparison

Product	Cost Per Unit	Cost Per Month*
Tlando® (testosterone undecanoate 112.5mg cap)	**$5.79**	**$694.80**
Jatenzo® (testosterone undecanoate 198mg cap)	$8.02	$962.40
testosterone cypionate 200mg/mL inj (Depo-Testosterone®)	$14.64	$58.56

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 30 days based on the maximum FDA recommended dosing for each product.
cap = capsule; inj = injection; Unit = mL or capsule

Recommendations

The College of Pharmacy recommends the following changes to the testosterone products Product Based Prior Authorization (PBPA) category based on new FDA approvals, product discontinuations, net costs, and recommendations from the Drug Utilization Review (DUR) Board (changes shown in red in the following Tier chart and approval criteria):

1. Placement of Tlando® (testosterone undecanoate) into the Special Prior Authorization (PA) Tier; and
2. Moving Androgel® (testosterone topical gel 1% packet and 1.62% packet) from Tier-1 to Tier-2; and
3. Moving Testim® (testosterone topical gel 1% tube) and Vogelxo® (testosterone topical gel 1% packet, 1% pump, and 1% tube) from Tier-2 to Tier-1; and
4. Updating the initial approval criteria for all testosterone products to verify evaluation of the member for a pituitary tumor as the potential cause of low testosterone prior to starting treatment with a testosterone product.

Testosterone Products		
Tier-1	**Tier-2**	**Special PA**
methyltestosterone powder	testosterone enanthate sub-Q auto-injector (Xyosted®)	fluoxymesterone oral tab (Androxy®)
testosterone cypionate IM inj (Depo-Testosterone®)	testosterone nasal gel (Natesto®)	methyltestosterone oral tab/cap (Android®, Methitest®, Testred®)
testosterone enanthate IM inj (Delatestryl®)	testosterone patch (Androderm®)	testosterone buccal tab (Striant®)
testosterone topical gel 1% (Testim®, Vogelxo®)	**testosterone topical gel 1%, 1.62% packet (Androgel®)**	testosterone pellets (Testopel®)
testosterone topical gel **1.62% pump** (Androgel® ~~**1%, 1.62%**~~) – **Brand Preferred**	testosterone topical gel **2% pump** (Fortesta®~~**, Testim®, Vogelxo®**~~)	testosterone undecanoate oral cap (Jatenzo®**, Tlando®)**
	testosterone topical solution (Axiron®)	
	testosterone undecanoate IM inj (Aveed®)	

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; IM = intramuscular; inj = injection; PA = prior authorization; sub-Q = subcutaneous; tab = tablet

Initial Approval Criteria for All Testosterone Products:

1. An FDA approved diagnosis of 1 of the following:
   a. Testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, or orchiectomy; or
   b. Idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency, or pituitary hypothalamic injury from tumors, trauma, or radiation; or

    c. Delayed puberty; or
    d. Advanced inoperable metastatic mammary cancer in females 1 to 5 years postmenopausal, or premenopausal females with breast cancer benefitting from oophorectomy and have been determined to have a hormone-responsive tumor; and
2. The prescriber must verify the member has been evaluated for the presence of a pituitary tumor as the potential cause of low testosterone and the member will receive appropriate follow-up and/or treatment as necessary; and
3. Must include 2 labs showing pre-medication, morning testosterone (total testosterone) levels <300ng/dL; and
4. Must include 1 lab showing abnormal gonadotropins and/or other information necessary to demonstrate diagnosis; or
5. Testosterone and gonadotropin labs are not required for authorization of testosterone therapy if documentation is provided for established hypothalamic pituitary or gonadal disease, if the pituitary gland or testes has/have been removed, or for postmenopausal females with advanced inoperable metastatic mammary cancer or premenopausal females with breast cancer benefitting from oophorectomy and that have been determined to have a hormone-responsive tumor.

Testosterone Products Tier-2 Approval Criteria:

1. All diagnoses and laboratory requirements listed in the initial approval criteria for all testosterone products must be met; and
2. Member must have a trial of at least 2 Tier-1 products (must include at least 1 injectable and 1 topical formulation) at least 12 weeks in duration; or
3. A patient-specific, clinically significant reason why member cannot use all available Tier-1 products must be provided; or
4. Prior stabilization on a Tier-2 product (within the past 180 days); and
5. Approvals will be for the duration of 1 year; and
6. For Xyosted® [testosterone enanthate subcutaneous (sub-Q) auto-injector]:
    a. Member must be trained by a health care professional on sub-Q administration and storage of Xyosted® sub-Q auto-injector.

Testosterone Products Special Prior Authorization (PA) Approval Criteria:

1. All diagnoses and laboratory requirements listed in the initial approval criteria for all testosterone products must be met; and
2. A patient-specific, clinically significant reason why member cannot use all other available formulations of testosterone must be provided; and
3. Approvals will be for the duration of 1 year.

[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 09/2022. Last Accessed 09/07/2022.
[2] Park B. FDA Approves Oral Testosterone Replacement Therapy Tlando®. *MPR*. Available online at: https://www.empr.com/home/news/fda-approves-oral-testosterone-replacement-therapy-tlando/. Issued 03/30/2022. Last accessed 08/25/2022.
[3] Tlando® Prescribing Information. Antares Pharma, Inc. Available online at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/208088s000lbl.pdf. Last revised 03/2022. Last accessed 08/25/2022.

Vote to Update the Approval Criteria for the Opioid Analgesics and Medication-Assisted Treatment (MAT) Medications

Oklahoma Health Care Authority
October 2022

Market News and Updates[1,2]

News:

- **March 2020:** BioDelivery Sciences International, Inc., announced it was discontinuing Bunavail® in the United States. This was a marketing decision; Bunavail® was not discontinued due to side effects or lack of effectiveness. Given the competition with other similar drugs on the market, the company decided to concentrate on its other products instead.

Recommendations

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

1. Moving hydrocodone/ibuprofen 10/200mg tablet (Ibudone®, Reprexain™) from Tier-1 to Tier-2 of the Short-Acting Opioid Analgesics category based on net cost

Opioid Analgesics*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
Long-Acting			
buprenorphine patch (Butrans®) – **Brand Preferred**	fentanyl patch (Duragesic®)	buprenorphine ER buccal film (Belbuca®)	oxycodone/APAP ER tab (Xartemis® XR)
oxycodone ER tab 10mg, 15mg, 20mg only (OxyContin®) – **Brand Preferred**	morphine ER tab (MS Contin®)	hydrocodone ER cap (Zohydro® ER)	oxymorphone ER tab
	oxycodone ER tab 30mg, 40mg, 60mg, 80mg (OxyContin®) – **Brand Preferred**	hydrocodone ER tab (Hysingla® ER)	tramadol ER cap (ConZip®)

Opioid Analgesics*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
Long-Acting			
	tramadol ER tab (Ultram ER®, Ryzolt®)	hydromorphone ER tab (Exalgo®)	
		methadone tab and oral soln (Dolophine®)	
		morphine ER cap (Avinza®, Kadian®)	
		morphine ER tab (Arymo™ ER)	
		morphine ER tab (MorphaBond™)	
		oxycodone ER cap (Xtampza® ER)	
		oxycodone/ naltrexone ER cap (Troxyca® ER)	
Short-Acting			
APAP/butalbital/ caff/codeine cap (Fioricet® with Codeine)	**hydrocodone/IBU tab 10/200mg (Ibudone®, Reprexain™)**	benzhydrocodone/ APAP tab (Apadaz®)	levorphanol tab
ASA/butalbital/caff/ codeine cap (Fiorinal® with Codeine)	oxymorphone IR tab (Opana®)	dihydrocodeine/ APAP/caff cap (Trezix®)	tramadol 100mg tab
codeine tab	tapentadol IR tab (Nucynta®)	hydrocodone/ APAP oral soln (Zamicet®, Liquicet®)	tramadol oral soln (Qdolo™)

Opioid Analgesics*			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
Short-Acting			
codeine/APAP tab (Tylenol® with Codeine)		hydrocodone/ APAP tab (Xodol®)	
dihydrocodeine/ ASA/caff cap (Synalgos-DC®)		oxycodone tab (Oxaydo®)	
hydrocodone/ APAP tab (Norco®)		oxycodone tab (RoxyBond™)	
hydrocodone/IBU tab **5/200mg, 7.5/200mg only** (Vicoprofen®, Ibudone®, Reprexain™)			
hydromorphone tab (Dilaudid®)			
morphine IR tab (MSIR®)			***Oncology Only:***
oxycodone/APAP tab (Percocet®)			fentanyl buccal film (Onsolis®)
oxycodone/ASA tab (Percodan®)			fentanyl buccal tab (Fentora®)
oxycodone IR cap (Oxy IR®)			fentanyl nasal spray (Lazanda®)
oxycodone IR tab (Roxicodone®)			fentanyl SL spray (Subsys®)
tramadol 50mg tab (Ultram®)			fentanyl SL tab (Abstral®)
tramadol/APAP tab (Ultracet®)			fentanyl transmucosal lozenge (Actiq®)

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

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

1. Removal of Bunavail® (buprenorphine/naloxone buccal film) based on product discontinuation

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

1. Generic buprenorphine/naloxone SL tablet is the preferred product. Authorization consideration of ~~Bunavail®,~~ Suboxone® films (brand and generic)~~,~~ and Zubsolv® requires a patient-specific, clinically significant reason why generic buprenorphine/naloxone SL tablets are not appropriate.
2. Subutex® (buprenorphine) 2mg and 8mg SL tablets will only be approved if the member is pregnant or has a documented serious allergy or adverse reaction to naloxone; and
3. Buprenorphine products FDA approved for a diagnosis of opioid abuse/dependence must be prescribed by a licensed practitioner who qualifies for a waiver under the Drug Addiction Treatment Act (DATA) and has notified the Center for Substance Abuse Treatment of the intention to treat addiction patients and has been assigned a Drug Enforcement Agency (DEA) X number; and
4. Member must have an FDA approved diagnosis of opioid abuse/dependence; and
5. Concomitant treatment with opioid analgesics (including tramadol) will be denied; and
6. Approvals will be for the duration of 90 days to allow for concurrent medication monitoring; and
7. The following limitations will apply:
    a. Suboxone® 2mg/0.5mg and 4mg/1mg SL tablets and films: A quantity limit of 90 SL units per 30 days will apply.
    b. Suboxone® 8mg/2mg SL tablets and films: A quantity limit of 60 SL units per 30 days will apply.
    c. Suboxone® 12mg/3mg SL films: A quantity limit of 30 SL films per 30 days will apply.
    d. Subutex® 2mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.
    e. Subutex® 8mg SL tablets: A quantity limit of 60 SL tablets per 30 days will apply.
    f. Zubsolv® 0.7mg/0.18mg, 1.4mg/0.36mg, and 2.9mg/0.71mg SL tablets: A quantity limit of 90 SL tablets per 30 days will apply.

g. Zubsolv® 5.7mg/1.4mg SL tablets: A quantity limit of 60 SL tablets per 30 days will apply.
h. Zubsolv® 8.6mg/2.1mg and 11.4mg/2.9mg SL tablets: A quantity limit of 30 SL tablets per 30 days will apply.
~~i. Bunavail® 2.1mg/0.3mg buccal films: A quantity limit of 90 buccal films per 30 days will apply.~~
~~j. Bunavail® 4.2mg/0.7mg buccal films: A quantity limit of 60 buccal films per 30 days will apply.~~
~~k. Bunavail® 6.3mg/1mg buccal films: A quantity limit of 30 buccal films per 30 days will apply.~~

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[2] 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 08/2022. Last accessed 08/10/2022.

Vote to Prior Authorize Adlarity® (Donepezil Transdermal System) and Aduhelm® (Aducanumab-avwa)

Oklahoma Health Care Authority
October 2022

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

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

- **June 2021:** The FDA approved Aduhelm® (aducanumab-avwa) for the treatment of Alzheimer's disease through the accelerated approval pathway. Aduhelm® is the first new treatment approved for Alzheimer's disease since 2003 and the first therapy that targets the fundamental pathophysiology of the disease by reducing amyloid beta plaques in the brain. The efficacy of Aduhelm® was evaluated in 3 Phase 3 clinical studies, EMERGE (study 1), ENGAGE (study 2), and PRIME (study 3), in patients with early stages of Alzheimer's disease (mild cognitive impairment and mild dementia) with confirmed presence of amyloid pathology. In these studies, Aduhelm® consistently showed a dose- and time-dependent effect on the lowering of amyloid beta plaques [by 59% (P<0.0001) in ENGAGE, 71% (P<0.0001) in EMERGE, and 61% (P<0.0001) in PRIME]. Continued approval for Aduhelm® may be contingent upon verification of clinical benefit in confirmatory studies.
- **March 2022:** The FDA approved Adlarity® (donepezil transdermal system) as a treatment for patients with mild, moderate, or severe dementia of the Alzheimer's type. This is the first and only once-weekly patch of donepezil. It uses Corium's proprietary CORPLEX transdermal technology that was developed to deliver continuous, controlled, and sustained release of a drug over a defined time. Adlarity® was approved through the FDA 505(b)(2) regulatory pathway and was shown to have bioequivalence to donepezil tablets. It will be supplied as a 5mg/day and 10mg/day patch and should be applied to the patient's back, thigh, or buttocks. Adlarity® is expected to be available in early fall 2022.

News:

- **March 2022:** New data released by Biogen showed that long-term treatment with Aduhelm® continues to reduce the underlying pathologies of Alzheimer's disease after more than 2 years of treatment. Patients receiving Aduhelm® in the long-term extension phase of 2 Phase 3 studies (ENGAGE and EMERGE) continued to experience significant reductions in amyloid beta plaque levels (P<0.001) out to

week 132 and plasma p-tau181 levels (P<0.001) out to week 128. In both studies, at 78 weeks, patients with a reduction in plasma p-tau181, an exploratory endpoint, had less clinical progression across all 4 clinical endpoints measuring cognition and function than patients whose plasma p-tau181 levels were not reduced. Biogen started screening patients in May 2022 for the Phase 4 confirmatory study with the primary readout of data expected 4 years later.

Aduhelm® (Aducanumab-avwa) Product Summary[5]

Indication(s): An amyloid beta-directed antibody indicated for the treatment of Alzheimer's disease in patients with mild cognitive impairment or mild dementia stage of disease, the population in which treatment was initiated in clinical studies

- Continued approval for this indication is contingent upon verification of clinical benefit in confirmatory studies.

How Supplied: 170mg/1.7mL and 300mg/3mL solution in a single dose vial

Dosing and Administration:

- The presence of amyloid beta pathology should be confirmed prior to initiating treatment.
- A recent (within 1 year) magnetic resonance imaging (MRI) should be obtained prior to treatment initiation.
- The recommended maintenance dosage is 10mg/kg via intravenous (IV) infusion over 1 hour every 4 weeks following a dose titration.
- An MRI should be obtained prior to the 5th, 7th, 9th, and 12th infusions. If amyloid-related imaging abnormalities (ARIA) occur, treatment recommendations are based on type, severity, and presence of symptoms.
- Refer to the full Aduhelm® *Prescribing Information* for the recommended dose titration and recommendations for patients with occurrence of ARIA.

Mechanism of Action: Aducanumab-avwa is a human, immunoglobulin gamma (IgG1) monoclonal antibody directed against aggregated soluble and insoluble forms of amyloid beta and thereby reduces amyloid beta plaques in the brain. The accumulation of amyloid beta plaques is a defining pathophysiological feature of Alzheimer's disease.

Contraindication(s): None

Warnings and Precautions:

- ARIA: Enhanced clinical vigilance for ARIA should be performed during the first 8 doses of treatment with Aduhelm®, particularly during titration. If a patient experiences symptoms which could be suggestive

of ARIA, clinical evaluation should be performed, including MRI testing if indicated.

- Hypersensitivity Reactions: Angioedema and urticaria have occurred. If a hypersensitivity reaction occurs, the infusion of Aduhelm® should be discontinued and appropriate therapy should be initiated.

Adverse Reactions: The most common adverse reactions reported in clinical studies (incidence ≥10%) were ARIA-edema (ARIA-E), headache, ARIA-hemosiderin deposition (ARIA-H) microhemorrhage, ARIA-H superficial siderosis, and fall.

Efficacy: The efficacy of Aduhelm® was evaluated in 3 double-blind, randomized, placebo-controlled studies in patients with Alzheimer's disease confirmed by the presence of amyloid pathology and mild cognitive impairment or mild dementia stage of disease. In studies 1 and 2, patients were randomized to receive Aduhelm® low dose [3 or 6mg/kg for apolipoprotein E (ApoE) 4 carriers and noncarriers, respectively], Aduhelm® high dose (10mg/kg), or placebo every 4 weeks for 18 months, followed by an optional, dose-blind, long-term extension period. In study 3, 197 patients were randomized to receive a fixed dose of Aduhelm® 1mg/kg, 3mg/kg, 6mg/kg, 10mg/kg, titration to 10mg/kg over 44 weeks, or placebo for 12 months.

- **Study 1:**
  - Primary Endpoint: The primary efficacy endpoint was the change from baseline on the Clinical Dementia Rating-Sum of Boxes (CDR-SB) at week 78. Additionally, sub-studies were conducted to assess the reduction of amyloid beta plaques biomarkers.
  - Results: Treatment with Aduhelm® high dose reduced clinical decline, as shown by a statistically significant treatment effect on change from baseline in CDR-SB compared to placebo [-0.39 (-22%), P=0.0120]. Differences from placebo observed in the low dose group numerically favored Aduhelm® but were not statistically significant. Biomarker results for Aduhelm® showed a significant dose- and time-dependent reduction of amyloid beta plaques [-60.8 (-71%), P<0.0001].
- **Study 2:**
  - Primary Endpoint: The primary efficacy endpoint was the change from baseline on the CDR-SB at week 78. Additionally, sub-studies were conducted to assess the reduction of amyloid beta plaques biomarkers.
  - Results: No statistically significant differences were seen between Aduhelm®-treated and placebo-treated patients on the primary efficacy endpoint. Biomarker results for Aduhelm® showed a statistically significant dose- and time-dependent reduction of amyloid beta plaques [-54.0 (-59%), P<0.0001].

- **Study 3:**
  - Primary Endpoint: The primary outcome was the number of patients with adverse effects from baseline to week 518 and to evaluate the safety and tolerability of multiple doses. A key exploratory endpoint was the measure of clinical decline on the CDR-SB and Mini-Mental State Examination (MMSE) scores.
  - Results: Results for clinical assessments were exploratory and directionally aligned with the findings from study 1, with less change from baseline in CDR-SB and MMSE scores at 1 year in the Aduhelm® 10mg/kg fixed-dose group than in patients on placebo [CDR-SB: -1.26, 95% confidence interval (CI): -2.356, -0.163; MMSE: 1.9, 95% CI: 0.06, 3.75]. The most common adverse events seen in the long-term extension study were fall, headache, and ARIA. The majority of ARIA events occurred early during treatment and were typically mild, asymptomatic, and resolved or stabilized within 4-12 weeks, with most patients continuing treatment.

Cost: The Wholesale Acquisition Cost (WAC) of Aduhelm® is $282 per mL, or $846 per 300mg/3mL single dose vial. A member weighing 80kg would have an annual cost of $32,994 at the recommended dosage of 10mg/kg every 4 weeks.

Recommendations

The College of Pharmacy recommends the prior authorization of Adlarity® (donepezil transdermal system) as a special formulation product. The following criteria will apply:

Alzheimer's Disease Medications Approval Criteria:

1. Special formulation products including oral solutions, transdermal patches, and other convenience formulations require prior authorization with the following approval criteria:
   a. A patient-specific, clinically significant reason why the special formulation is necessary in place of the standard formulation.

Additionally, the College of Pharmacy recommends the prior authorization of Aduhelm® (aducanumab-avwa) with the following criteria:

Aduhelm® (Aducanumab-avwa) Approval Criteria:

1. An FDA approved diagnosis of mild cognitive impairment or mild dementia stage of Alzheimer's disease [stage 3 or stage 4 Alzheimer's disease based on the Global Deterioration Scale (GDS)]. Diagnosis must be confirmed by at least 2 of the following:
   a. Mini-Mental State Exam (MMSE) score between 24 and 30; or
   b. Clinical Dementia Rating Global Score (CDR-GS) equal to 0.5; or
   c. Montreal Cognitive Assessment (MoCA) score ≥19; or

   d. Quick Dementia Rating System (QDRS) score ≤5; and
2. Member must have presence of amyloid pathology confirmed by a positive amyloid positron emission tomography (PET) scan or cerebral spinal fluid (CSF) test; and
3. Aduhelm® must be prescribed by, or in consultation with, a neurologist (or an advanced care practitioner with a supervising physician who is a neurologist); and
4. Other known medical or neurological causes of dementia have been ruled out (i.e., vascular dementia, dementia with Lewy bodies, frontotemporal dementia, Parkinson's disease dementia); and
5. Member must not have brain hemorrhage, bleeding disorder, or cerebrovascular abnormalities that increase the risk of hemorrhage; and
6. Member must not be taking anticoagulant or antiplatelet agents except for aspirin 325mg per day or less; and
7. Member must not have had a stroke or transient ischemic attack (TIA) or unexplained loss of consciousness in the past year; and
8. Member must not have any contraindications to brain magnetic resonance imaging (MRI) or PET scans; and
9. Member must not have any pre-treatment localized superficial siderosis, ≥10 brain microhemorrhages, or a brain hemorrhage >1cm within 1 year of treatment initiation as safety with Aduhelm® has not been established in patients with these conditions; and
10. Member must have a recent (within 1 year) brain MRI prior to initiating treatment with Aduhelm® and prior to the 7th infusion (1st dose of 10mg/kg) and 12th infusion (6th dose of 10mg/kg); and
11. The prescriber must confirm that the member will be monitored for amyloid-related imaging abnormalities (ARIA) during the first 8 doses of treatment with Aduhelm®, particularly during titration, and also throughout treatment; and
12. If ≥10 new incident microhemorrhages or >2 focal areas of superficial siderosis [radiographic severe amyloid related imaging abnormalities-hemosiderin deposition (ARIA-H)] are observed on MRI, prescriber must confirm that treatment will be continued with caution and only after a clinical evaluation and a follow-up MRI demonstrating radiographic stabilization (i.e., no increase in size or number of ARIA-H); and
13. Aduhelm® must be administered by a health care provider; and
14. Aduhelm® must be shipped via cold chain supply shipping and stored in a refrigerator; and
15. Member's weight must be provided and have been taken within the last 4 weeks to ensure accurate weight-based dosing; and
16. Initial approvals will be for 6 months. Confirmation that MRI has been completed and is acceptable to the provider prior to 7th infusion is required for continuation; and

17. Subsequent approvals will be for 6 months and prescriber must document that the member has responded well to therapy compared to pretreatment baseline status as evidenced by improvement, stability, or slowing in cognitive and/or functional impairment using the same baseline test(s) performed at initiation of therapy; and
18. Approval quantities will be dependent on the member's weight and dosing based on the Aduhelm® *Prescribing Information*; and
19. The maximum dose approvable is 10mg/kg per 28 days.

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[1] U.S. Food and Drug Administration (FDA). FDA Grants Accelerated Approval for Alzheimer's Drug. Available online at: https://www.fda.gov/news-events/press-announcements/fda-grants-accelerated-approval-alzheimers-drug. Issued 06/07/2021. Last accessed 08/02/2022.
[2] Biogen. FDA Grants Accelerated Approval for Aduhelm® as the First and Only Alzheimer's Disease Treatment to Address a Defining Pathology of the Disease. Available online at: https://investors.biogen.com/news-releases/news-release-details/fda-grants-accelerated-approval-aduhelmtm-first-and-only. Issued 06/07/2021. Last accessed 08/02/2022.
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[4] Brauser D. Aducanumab Reduces Amyloid Plaques in Early Alzheimer's: PRIME Published. *Medscape*. Available online at: https://www.medscape.com/viewarticle/868438#vp_2. Issued 09/06/2016. Last accessed 08/02/2022.
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Vote to Update the Approval Criteria for the Topical Corticosteroids

Oklahoma Health Care Authority
October 2022

Recommendations

The College of Pharmacy recommends the following changes to the topical corticosteroids Product Based Prior Authorization (PBPA) Tier chart based on net costs (changes shown in red in the following Tier chart):

1. Ultra-High to High Potency:
    a. Augmented betamethasone 0.05% gel from Tier-1 to Tier-2; and
    b. Augmented betamethasone 0.05% ointment from Tier-2 to Tier-1; and
    c. Betamethasone dipropionate 0.05% cream and ointment from Tier-2 to Tier-1; and
    d. Clobetasol propionate 0.05% lotion from Tier-1 to Tier-2; and
    e. Desoximetasone 0.25% cream and ointment from Tier-3 to Tier-1; and
    f. Fluocinonide 0.1% cream from Tier-2 to Tier-1; and
    g. Halobetasol 0.05% ointment from Tier-2 to Tier-1.
2. Medium-High to Medium Potency:
    a. Betamethasone valerate 0.1% lotion from Tier-1 to Tier-2; and
    b. Desoximetasone 0.05% cream and ointment from Tier-2 to Tier-3.
3. Low Potency:
    a. Alclometasone 0.05% ointment from Tier-2 to Tier-3.
    b. Desonate® (desonide 0.05%) gel from Tier-1 to Tier-3; and
    c. Desonide emollient 0.05% cream and ointment from Tier-3 to Tier-1; and
    d. Fluocinolone 0.01% solution from Tier-2 to Tier-1; and
    e. Fluocinolone 0.01% oil from Tier-3 to Tier-2.

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

Topical Corticosteroids					
Tier-1		**Tier-2**		**Tier-3**	
betamethasone dipropionate 0.05% (Diprosone®)	**C,O**	augmented betamethasone dipropionate 0.05% (Diprolene®, **Diprolene AF®**)	**G**,L,~~**O**~~	clobetasol propionate 0.05% (Olux®, Olux-E®, Tovet®)	F
~~**clobetasol propionate 0.05% (Clobex®)**~~	~~**L**~~	~~**betamethasone dipropionate 0.05% (Diprosone®)**~~	~~**C,O**~~	clobetasol propionate 0.05% (Impeklo™)	L
clobetasol propionate 0.05% (Temovate®)	C,O,So	**clobetasol propionate 0.05% (Clobex®)**	**L**	desoximetasone 0.25% (Topicort®)	~~**C,O**~~,Spr
desoximetasone 0.25% (Topicort®)	**C,O**	clobetasol propionate 0.05% (Temovate®)	G	diflorasone diacetate 0.05% (Apexicon®)	C,O
fluocinonide 0.05%	C,O,So	desoximetasone 0.05% (Topicort®)	G	diflorasone diacetate 0.05% (Apexicon E®)	C
fluocinonide 0.1% (Vanos®)	**C**	fluocinonide 0.05%	G	halobetasol propionate 0.01% (Bryhali®)	L
halobetasol propionate 0.05% (Ultravate®)	C,**O**	~~**fluocinonide 0.1% (Vanos®)**~~	~~**C**~~	halobetasol propionate 0.05% (Lexette®)	F
		flurandrenolide tape 0.05% (Cordran®)	Tape		
		halcinonide 0.1% (Halog®)	C,O,So		
		halobetasol propionate 0.05% (Ultravate®)	L,~~**O**~~		
Medium-High to Medium Potency					
betamethasone dipropionate 0.05%	L	betamethasone dipropionate/ calcipotriene 0.064%/ 0.005% (Taclonex®)	O,Spr, Sus	**desoximetasone 0.05% (Topicort LP®)**	**C,O**
betamethasone valerate 0.1% (Beta-Val®)	C,~~**L**~~,O	betamethasone valerate 0.12% (Luxiq®)	F	hydrocortisone valerate 0.2% (Westcort®)	C,O
fluticasone propionate 0.005% (Cutivate®)	O	**betamethasone valerate 0.1% (Beta-Val®)**	**L**		
fluticasone propionate 0.05% (Cutivate®)	C	calcipotriene/ betamethasone dipropionate 0.064%/0.005% (Enstilar®)	F		

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

Topical Corticosteroids					
Tier-1		**Tier-2**		**Tier-3**	
hydrocortisone acetate 2.5%	C,L,O				

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

Topical Corticosteroids Tier-2 Approval Criteria:

1. Documented trials of all Tier-1 topical corticosteroids of similar potency in the past 30 days that did not yield adequate relief; and
2. If Tier-1 trials are completed and do not yield adequate relief, the member must also provide a patient-specific, clinically significant reason for requesting a Tier-2 in the same potency instead of trying a higher potency; and
3. When the same medication is available in Tier-1, a patient-specific, clinically significant reason must be provided for using a special dosage formulation of that medication in Tier-2 (foams, shampoos, sprays, kits, etc.); and
4. Topical corticosteroid kits require tier trials and a patient-specific, clinically significant reason for use of the kit over standard formulations.

Topical Corticosteroids Tier-3 Approval Criteria:

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

Vote to Prior Authorize Camzyos™ (Mavacamten)

Oklahoma Health Care Authority
October 2022

Market News and Updates[1,2]

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

- **April 2022:** The FDA approved Camzyos™ (mavacamten) to treat adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms. HCM is the most common form of genetic heart disease and is most often caused by abnormal genes in the heart muscle that cause the walls of the heart chamber to become thicker than normal. The most common form is obstructive HCM, where the thickened walls block or reduce the blood flow from the left ventricle to the aorta. It is estimated that 1 in every 500 people have HCM, but most are undiagnosed; of those diagnosed, about two-thirds of patients have obstructive HCM. The current treatment for obstructive HCM is dependent on the patient's severity of symptoms and is focused on symptom relief and prevention of sudden cardiac death. First-line therapies typically consist of beta blockers and nondihydropyridine calcium channel blockers; however, these current pharmacological options only provide symptomatic relief and do not target the underlying pathophysiology of HCM. Camzyos™ is the first FDA approved cardiac myosin inhibitor that targets the underlying pathophysiology of obstructive HCM.

Camzyos™ (Mavacamten) Product Summary[3]

Indication(s): A cardiac myosin inhibitor indicated for the treatment of adults with symptomatic NYHA class II-III obstructive HCM to improve functional capacity and symptoms

How Supplied: 2.5mg, 5mg, 10mg, and 15mg oral capsules

Dosing and Administration:

- Dosage should be individualized based on clinical status and echocardiogram assessment of patient response.
- The recommended starting dose is 5mg once daily without regard to food.
- Regular left ventricular ejection fraction (LVEF) and Valsalva left ventricular outflow tract (LVOT) gradient assessment should be performed for careful titration of mavacamten.

- Refer to the full *Prescribing Information* for the recommended initiation and maintenance dosing algorithm.

Boxed Warning: Risk of Heart Failure

- Mavacamten can cause heart failure due to systolic dysfunction.
  - Echocardiogram assessments of LVEF are required before and during use.
  - Initiation in patients with LVEF <55% is not recommended.
  - Treatment should be interrupted if LVEF is <50% or if worsening clinical status occurs.
- Concomitant use of mavacamten with certain cytochrome P450 inhibitors or discontinuation of certain cytochrome P450 inducers may increase the risk of heart failure due to systolic dysfunction; therefore, the use of mavacamten is contraindicated with the following:
  - Moderate to strong CYP2C19 inhibitors or strong CYP3A4 inhibitors
  - Moderate to strong CYP2C19 inducers or moderate to strong CYP3A4 inducers
- Mavacamten is only available through the Risk Evaluation and Mitigation Strategy (REMS) program.

Warnings and Precautions:

- Heart Failure: Mavacamten reduces systolic contraction and can cause heart failure or totally block ventricular function. Patients who experience a serious intercurrent illness (e.g., serious infection) or arrhythmia (e.g., atrial fibrillation or other uncontrolled tachyarrhythmia) are at greater risk of developing systolic dysfunction and heart failure. Interruption of mavacamten should be considered in patients with serious infections or arrhythmias.
- Drug Interactions Leading to Heart Failure or Loss of Effectiveness: Patients should be advised of potential drug interactions including over-the-counter medications (e.g., omeprazole, esomeprazole, cimetidine, St. John's wort).
- Embryo-Fetal Toxicity: Females of reproductive potential should be advised to use effective contraception until 4 months after the last dose. A contraceptive not affected by CYP450 enzyme induction [e.g., intrauterine device (IUD)] or nonhormonal contraception should be used.

Mechanism of Action: Mavacamten is an allosteric and reversible inhibitor selective for cardiac myosin. It modulates the number of myosin heads that can enter "on actin" (power-generating) states, thus reducing the probability of force-producing (systolic) and residual (diastolic) cross-bridge formation. Excess myosin actin cross-bridge formation and dysregulation of the super-relaxed state are mechanistic hallmarks of HCM. Mavacamten shifts the

overall myosin population towards an energy-sparing, recruitable, super-relaxed state. In HCM patients, myosin inhibition with mavacamten reduces dynamic LVOT obstruction and improves cardiac filling pressures.

Contraindication(s):

- Moderate to strong CYP2C19 (e.g., proton pump inhibitors, clopidogrel, voriconazole, fluvoxamine) or strong CYP3A4 (e.g., itraconazole, ketoconazole, ritonavir) inhibitors
- Moderate to strong CYP2C19 (e.g., rifampicin, carbamazepine) or CYP3A4 (e.g., rifampin, carbamazepine, phenytoin) inducers

Use in Specific Populations:

- Pregnancy: Based on animal data, mavacamten may cause fetal harm when administered to a pregnant female. There is no human data on the use of mavacamten during pregnancy to evaluate for a drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes.
- Lactation: The presence of mavacamten in human or animal milk, the drug's effects on the breastfed infant, and the effects on milk production are unknown.
- Females and Males of Reproductive Potential: Mavacamten may cause fetal harm when administered to a pregnant female. Absence of pregnancy should be confirmed in females of reproductive potential prior to initiation. Females of reproductive potential should use effective contraception during treatment and for 4 months after the last dose.
- Pediatric Use: The safety and effectiveness of mavacamten have not been established in pediatric patients.
- Geriatric Use: Clinical trials of mavacamten included 263 patients 65 years of age and older. Safety, effectiveness, and pharmacokinetics were similar between elderly patients and younger patients.

Adverse Reactions: The most common adverse reactions reported in clinical studies (incidence >5%) were dizziness and syncope.

Efficacy: The approval of mavacamten was based on a Phase 3, double-blind, randomized study in 251 adults. Patients were randomized 1:1 to receive either mavacamten 5mg or placebo once daily for 30 weeks. All patients were initiated on 5mg once daily of mavacamten or placebo and the dose was adjusted periodically to optimize patient response and maintain LVEF ≥50%.

- Primary Endpoint: The primary composite functional endpoint was defined as the proportion of patients who achieved either improvement of peak oxygen consumption (pVO2) by ≥1.5mL/kg/min plus improvement in NYHA class by at least 1 class or improvement of pVO2 by ≥3.0 mL/kg/min plus no worsening in NYHA class.

- Results: A greater proportion of patients met the primary endpoint at week 30 in the mavacamten group compared to the placebo group [37% vs. 17%, respectively; difference of 19% (95% confidence interval: 9, 30; P=0.0005)].

Cost: The Wholesale Acquisition Cost (WAC) of Camzyos™ is $245.21 per capsule regardless of strength, resulting in an annual cost of $88,275.60 for the recommended dosage of 1 capsule once daily.

Recommendations

The College of Pharmacy recommends the prior authorization of Camzyos™ (mavacamten) with the following criteria:

Camzyos™ (Mavacamten) Approval Criteria:

1. An FDA approved diagnosis of obstructive hypertrophic cardiomyopathy (HCM); and
2. Member must be 18 years of age or older; and
3. Member must have New York Heart Association (NYHA) class II to III heart failure; and
4. Camzyos™ must be prescribed by, or in consultation with, a cardiologist (or an advanced care practitioner with a supervising physician who is a cardiologist); and
5. Member must have left ventricular ejection fraction (LVEF) ≥55%; and
6. Member must be on current treatment with or have a documented failure, contraindication, or intolerance to beta blockers or nondihydropyridine calcium channel blockers; and
7. Member must not be taking concurrent moderate to strong CYP2C19 inhibitors (e.g., proton pump inhibitors, clopidogrel, voriconazole, fluvoxamine), strong CYP3A4 inhibitors (e.g., itraconazole, ketoconazole, ritonavir), moderate to strong CYP2C19 inducers (e.g., rifampicin, carbamazepine), or moderate to strong CYP3A4 inducers (e.g., rifampin, carbamazepine, phenytoin); and
8. Member must not be taking or planning to take disopyramide, ranolazine, or a combination of a beta blocker and a calcium channel blocker concomitantly with Camzyos™; and
9. Female members of reproductive potential must have a negative pregnancy test prior to initiation of therapy and must agree to use effective contraception during treatment and for 4 months after the final dose of Camzyos™; and
10. Prescriber, pharmacy, and member must be enrolled in the Camzyos™ Risk Evaluation and Mitigation Strategy (REMS) program and maintain enrollment throughout therapy; and

11. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment; and
12. Subsequent approvals will be for the duration of 1 year.

[1] Bristol Myers Squibb. U.S. Food and Drug Administration Approves Camzyos™ (Mavacamten) for the Treatment of Adults With Symptomatic New York Heart Association Class II-III Obstructive Hypertrophic Cardiomyopathy (HCM) to Improve Functional Capacity and Symptoms. Available online at: https://news.bms.com/news/corporate-financial/2022/U.S.-Food-and-Drug-Administration-Approves-Camzyos-mavacamten-for-the-Treatment-of-Adults-With-Symptomatic-New-York-Heart-Association-Class-II-III-ObstructiveHypertrophic-Cardiomyopathy-HCM-to-Improve-Functional-Capacity-and-Symptoms/default.aspx. Issued 04/28/2022. Last accessed 08/04/2022.
[2] American Heart Association. Hypertrophic Cardiomyopathy. Available online at: https://www.heart.org/en/health-topics/cardiomyopathy/what-is-cardiomyopathy-in-adults/hypertrophic-cardiomyopathy. Last revised 05/13/2022. Last accessed 08/04/2022.
[3] Camzyos™ Prescribing Information. Bristol Myers Squibb. Available online at: https://packageinserts.bms.com/pi/pi_camzyos.pdf. Last revised 05/2022. Last accessed 08/04/2022.

Vote to Update the Approval Criteria for the Cystic Fibrosis Transmembrane Conductance Regulator (CFTR) Modulators

Oklahoma Health Care Authority
October 2022

Market News and Updates[1,2]

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

- **September 2022:** Vertex Pharmaceuticals announced FDA approval of their supplemental New Drug Application (sNDA) to expand the use of Orkambi® (lumacaftor/ivacaftor) to include children with cystic fibrosis (CF) ages 12 months to younger than 24 months who are homozygous for the *F508del* mutation. Orkambi® was previously approved for use in patients 2 years of age and older. The sNDA approval was based on a 24-week, Phase 3, open-label, multi-center study in 46 children ages 12 months to younger than 24 months who were homozygous for the *F508del* mutation. With the sNDA approval, a new strength of granule packets was also approved, lumacaftor/ivacaftor 75mg/94mg per packet. Orkambi® was generally well tolerated, and the safety profile and pharmacokinetics were similar to that observed in studies in patients 2 years of age and older. Additional study results, including reductions in sweat chloride concentration, suggest the potential for CF disease modification with the use of Orkambi®.

Recommendations

The College of Pharmacy recommends updating the current prior authorization criteria for the CFTR modulators to be consistent with clinical practice and recommends updating the age restriction for Orkambi® based on the newly FDA approved age expansion (changes shown in red):

Kalydeco® (Ivacaftor) Approval Criteria:

1. An FDA approved diagnosis of cystic fibrosis (CF) with a mutation in the CF transmembrane conductance regulator *(CFTR)* gene detected by genetic testing that is responsive to ivacaftor based on clinical and/or *in vitro* assay data; and
2. Documentation must be submitted with results of *CFTR* genetic testing; and
3. Member must be 4 months of age or older; and

4. A quantity limit of 2 tablets or 2 granule packets per day or 56 tablets or granule packets per 28 days will apply; and
5. An age restriction of 4 months to younger than 6 years of age will apply to Kalydeco® oral granule packets. Members 6 years of age or older will require a patient-specific, clinically significant reason why the member cannot use the oral tablet formulation; and
6. Approvals will be based on the recommended dosing per package labeling based on the member's age and recent weight, if applicable. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
7. Initial approvals will be for the duration of 6 ~~3~~ months~~, after which time compliance will be required for continued approval~~. After 6 months of utilization, compliance and information regarding efficacy, such as improvement in forced expiratory volume in 1 second (FEV_1), will be required for continued approval; and
8. Subsequent approvals will be for the duration of 1 year.

Orkambi® (Lumacaftor/Ivacaftor) Approval Criteria:

1. An FDA approved diagnosis of cystic fibrosis (CF) in members who are homozygous for the *F508del* mutation in the CF transmembrane conductance regulator *(CFTR)* gene detected by genetic testing; and
2. If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the *F508del* mutation on both alleles of the *CFTR* gene; and
3. Orkambi® will not be approved for members with CF other than those homozygous for the *F508del* mutation; and
4. Member must be 12 months ~~2 years~~ of age or older; and
5. Members using Orkambi® must be supervised by a pulmonary disease specialist; and
6. Prescriber must verify that ALT, AST, and bilirubin will be assessed prior to initiating Orkambi®, every 3 months during the first year of treatment, and annually thereafter; and
7. Member must not be taking any of the following medications concomitantly with Orkambi®: rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John's wort; and
8. A quantity limit of 4 tablets per day or 112 tablets per 28 days will apply or a quantity limit of 2 granule packets per day or 56 packets per 28 days will apply; and
9. An age restriction of 12 months ~~2 years~~ to younger than 6 years of age will apply to Orkambi® oral granule packets. Members 6 years of age or older will require a patient-specific, clinically significant reason why the member cannot use the oral tablet formulation; and
10. Approvals will be based on the recommended dosing per package labeling based on the member's age and recent weight, if applicable.

For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and

11. Initial approvals will be for the duration of 6 ~~3~~ months~~, after which time compliance will be required for continued approval~~. After 6 months of utilization, compliance and information regarding efficacy, such as improvement in forced expiratory volume in 1 second (FEV_1), will be required for continued approval; and
12. Subsequent approvals will be for the duration of 1 year.

Symdeko® (Tezacaftor/Ivacaftor and Ivacaftor) Approval Criteria:

1. An FDA approved diagnosis of cystic fibrosis (CF) in members who are homozygous for the *F508del* mutation or who have at least 1 mutation in the CF transmembrane conductance regulator *(CFTR)* gene detected by genetic testing that is responsive to tezacaftor/ivacaftor based on *in vitro* data and/or clinical evidence; and
2. If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a *CFTR* mutation followed by verification with bi-directional sequencing when recommended by the mutation test's instructions for use; and
3. Member must be 6 years of age or older; and
4. Members using Symdeko® must be supervised by a pulmonary disease specialist; and
5. If the member is currently stabilized on Orkambi® (lumacaftor/ivacaftor) and experiencing adverse effects associated with Orkambi® use, the prescriber must indicate that information on the prior authorization request; and
6. Prescriber must verify the member has been counseled on proper administration of Symdeko® including taking with a fat-containing food; and
7. Prescriber must verify that ALT, AST, and bilirubin will be assessed prior to initiating Symdeko®, every 3 months during the first year of treatment, and annually thereafter; and
8. Member must not be taking any of the following medications concomitantly with Symdeko®: rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John's wort; and
9. A quantity limit of 2 tablets per day or 56 tablets per 28 days will apply; and
10. Approvals will be based on the recommended dosing per package labeling based on the member's age and recent weight, if applicable. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
11. Initial approvals will be for the duration of 6 ~~3~~ months~~, after which time compliance will be required for continued approval~~. After 6 months of utilization, compliance and information regarding efficacy, such as

improvement in forced expiratory volume in 1 second (FEV_1), will be required for continued approval. Additionally, after 6 months of utilization, information regarding efficacy as previously mentioned or fewer adverse events must be provided for members who switched from Orkambi® to Symdeko®; and

12. Subsequent approvals will be for the duration of 1 year.

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

1. An FDA approved diagnosis of cystic fibrosis (CF) in members who have at least 1 *F508del* mutation in the CF transmembrane conductance regulator *(CFTR)* gene or a mutation in the *CFTR* gene that is responsive based on *in vitro* data; and
2. If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a *CFTR* mutation followed by verification with bi-directional sequencing when recommended by the mutation test's instructions for use; and
3. Member must be 6 years of age or older; and
4. Members using Trikafta® must be supervised by a pulmonary disease specialist; and
5. If the member is currently stabilized on Orkambi® (lumacaftor/ivacaftor) or Symdeko® (tezacaftor/ivacaftor and ivacaftor) and experiencing adverse effects associated with Orkambi® or Symdeko® use, the prescriber must indicate that information on the prior authorization request; and
6. Prescriber must verify the member has been counseled on proper administration of Trikafta® including taking with a fat-containing food; and
7. Prescriber must verify that ALT, AST, and bilirubin will be assessed prior to initiating Trikafta®, every 3 months during the first year of treatment, and annually thereafter; and
8. Prescriber must verify the member does not have severe hepatic impairment; and
9. Prescriber must verify that pediatric members will receive baseline and follow-up ophthalmological examinations as recommended in the Trikafta® *Prescribing Information*; and
10. Member must not be taking any of the following medications concomitantly with Trikafta®: rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John's wort; and
11. ~~For members 6 to 11 years of age, the member's recent weight must be provided on the prior authorization request in order to authorize the appropriate dose according to package labeling, as follows:~~

~~a. Members 6 to 11 years of age weighing <30kg will be approved for Trikafta® (elexacaftor 50mg/tezacaftor 25mg/ivacaftor 37.5mg and ivacaftor 75mg) upon meeting approval criteria; or~~

~~b. Members 6 to 11 years of age weighing ≥30kg and members 12 years of age and older will be approved for Trikafta® (elexacaftor 100mg/tezacaftor 50mg/ivacaftor 75mg and ivacaftor 150mg) upon meeting approval criteria; and~~

12. A quantity limit of 3 tablets per day or 84 tablets per 28 days will apply; and
13. Approvals will be based on the recommended dosing per package labeling based on the member's age and recent weight, if applicable. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
14. Initial approvals will be for the duration of 6 ~~3~~ months~~, after which time compliance will be required for continued approval~~. After 6 months of utilization, compliance and information regarding efficacy, such as improvement in forced expiratory volume in 1 second (FEV_1), will be required for continued approval. Additionally, after 6 months of utilization, information regarding efficacy as previously mentioned or fewer adverse events than with a previous CFTR therapy must be provided for members who switched from Orkambi® or Symdeko® to Trikafta®; and
15. Subsequent approvals will be for the duration of 1 year.

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[1] Vertex Pharmaceuticals Inc. Vertex Announces U.S. FDA Approval for Orkambi® (Lumacaftor/Ivacaftor) in Children with Cystic Fibrosis Ages 12 to <24 months. *Business Wire*. Available online at: https://www.businesswire.com/news/home/20220902005252/en/Vertex-Announces-U.S.-FDA-Approval-for-ORKAMBI%C2%AE-lumacaftorivacaftor-in-Children-With-Cystic-Fibrosis-Ages-12-to-24-months. Issued 09/02/2022. Last accessed 09/06/2022.

[2] Orkambi® (Lumacaftor/Ivacaftor) Prescribing Information. Vertex Pharmaceutics. Available online at: uspi_lumacaftor_ivacaftor.pdf (vrtx.com). Last revised 09/2022. Last accessed 09/06/2022.

Vote to Prior Authorize Alymsys® (Bevacizumab-maly), Lonsurf® (Trifluridine/Tipiracil), and Stivarga® (Regorafenib) and Update the Approval Criteria for the Colorectal Cancer Medications

Oklahoma Health Care Authority
October 2022

Market News and Updates[1,2,3,4,5,6,7,8]

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

- **April 2017:** The FDA approved Stivarga® (regorafenib) for the treatment of patients with hepatocellular carcinoma (HCC) who have been previously treated with the drug sorafenib. Stivarga® was first FDA approved in 2012 and is also indicated to treat colorectal cancer (CRC) and gastrointestinal stromal tumors (GIST) that are no longer responding to previous treatments.
- **August 2017:** The FDA approved Opdivo® (nivolumab) for the treatment of adult and pediatric patients 12 years of age and older with microsatellite instability high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer (mCRC) that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan. Approval for this indication was granted under accelerated approval based on overall response rate (ORR) and duration of response (DOR). In 2018, the combination of Opdivo® and Yervoy® (ipilimumab) was granted an expanded indication for the treatment of adult and pediatric patients 12 years of age and older with MSI-H or dMMR mCRC that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan.
- **February 2019:** The FDA approved Lonsurf® (trifluridine/tipiracil tablets) for the treatment of adults with metastatic gastric or gastroesophageal junction (GEJ) adenocarcinoma previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, human epidermal receptor type 2 (HER2)/neu-targeted therapy. This approval expands the indication for Lonsurf® which includes the treatment of adults with mCRC who have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, anti-vascular endothelial growth factor (VEGF) biological therapy, and if RAS wild-type, an anti-epidermal growth factor receptor (EGFR) therapy. Lonsurf® was originally FDA approved in 2015.

- **June 2020:** The FDA approved Keytruda® (pembrolizumab) for the treatment of unresectable or metastatic MSI-H or dMMR CRC based on improved progression-free survival (PFS) in the frontline setting.
- **April 2022:** The FDA approved Alymsys® (bevacizumab-maly), a biosimilar to Avastin® (bevacizumab). The approval was based on data demonstrating the biosimilar product and the reference product were highly similar, and there were no clinically meaningful differences between the agents. Alymsys® is a VEGF inhibitor indicated for the treatment of mCRC; unresectable, locally advanced, recurrent, or metastatic non-squamous non-small cell lung cancer (NSCLC); recurrent glioblastoma in adults; metastatic renal cell carcinoma (RCC); persistent, recurrent, or metastatic cervical cancer; and epithelial ovarian, fallopian tube, or primary peritoneal cancer. Alymsys® is not indicated for the adjuvant treatment of colon cancer.
- **May 2022:** The FDA approved Opdivo® (nivolumab) in combination with fluoropyrimidine- and platinum-based chemotherapy or in combination with ipilimumab for the first-line treatment of patients with advanced or metastatic esophageal squamous cell carcinoma (ESCC).

Guideline Update(s):

- **February 2022:** The National Comprehensive Caner Network (NCCN) Guidelines for colon cancer recommend the use of Herceptin® (trastuzumab) or its biosimilars in combination with Perjeta® (pertuzumab) or Tykerb® (lapatinib) for use in colon cancer patients with HER2/neu amplified disease who do not have BRAF or RAS mutations. The combination regimens produced a 30% objective response rate in this patient population. Additionally, Enhertu® (fam-trastuzumab deruxtecan-nxki) is now recommended in patients with HER2/ neu positive and BRAF/RAS wild-type disease in the second-line setting. Median PFS in patients with strong HER2/neu expressing tumors was 6.9 months and overall survival (OS) has not yet been reached.

Product Summaries[9,10,11]

Alymsys® (Bevacizumab-maly):

- **Therapeutic Class:** VEGF inhibitor, biosimilar to Avastin® (bevacizumab)
- **Indication(s):**
  - mCRC:
    - In combination with intravenous (IV) fluorouracil-based chemotherapy for first- or second-line treatment
    - In combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-

line treatment in patients who have progressed on a first-line bevacizumab product-containing regimen
    - Unresectable locally advanced, recurrent, or metastatic non-squamous NSCLC, in combination with carboplatin and paclitaxel for first-line treatment
    - Recurrent glioblastoma in adults
    - Metastatic RCC in combination with interferon alfa
    - Persistent, recurrent, or metastatic cervical cancer, in combination with paclitaxel and either cisplatin or topotecan
    - Epithelial ovarian, fallopian tube, or primary peritoneal cancer in combination with paclitaxel, pegylated liposomal doxorubicin, or topotecan for platinum-resistant recurrent disease who received no more than 2 prior chemotherapy regimens
    - Limitation(s) of Use: Alymsys® is not indicated for the adjuvant treatment of colon cancer.
- **How Supplied:** 100mg/4mL (25mg/mL) or 400mg/16mL (25mg/mL) sterile solution for IV infusion in single-dose vials
- **Dose:** 5mg/kg to 15mg/kg every 2 to 3 weeks based on diagnosis (see Alymsys® *Prescribing Information* for diagnosis-dependent dosing regimens)
- **Cost:** The Wholesale Acquisition Cost (WAC) is $179.65 per mL, resulting in a monthly cost of $11,497.60 and annual cost of $149,468.80 based on the recommended dosing of 10mg/kg every 2 weeks for the treatment of mCRC for an 80kg adult.

Lonsurf® (Trifluridine/Tipiracil):
- **Therapeutic Class:** Combination nucleoside metabolic inhibitor and thymidine phosphorylase inhibitor
- **Indication(s):**
    - mCRC previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF biological therapy, and if RAS wild-type, an anti-EGFR therapy
    - GEJ adenocarcinoma previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy
- **How Supplied:** 15mg/6.14mg and 20mg/8.19mg trifluridine/tipiracil oral tablets
- **Dose:** 35mg/m^2 per dose twice daily up to a maximum of 80mg per dose (based on the trifluridine component) on days 1 through 5 and days 8 through 12 of each 28-day cycle
- **Cost:** The WAC is $250.67 per 20mg/8.19mg trifluridine/tipiracil tablet resulting in a monthly cost of $20,053.60 and an annual cost of $260,696.80 based on the maximum recommended dosing.

Stivarga® (Regorafenib):

- **Therapeutic Class:** Kinase inhibitor
- **Indication(s):**
  - mCRC previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy
  - Locally advanced unresectable or metastatic GIST previously treated with imatinib mesylate and sunitinib malate
  - HCC previously treated with sorafenib
- **How Supplied:** 40mg oral tablet
- **Dose:** 160mg [(4) 40mg tablets] once daily for the first 21 days of each 28-day cycle
- **Cost:** The WAC is $243.48 per tablet resulting in a monthly cost of $20,452.32 and an annual cost of $265,880.16 based on the recommended dosing.

Recommendations

The College of Pharmacy recommends the prior authorization of Alymsys® (bevacizumab-maly), Lonsurf® (trifluridine/tipiracil), and Stivarga® (regorafenib) with the following criteria (new criteria and updates listed in red):

Alymsys® (Bevacizumab-maly) and Mvasi® (Bevacizumab-awwb) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use Avastin® (bevacizumab) or Zirabev® (bevacizumab-bvzr), which are available without prior authorization, must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Lonsurf® (Trifluridine/Tipiracil) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of metastatic, recurrent, or unresectable CRC; and
2. Previously treated with a fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy; and
3. Previously treated with an anti-vascular endothelial growth factor (VEGF) therapy; and
   a. If RAS wild-type disease, previously treated with an anti-epidermal growth factor receptor (EGFR) therapy; and
4. Used as monotherapy or in combination with bevacizumab.

Lonsurf® (Trifluridine/Tipiracil) Approval Criteria [Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of metastatic gastric or GEJ adenocarcinoma; and
2. Previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, paclitaxel, docetaxel, or irinotecan; and
3. If human epidermal receptor type 2 (HER2) positive disease, prior treatment should have included HER2 targeted therapy.

Stivarga® (Regorafenib) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of metastatic, recurrent, or unresectable CRC; and
2. Previous treatment with a fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy; and
3. Previous treatment with an anti-vascular endothelial growth factor (VEGF) therapy; and
    a. If RAS wild-type disease, previously treated with an anti-epidermal growth factor receptor (EGFR) therapy.

Stivarga® (Regorafenib) Approval Criteria [Gastrointestinal Stromal Tumor (GIST) Diagnosis]:

1. Diagnosis of locally advanced unresectable or metastatic GIST; and
2. Previously treated with imatinib and sunitinib.

Stivarga® (Regorafenib) Approval Criteria [Hepatocellular Carcinoma (HCC) Diagnosis]:

1. Diagnosis of HCC; and
2. Previous treatment with sorafenib.

Additionally, the College of Pharmacy recommends updating the Enhertu® (fam-trastuzumab deruxtecan-nxki), Herceptin® (trastuzumab), Herzuma® (trastuzumab-pkrb), Kanjinti® (trastuzumab-anns), Ogivri® (trastuzumab-dkst), Ontruzant® (trastuzumab-dttb), Trazimera® (trastuzumab-qyyp), Keytruda® (pembrolizumab), Opdivo® (nivolumab), Perjeta® (pertuzumab), and Yervoy® (ipilimumab) prior authorization criteria based on FDA approvals, NCCN guideline recommendations, and net costs (changes noted in red):

Enhertu® (Fam-Trastuzumab Deruxtecan-nxki) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of advanced or metastatic disease; and
2. Disease has progressed on prior therapy; and
3. Human epidermal receptor type 2 (HER2) amplified disease; and
4. RAS and BRAF mutation negative; and
5. Used as a single agent.

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

1. Diagnosis of human epidermal receptor type 2 (HER2)-positive CRC; and
2. RAS and BRAF mutation negative; and
3. Used in combination with ~~trastuzumab~~ pertuzumab or lapatinib; and
4. Used in 1 of the following settings:
    a. If first-line therapy, member should not be a candidate for intensive therapy; or
    b. For the treatment of advanced or metastatic disease following disease progression; and
5. Authorization of Herceptin® (trastuzumab), Herzuma® (trastuzumab-pkrb), ~~or~~ Kanjinti® (trastuzumab-anns), or Ogivri® (trastuzumab-dkst) will also require a patient-specific, clinically significant reason why the member cannot use ~~Ogivri® (trastuzumab-dkst),~~ Ontruzant® (trastuzumab-dttb)~~,~~ or Trazimera® (trastuzumab-qyyp). Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

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

1. Diagnosis of unresectable or metastatic CRC; and
2. ~~First-line treatment; and~~
3. Tumor is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR).

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

1. Diagnosis of unresectable advanced or metastatic ESCC; and
    a. Used in the first-line setting; and
    b. Used in combination with 1 of the following:
        i. Fluoropyrimidine- and platinum-based chemotherapy; or
        ii. Ipilimumab; 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. Used in first-line setting; and
            1. Used in combination with oxaliplatin and fluorouracil or capecitabine; and
            2. Adenocarcinoma pathology; or
        ii. Used in the second-line or greater setting; and
            1. As a single agent; and
            2. Squamous cell pathology.

Opdivo® (Nivolumab) Approval Criteria [~~Metastatic~~ Colorectal Cancer (~~m~~CRC) Diagnosis]:

1. Diagnosis of unresectable or metastatic CRC; and
2. ~~Disease has progressed on treatment with 5-fluorouracil (5-FU), oxaliplatin, and irinotecan; and~~
3. Tumor is microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR).~~; and~~
4. ~~Used as a single agent or in combination with ipilimumab.~~

~~**Opdivo® (Nivolumab) Approval Criteria [Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) Metastatic Colorectal Cancer (mCRC) Diagnosis]:**~~

1. ~~A diagnosis of MSI-H or dMMR mCRC; and~~
2. ~~Member has not previously failed other PD-1 inhibitors [e.g., Keytruda® (pembrolizumab)]; and~~
3. ~~Progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan.~~

Perjeta® (Pertuzumab) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of human epidermal receptor type 2 (HER2)-positive CRC; and
2. RAS and BRAF mutation negative; and
3. Used in combination with trastuzumab; and
4. Used in 1 of the following settings:
    a. If first-line therapy, member should not be a candidate for intensive therapy; or
    b. For the treatment of advanced or metastatic disease following disease progression.

Yervoy® (Ipilimumab) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of unresectable or metastatic CRC; and

~~2. Disease has progressed on treatment with 5-fluorouracil (5-FU), oxaliplatin, and irinotecan; and~~

3. Tumor is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and
4. Used in combination with nivolumab.

Yervoy® (Ipilimumab) Approval Criteria [Esophageal Squamous Cell Carcinoma (ESCC) Diagnosis]:

1. Diagnosis of unresectable advanced or metastatic ESCC; and
   a. Used in the first-line setting; and
   b. Used in combination with nivolumab.

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Appendix D

Vote to Prior Authorize Amvuttra™ (Vutrisiran) and Update the Approval Criteria for the Amyloidosis Medications

Oklahoma Health Care Authority
October 2022

Market News and Updates[1]

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

- **June 2022:** Alnylam Pharmaceuticals, Inc. announced FDA approval of Amvuttra™ (vutrisiran), a small interfering ribonucleic acid (siRNA) administered via subcutaneous (sub-Q) injection once every 3 months for the treatment of the polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis in adults. The FDA approval is based on positive 9-month results from the HELIOS-A Phase 3 study, where Amvuttra™ significantly improved the signs and symptoms of polyneuropathy, with more than 50% of patients experiencing halting or reversal of their disease manifestations.

Amvuttra™ (Vutrisiran) Product Summary[2]

Indication(s): Amvuttra™ (vutrisiran) is a transthyretin (TTR)-siRNA indicated for the treatment of the polyneuropathy of hATTR amyloidosis in adults.

How Supplied: Amvuttra™ is supplied as 25mg/0.5mL solution in a single-dose prefilled syringe for sub-Q injection.

Dosing and Administration:

- The recommended dosing is 25mg via sub-Q injection once every 3 months.
- Amvuttra™ is for sub-Q use only and should be administered by a health care professional.

Contraindication(s): None

Mechanism of Action:

- Vutrisiran is a double-stranded siRNA-N-acetylgalactosamine conjugate that causes degradation of mutant and wild-type TTR messenger RNA through RNA interference, which results in a reduction of serum TTR protein and TTR protein deposits in tissues.

Safety:

- Reduced Serum Vitamin A Levels: Treatment with vutrisiran leads to a decrease in serum vitamin A levels. Supplementation at the recommended daily allowance of vitamin A is advised for patients taking vutrisiran (700-900mcg retinol activity equivalents for adults). Higher doses than the recommended daily allowance of vitamin A should not be given to try to achieve normal serum vitamin A levels during treatment with vutrisiran, as serum vitamin A levels do not reflect the total vitamin A in the body. Patients should be referred to an ophthalmologist if they develop ocular symptoms suggestive of vitamin A deficiency (e.g., night blindness).
- Pregnancy: There are no available data on vutrisiran use in pregnant women to inform a drug-associated risk of adverse developmental outcomes. Treatment with vutrisiran leads to a decrease in serum vitamin A levels, and vitamin A supplementation is advised for patients taking vutrisiran. Vitamin A is essential for normal embryofetal development; however, excessive levels of vitamin A are associated with adverse developmental effects. The effects on the fetus of a reduction in maternal serum TTR caused by vutrisiran and of vitamin A supplementation are unknown. In animal studies, sub-Q administration of vutrisiran to pregnant rats resulted in developmental toxicity (reduced fetal body weight and embryofetal mortality) at doses associated with maternal toxicity.
- Lactation: There is no information regarding the presence of vutrisiran in human milk, the effects on the breastfed infant, or the effects on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for vutrisiran and any potential adverse effects on the breastfed infant from vutrisiran or from the underlying maternal condition.
- Pediatric Use: Safety and effectiveness in pediatric patients have not been established.
- Geriatric Use: No dose adjustment is required in patients 65 years of age or older. A total of 46 (38%) patients 65 years of age or older, including 7 (6%) patients 75 years of age or older, received vutrisiran in the clinical study. No overall differences in safety or effectiveness were observed between these patients and younger patients, but greater sensitivity of some older individuals cannot be ruled out.
- Renal Impairment: No dose adjustment is recommended in patients with mild or moderate renal impairment [estimated glomerular filtration rate (eGFR) ≥30 to <90mL/min/1.73m^2]. Vutrisiran has not been studied in patients with severe renal impairment or end stage renal disease (ESRD).
- Hepatic Impairment: No dose adjustment is recommended in patients with mild hepatic impairment [total bilirubin ≤1x upper limit of normal

(ULN) and aspartate aminotransferase (AST) >1x ULN, or total bilirubin >1.0 to 1.5x ULN and any level of AST]. Vutrisiran has not been studied in patients with moderate or severe hepatic impairment.

Adverse Reactions: The most common adverse reactions (≥5%) were arthralgia, dyspnea, and reduced serum vitamin A levels.

Efficacy:

- Study: The efficacy of vutrisiran was evaluated in the Phase 3 HELIOS-A study, a randomized, open-label clinical study in adult patients with polyneuropathy caused by hATTR amyloidosis. Patients were randomized 3:1 to receive 25mg of vutrisiran sub-Q once every 3 months (N=122), or 0.3mg/kg patisiran intravenously every 3 weeks (N=42). The patisiran-treated group was a reference group and the differences between this group and the vutrisiran and placebo groups were not evaluated against the primary endpoint. Efficacy assessments were based on a comparison of the vutrisiran arm of the study with an external placebo group from the Phase 3 APOLLO study of patisiran which was composed of a comparable population of adult patients with polyneuropathy caused by hATTR amyloidosis.
- Primary Efficacy Endpoint: The primary endpoint was the change from baseline to month 9 in modified Neuropathy Impairment Score +7 (mNIS+7). The mNIS+7 is an objective assessment of neuropathy and comprises the NIS and Modified +7 composite scores. In the version of the mNIS+7 used in the trial, the NIS objectively measures deficits in cranial nerve function, muscle strength, and reflexes, and the +7 assesses postural blood pressure, quantitative sensory testing, and peripheral nerve electrophysiology. The mNIS+7 has a total score range from 0 to 304 points, with higher scores representing a greater severity of disease.
- Results: Treatment with vutrisiran in HELIOS-A resulted in statistically significant improvements in the mNIS+7 (P<0.001) from baseline to month 9 compared to placebo. Additionally, treatment with vutrisiran in HELIOS-A resulted in statistically significant improvements in the Norfolk Quality of Life-Diabetic Neuropathy total score and 10-meter walk test at month 9 compared to placebo (P<0.001).

Cost Comparison:

Medication	Cost Per mL	Cost Per Year*
Amvuttra™ (vutrisiran) 25mg/0.5mL	**$231,750.00**	**$463,500.00**
Onpattro® (patisiran) 10mg/5mL	$1,957.00	$528,390.00
Tegsedi® (inotersen) 284mg/1.5mL	$6,117.86	$477,193.08

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 year based on maximum FDA recommended dosing for Amvuttra™ 25mg every 3 months, Onpattro® 30mg once every 3 weeks, and Tegsedi® 284mg once a week.

Recommendations[3]

The College of Pharmacy recommends the prior authorization of Amvuttra™ (vutrisiran) with criteria similar to Onpattro® (patisiran) as follows (changes shown in red):

Amvuttra™ (Vutrisiran) and Onpattro® (Patisiran) Approval Criteria:

1. An FDA approved indication for the treatment of polyneuropathy of hereditary transthyretin-mediated (hATTR) amyloidosis; and
2. Diagnosis confirmed by the following:
   a. Tissue (fat pad) biopsy confirming amyloid deposits; ~~and~~ or
   b. Genetic confirmation of transthyretin (TTR) gene mutation (e.g., Val30Met); and
3. Prescriber must verify member is currently experiencing signs and symptoms of polyneuropathy and other causes of polyneuropathy have been ruled out; and
4. Must be prescribed by or in consultation with a cardiologist, geneticist, or neurologist (or an advanced care practitioner with a supervising physician who is a cardiologist, geneticist, or neurologist); and
5. Prescriber must confirm the member will take the recommended daily allowance of vitamin A; and
6. Prescriber must confirm the member does not have severe renal impairment, end-stage renal disease, and/or moderate or severe hepatic impairment; and
7. Prescriber must confirm the member has not undergone a liver transplant; and
8. For Onpattro®, prescriber must confirm the member will be pre-medicated with intravenous (IV) corticosteroid, oral acetaminophen, IV histamine-1 (H_1) antagonist, and IV histamine-2 (H_2) antagonist 60 minutes prior to administration to reduce the risk of infusion-related reaction(s); and
9. Amvuttra™ will not be approved for concomitant use with Onpattro® (patisiran), Tegsedi® (inotersen), Vyndamax® (tafamidis), or Vyndaqel® (tafamidis meglumine); and
10. Authorization for Amvuttra™ will also require a patient-specific, clinically significant reason why the member cannot use Onpattro®; and
11. Onpattro® will not be approved for concomitant use with Amvuttra™ (vutrisiran), Tegsedi® (inotersen), Vyndamax® (tafamidis), or Vyndaqel® (tafamidis meglumine); and
12. For Onpattro®, member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
13. For Amvuttra™, a quantity limit of 0.5mL per 90 days will apply; and

14. Approvals will be for the duration of 1 year ~~6 months~~. Reauthorization may be granted if the prescriber documents the member is responding well to treatment and member has not undergone a liver transplant.

The College of Pharmacy also recommends updating the prior authorization criteria for Tegsedi® (inotersen), Vyndamax® (tafamidis), and Vyndaqel® (tafamidis meglumine) as follows (changes shown in red):

Tegsedi® (Inotersen) Approval Criteria:

1. An FDA approved indication for the treatment of polyneuropathy associated with hereditary transthyretin-mediated (hATTR) amyloidosis; and
2. Diagnosis confirmed by the following:
   ~~a.~~ Tissue (fat pad) biopsy confirming amyloid deposits; ~~and~~ or
   b. Genetic confirmation of transthyretin (*TTR*) gene mutation (e.g., Val30Met); and
3. Prescriber must verify member is currently experiencing signs and symptoms of polyneuropathy and other causes of polyneuropathy have been ruled out; and
4. Tegsedi® must be prescribed by or in consultation with a cardiologist, geneticist, or neurologist (or an advanced care practitioner with a supervising physician who is a cardiologist, geneticist, or neurologist); and
5. Prescriber must confirm the member will take the recommended daily allowance of vitamin A; and
6. Prescriber must agree to monitor ALT, AST, and total bilirubin prior to initiation of Tegsedi® and every 4 months during treatment; and
7. Prescriber must confirm the first injection of Tegsedi® administered by the member or caregiver will be performed under the guidance of a health care professional; and
8. Prescriber must confirm the member or caregiver has been trained by a health care professional on the subcutaneous (sub-Q) administration and proper storage of Tegsedi®; and
9. Prescriber must confirm the member has not undergone a liver transplant; and
10. Tegsedi® will not be approved for concomitant use with Amvuttra™ (vutrisiran), Onpattro® (patisiran), Vyndamax® (tafamidis), or Vyndaqel® (tafamidis meglumine); and
11. Prescriber, pharmacy, and member must be enrolled in the Tegsedi® Risk Evaluation and Mitigation Strategy (REMS) program and maintain enrollment throughout therapy; and
12. Tegsedi® approvals will be for the duration of 1 year ~~6 months~~. Reauthorization may be granted if the prescriber documents the

member is responding well to treatment and member has not undergone a liver transplant; and

13. A quantity limit of 4 syringes per 28 days will apply.

Vyndamax® (Tafamidis) and Vyndaqel® (Tafamidis Meglumine) Approval Criteria:

1. An FDA approved indication for the treatment of the cardiomyopathy of wild-type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular (CV) mortality and CV-related hospitalization; and
2. Diagnosis confirmed by:
   a. Genetic confirmation of transthyretin (*TTR*) mutation (e.g., Val122Ile) or wild-type amyloidosis; and
   b. Cardiac imaging (e.g., ultrasound, MRI) confirming cardiac involvement; and
3. Presence of amyloid deposits confirmed by:
   a. Nuclear scintigraphy; or
   b. Endomyocardial biopsy; and
4. Member must have medical history of heart failure (NYHA Class I to III); and
5. Prescriber must confirm light-chain amyloidosis (AL) has been ruled out; and
6. Prescriber must confirm the member has not undergone a liver transplant; and
7. Vyndamax® or Vyndaqel® must be prescribed by or in consultation with a cardiologist or geneticist (or an advanced care practitioner with a supervising physician who is a cardiologist or geneticist); and
8. Vyndamax® or Vyndaqel® will not be approved for concomitant use Amvuttra™ (vutrisiran), Onpattro® (patisiran) or Tegsedi® (inotersen); and
9. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment and member has not undergone a liver transplant; and
10. A quantity limit of 1 Vyndamax® capsule or 4 Vyndaqel® capsules per day will apply.

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[1] Alnylam Pharmaceuticals, Inc. Alnylam Announces FDA Approval of Amvuttra™ (Vutrisiran), an RNAi Therapeutic for the Treatment of the Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis in Adults. *Business Wire*. Available online at: https://www.businesswire.com/news/home/20220603005487/en/. Issued 06/13/2022. Last accessed 09/22/2022.

[2] Amvuttra™ (Vutrisiran) Prescribing Information. Alnylam Pharmaceuticals, Inc. Available online at: https://www.alnylam.com/sites/default/files/pdfs/amvuttra-us-prescribing-information.pdf. Last revised 06/2022. Last accessed 09/20/2022.

[3] Luigetti M, Romano A, Di Paolantonio A, et al. Diagnosis and Treatment of Hereditary Transthyretin Amyloidosis (hATTR) Polyneuropathy: Current Perspectives on Improving Patient Care. *Ther Clin Risk Manag* 2020; 16:109-123. doi: 10.2147/TCRM.S219979.

Appendix E

Vote to Prior Authorize Herceptin Hylecta™ (Trastuzumab/Hyaluronidase-oysk) and Update the Approval Criteria for the Breast Cancer Medications

Oklahoma Health Care Authority
October 2022

Market News and Updates[1,2,3]

New U.S. FDA Approval(s) and Indication(s):

- **February 2019:** The FDA approved Herceptin Hylecta™ (trastuzumab/ hyaluronidase-oysk) for subcutaneous (sub-Q) injection. Herceptin Hylecta™ is a combination of trastuzumab, a human epidermal growth factor receptor 2 (HER2)/neu receptor antagonist, and hyaluronidase, an endoglycosidase, for the treatment of HER2-overexpressing breast cancer.
- **October 2021:** The FDA approved Verzenio® (abemaciclib) with endocrine therapy (tamoxifen or an aromatase inhibitor) for adjuvant treatment of adult patients with hormone receptor (HR)-positive, HER2-negative, node-positive, early breast cancer at high risk of recurrence and a Ki-67 score ≥20%. This is the first cyclin-dependent kinase (CDK) 4/6 inhibitor approved for adjuvant treatment of breast cancer.
- **March 2022:** The FDA approved Lynparza® (olaparib) for the adjuvant treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated (gBRCAm), HER2-negative, high-risk early breast cancer who have been treated with neoadjuvant or adjuvant chemotherapy.
- **May 2022:** The FDA granted regular approval to Enhertu® (fam-trastuzumab deruxtecan-nxki) for the treatment of adult patients with unresectable or metastatic HER2-positive breast cancer who have received a prior anti-HER2-based regimen either in the metastatic setting or in the neoadjuvant or adjuvant setting and have developed disease recurrence during or within 6 months of completing therapy. Previously, in December 2019, Enhertu® received accelerated approval for the treatment of adult patients with unresectable or metastatic HER2-positive breast cancer who have received 2 or more prior anti-HER2-based regimens in the metastatic setting.
- **August 2022:** The FDA approved Enhertu® (fam-trastuzumab deruxtecan-nxki) for the treatment of adult patients with unresectable or metastatic HER2-low [immunohistochemistry (IHC) 1+ or IHC 2+/in situ hybridization (ISH)-] breast cancer who have received prior chemotherapy in the metastatic setting or developed disease

recurrence during or within 6 months of completing adjuvant chemotherapy.
- **August 2022:** The FDA granted accelerated approval to Enhertu® (fam-trastuzumab deruxtecan-nxki) for the treatment of adult patients with unresectable or metastatic non-small cell lung cancer (NSCLC) whose tumors have activating HER2 (ERBB2) mutations and who have received a prior systemic therapy. This is the first drug approved for HER2-mutant NSCLC.

Guideline Update(s):
- **Ixempra® (Ixabepilone):** Based on several Phase 2 trial results, ixabepilone now has a role as monotherapy in the treatment of metastatic breast cancer. In these trials, objective response rates ranged from 11.5% in refractory patients to 41.5% in the first-line setting. The National Comprehensive Cancer Network (NCCN) guidelines were updated to reflect the use of ixabepilone in these settings.

Herceptin Hylecta™ (Trastuzumab/Hyaluronidase-oysk) Product Summary[4]

- **Therapeutic Class:** Combination HER2/neu receptor antagonist and endoglycosidase
- **Indication(s):** HER2-overexpressing breast cancer
- **How Supplied:** 600mg trastuzumab/10,000 units hyaluronidase/5mL (120mg/2,000 units/mL) solution in a single-dose vial
- **Dose:** 600mg trastuzumab/10,000 units hyaluronidase via sub-Q administration once every 3 weeks
- **Cost:** The Wholesale Acquisition Cost (WAC) is $935.05 per mL, resulting in a cost per dose of $4,675.25 and an annual cost of $84,154.50 based on the recommended dosing.

Recommendations

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

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

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

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

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

The College of Pharmacy also recommends updating the approval criteria for Enhertu® (fam-trastuzumab deruxtecan-nxki), Lynparza® (olaparib), and Verzenio® (abemaciclib) based on recent FDA approvals (changes and new criteria noted in red; only criteria with updates are listed):

Enhertu® (Fam-Trastuzumab Deruxtecan-nxki) Approval Criteria [Breast Cancer Diagnosis]:

1. Adult members with unresectable or metastatic disease ~~human epidermal growth factor receptor 2 (HER2)-positive breast cancer~~; and

a. For human epidermal growth factor receptor 2 (HER2)-positive disease, must meet the following:
    i. Member received prior therapy in the metastatic, neoadjuvant, or adjuvant setting and developed disease recurrence during or within 6 months of completing therapy; and
    ii. Member has received ≥~~2~~ 1 prior anti-HER2-based regimen~~s in the metastatic setting.~~; or
b. For HER-2 low [immunohistochemistry (IHC) 1+ or IHC 2+/in situ hybridization (ISH)-] disease, must meet the following:
    i. Member received prior chemotherapy in the metastatic setting or developed disease recurrence during or within 6 months of completing adjuvant chemotherapy.

Enhertu® (Fam-Trastuzumab Deruxtecan-nxki) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Unresectable or metastatic NSCLC; and
2. Disease is human epidermal growth factor receptor 2 (HER2)-positive; and
3. Member must have received a prior systemic therapy.

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

1. Diagnosis of human epidermal growth factor receptor 2 (HER2)-negative, high-risk early breast cancer previously treated with neoadjuvant or adjuvant chemotherapy; and
    a. Used in the adjuvant setting; and
    b. Positive test for a germline BRCA-mutation (gBRCAm); and
    c. Maximum treatment duration of 1 year; or
2. Diagnosis of metastatic breast cancer; and
    a. Member must have shown progression on previous chemotherapy ~~in any setting~~; and
    b. Members with hormone receptor positive disease must have failed prior endocrine therapy or are considered to not be a candidate for endocrine therapy.

Verzenio® (Abemaciclib) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of advanced or metastatic breast cancer; and
    a. Hormone receptor positive disease; and
    b. Human epidermal growth factor receptor 2 (HER2)-negative disease; and
        i. Used in 1 of the following settings:
            1. In combination with an aromatase inhibitor as initial endocrine-based therapy for postmenopausal women; or
            2. In combination with fulvestrant with disease progression following endocrine therapy; or

3. As monotherapy for disease progression following endocrine therapy and prior chemotherapy; or

2. Diagnosis of early-stage breast cancer; and
   a. Hormone receptor positive disease; and
   b. HER2-negative disease; and
   c. Node-positive disease high risk for recurrence with Ki-67 ≥20%; and
   d. Used as adjuvant treatment in combination with endocrine therapy.

Additionally, the College of Pharmacy recommends updating the prior authorization criteria for Ixempra® (ixabepilone) based on NCCN compendium approval (changes noted in red):

Ixempra® (Ixabepilone) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of metastatic or locally advanced breast cancer; and
2. Used in combination with capecitabine; and
   a. After failure of an anthracycline and a taxane unless anthracycline contraindicated; or
3. Used as a single agent; and
   a. Used in 1 of the following settings:
      i. After failure of capecitabine, an anthracycline, and a taxane; or
      ii. In members with no response to preoperative systemic therapy; or
      iii. After at least 1 line of therapy for recurrent unresectable (local or regional) disease; or
      iv. Disease is human epidermal growth factor receptor 2 (HER2)-negative; or
4. Used in combination with trastuzumab; and
   a. Disease is HER2-positive; and
   b. Third-line or subsequent therapy.

Finally, the College of Pharmacy also recommends updating the prior authorization criteria for Perjeta® (pertuzumab) to more closely reflect the FDA approval granted to pertuzumab for this indication (changes noted in red):

Perjeta® (Pertuzumab) Approval Criteria [Breast Cancer Diagnosis]:

1. Human epidermal growth factor receptor 2 (HER2)-positive; and
2. Used in 1 of the following settings:
   a. Metastatic breast cancer in members who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease; and
      i. Used in combination with trastuzumab and ~~docetaxel~~ chemotherapy; or

b. Neoadjuvant treatment of members with locally advanced, inflammatory, or early stage breast cancer (either >2cm in diameter or node positive); and
    i. Used in combination with trastuzumab and ~~docetaxel or paclitaxel (neoadjuvant treatment may also contain other agents in addition to trastuzumab and docetaxel or paclitaxel~~ chemotherapy; or
c. Adjuvant systemic therapy for members with node positive, HER2-positive tumors or members with high-risk node negative tumors [tumor >1cm; tumor 0.5 to 1cm with histologic or nuclear grade 3; estrogen receptor (ER)/progesterone receptor (PR) negative; or younger than 35 years of age]; and
    i. Used in combination with trastuzumab and chemotherapy ~~paclitaxel following doxorubicin/cyclophosphamide (AC)~~; or
    ii. Used in combination with trastuzumab and docetaxel following doxorubicin/cyclophosphamide (AC); or
    iii. Used in combination with docetaxel/carboplatin/trastuzumab (TCH); or
    iv. Used in combination with trastuzumab following neoadjuvant therapy with paclitaxel/docetaxel/carboplatin/trastuzumab/pertuzumab (pTCHP).

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[1] U.S. Food and Drug Administration (FDA). Drug Approvals and Databases. FDA Approves New Formulation of Herceptin® for Subcutaneous Use. Available online at: https://www.fda.gov/drugs/drug-approvals-and-databases/fda-approves-new-formulation-herceptin-subcutaneous-use#:~:text=On%20February%2028%2C%202019%2C%20the,Hylecta%2C%20Genentech%20Inc. Last revised 03/08/2019. Last accessed 09/20/2022.

[2] U.S. FDA. Hematology/Oncology (Cancer) Approvals & Safety Notifications. Available online at: https://www.fda.gov/drugs/resources-information-approved-drugs/hematologyoncology-cancer-approvals-safety-notifications. Last revised 09/02/2022. Last accessed 09/20/2022.

[3] National Comprehensive Cancer Network (NCCN). *NCCN Drugs & Biologics Compendium (NCCN Compendium)*. Available online at: http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Last accessed 09/20/2022.

[4] Herceptin Hylecta™ (Trastuzumab/Hyaluronidase-oysk) Prescribing Information. Genentech. Available online at: https://www.gene.com/download/pdf/herceptin_hylecta_prescribing.pdf. Last revised 02/2019. Last accessed 09/20/2022.

Appendix F

Fiscal Year 2022 Annual Review of Bylvay® (Odevixibat) and Livmarli® (Maralixibat)

Oklahoma Health Care Authority
October 2022

Current Prior Authorization Criteria

Bylvay® (Odevixibat) Approval Criteria:

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

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

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

Livmarli® (Maralixibat) Approval Criteria:

1. An FDA approved indication for the treatment of cholestatic pruritus in members with Alagille Syndrome (ALGS); and
    a. Diagnosis must be confirmed by genetic testing identifying mutations in the *JAG1* or *NOTCH2* genes; and
2. Member must be 1 year of age or older; and
3. Livmarli® must be prescribed by a gastroenterologist, hepatologist, geneticist, or other specialist with expertise in the treatment of ALGS (or an advanced care practitioner with a supervising physician who is a gastroenterologist, hepatologist, geneticist, or other specialist with expertise in the treatment of ALGS); and
4. Prescriber must verify member has a history of significant pruritus that is unresponsive to treatment with ursodeoxycholic acid (UDCA) and at least 2 of the following medications, unless contraindicated:
    a. Cholestyramine; or
    b. Rifampin; or
    c. Sertraline; or
    d. Naltrexone; and
5. Member must have evidence of cholestasis demonstrated by ≥1 of the following:
    a. Total serum bile acid >3x upper limit of normal (ULN) for age; or
    b. Conjugated bilirubin >1mg/dL; or
    c. Fat soluble vitamin deficiency otherwise unexplainable; or
    d. Gamma-glutamyl transferase (GGT) >3x ULN for age; or
    e. Intractable pruritus explainable only by liver disease; and
6. Members with a history of liver transplantation will not generally be approved for Livmarli®; and

7. Prescriber must verify surgical intervention (e.g., biliary diversion, liver transplantation) is not currently clinically appropriate for the member; and
8. Prescriber must agree to monitor alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, direct bilirubin, and international normalized ratio (INR) at baseline and during treatment with Livmarli®; and
9. Prescriber must verify the member and/or member's caregiver has been counseled on appropriate storage, dosing, and administration of Livmarli®, including the use of a calibrated oral dosing dispenser for accurate measurement; and
10. Member's current weight (taken within the past 3 weeks) must be provided on initial and subsequent prior authorization requests in order to authorize the appropriate amount of drug required according to package labeling; and
11. Initial approvals will be for a duration of 3 months. After 3 months of treatment, further approval may be granted for a duration of 1 year if the prescriber documents the member is responding well to treatment and surgical intervention is still not clinically appropriate.

Utilization of Bylvay® (Odevixibat) and Livmarli® (Maralixibat): Fiscal Year 2022

There was no SoonerCare utilization of Bylvay® (odevixibat) or Livmarli® (maralixibat) during fiscal year 2022 (07/01/2021 to 06/30/2022).

Prior Authorization of Bylvay® (Odevixibat) and Livmarli® (Maralixibat)

There were 3 prior authorization requests submitted for 1 unique member for Bylvay® (odevixibat) during fiscal year 2022. There were no prior authorization requests submitted for Livmarli® (maralixibat) during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions

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

Anticipated Exclusivity Expiration(s):

- Bylvay® (odevixibat): June 2039
- Livmarli® (maralixibat): February 2040

Pipeline:

- **Maralixibat:** Mirum Pharmaceuticals, the manufacturer of Livmarli® (maralixibat), is evaluating the use of maralixibat for potential additional indications for cholestatic liver diseases. The Phase 3 MARCH-PFIC study is ongoing and will assess the efficacy and safety of maralixibat for the treatment of pruritus in patients with progressive familial intrahepatic cholestasis (PFIC). Additionally, the Phase 2b EMBARK study will assess the efficacy and safety of maralixibat for the treatment of biliary atresia.
- **Odevixibat:** Albireo Pharma, the manufacturer of Bylvay® (odevixibat), is evaluating the use of odevixibat for potential additional indications for cholestatic liver diseases. The Phase 3 ASSERT study will assess the efficacy and safety of odevixibat for the treatment of pruritus in patients with Alagille syndrome (ALGS). Further, the Phase 3 BOLD study will assess the efficacy and safety of odevixibat for the treatment of biliary atresia.

Recommendations

The College of Pharmacy recommends updating the Bylvay® (odevixibat) prior authorization criteria with the following changes to be consistent with the Livmarli® (maralixibat) prior authorization criteria (changes shown in red):

Bylvay® (Odevixibat) Approval Criteria:

1. An FDA approved indication for the treatment of pruritus in members with progressive familial intrahepatic cholestasis (PFIC); and
   a. Diagnosis must be confirmed by genetic testing identifying mutations in the *ATP8B1, ABCB11, or ABCB4* genes; and
2. Member must be 3 months of age or older; and
3. Bylvay® must be prescribed by a gastroenterologist, hepatologist, geneticist, or other specialist with expertise in the treatment of PFIC (or an advanced care practitioner with a supervising physician who is a gastroenterologist, hepatologist, geneticist, or other specialist with expertise in the treatment of PFIC); and
4. Prescriber must verify member has a history of significant pruritus that is unresponsive to treatment with ursodeoxycholic acid (UDCA) and at least 2 ~~3~~ of the following medications, unless contraindicated:
   ~~a. Ursodeoxycholic acid (UDCA); or~~
   b. Cholestyramine; or
   c. Rifampin; or

    d. Sertraline; or
    e. Naltrexone; and
5. Member must have elevated serum bile acid concentration ≥100micromol/L at baseline; and
6. Prescriber must verify member does not have known pathologic variants of the *ABCB11* gene predicting a non-functional or absent bile salt export pump protein (BSEP-3); and
7. Members with a history of liver transplantation will generally not be approved for Bylvay®; and
8. Prescriber must verify surgical intervention (e.g., biliary diversion, liver transplantation) is not currently clinically appropriate for the member; and
9. Prescriber must agree to monitor alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin, direct bilirubin, and international normalized ratio (INR) at baseline and during treatment with Bylvay®; and
10. Member's current weight (taken within the past 3 weeks) must be provided on initial and subsequent prior authorization requests in order to authorize the appropriate amount of drug required according to package labeling; and
11. Initial approvals will be for 40mcg/kg/day for a duration of 3 months. After 3 months of treatment, further approval may be granted at the 40mcg/kg/day dose if the prescriber documents the member is responding well to treatment and surgical intervention is still not clinically appropriate; or
12. Dose increases to 80mcg/kg/day (for 3 months) and 120mcg/kg/day (for 3 months) may be approved if there is no improvement in pruritus after 3 months of treatment with the lower dose(s). Further approval may be granted if the prescriber documents the member is responding well to treatment at the current dose and is still not a candidate for surgical intervention; and
13. If there is no improvement in pruritus after 3 months of treatment with the maximum 120mcg/kg/day dose, further approval of Bylvay® will not be granted.

[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 09/2022. Last accessed 09/02/2022.
[2] Mirum Pharmaceuticals, Inc. Our Science: Pipeline. Available online at: https://mirumpharma.com/our-science/pipeline/. Last accessed 10/03/2022.
[3] Mirum Pharmaceuticals, Inc. Mirum Pharmaceuticals to Announce Second Quarter 2022 Financial Results and Host Conference Call on August 4, 2022. Available online at: https://ir.mirumpharma.com/news-events/News/news-details/2022/Mirum-Pharmaceuticals-to-Announce-Second-Quarter-2022-Financial-Results-and-Host-Conference-Call-on-August-4-2022/default.aspx. Issued 07/28/2022. Last accessed 10/03/2022.
[4] Albireo Pharma. Science & Medicine: Pipeline. Available online at: https://albireopharma.com/science-medicine/pipeline/. Last accessed 10/03/2022.
[5] Albireo Pharma, Inc. Albireo Completes Enrollment in Pivotal Phase 3 ASSERT Study of Bylvay® (Odevixibat) in Alagille Syndrome. Available online at: https://ir.albireopharma.com/news-releases/news-release-details/albireo-completes-enrollment-pivotal-phase-3-assert-study. Issued 03/29/2022. Last accessed 10/03/2022.

Appendix G

Fiscal Year 2022 Annual Review of Spinal Muscular Atrophy (SMA) Medications

Oklahoma Health Care Authority
October 2022

Current Prior Authorization Criteria

Evrysdi® (Risdiplam) Approval Criteria:

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

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

Spinraza® (Nusinersen) Approval Criteria:

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

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

Zolgensma® (Onasemnogene Abeparvovec-xioi) Approval Criteria:

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

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

Utilization of SMA Medications: Fiscal Year 2022

Fiscal Year Comparison: Pharmacy Claims

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	25	93	$10,610,458.19	$114,090.95	$2,448.76	9,588	4,333
2022	28	177	$10,035,708.96	$56,698.92	$1,702.70	22,922	5,894
% Change	**12.00%**	**90.30%**	**-5.42%**	**-50.30%**	**-30.47%**	**139.10%**	**36.00%**
Change	**3**	**84**	**-$574,749.23**	**-$57,392.03**	**$746.06**	**13,334**	**1,561**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Fiscal Year 2022 Utilization: Medical Claims

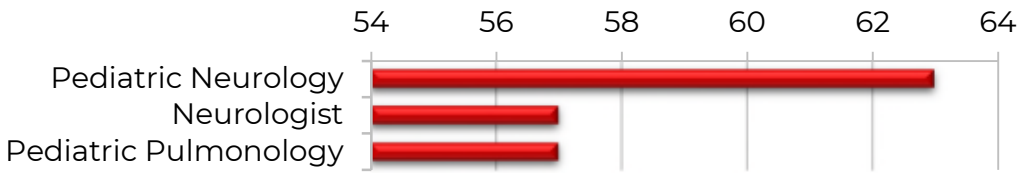
Fiscal Year	*Total Members	†Total Claims	Total Cost	Cost/ Claim	Claims/ Member
2022	1	3	$510,000.00	$170,000.00	3

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
†Total number of unduplicated claims.
Fiscal Year 2022 = 07/01/2021 to 06/30/2022
Please note: There were no paid medical claims for SMA medications during fiscal year 2021 (07/01/2020 to 06/30/2021) to allow for a fiscal year comparison.

Demographics of Members Utilizing SMA Medications: Pharmacy Claims

- Due to the limited number of members utilizing SMA medications during fiscal year 2022, detailed demographic information could not be provided.

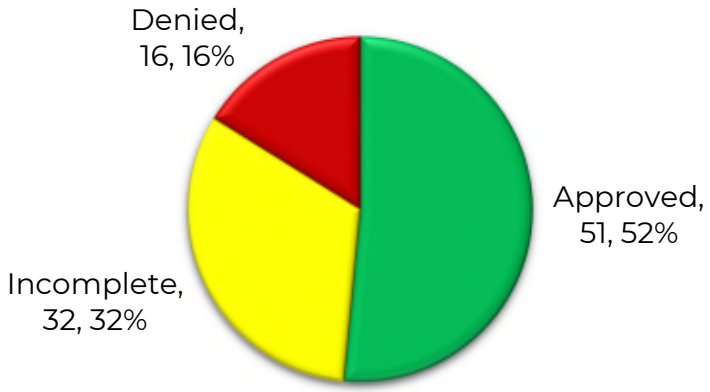
Top Prescriber Specialties of SMA Medications by Number of Claims: Pharmacy Claims



Prior Authorization of SMA Medications

There were 99 prior authorization requests submitted for SMA medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



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

Anticipated Patent Expiration(s):

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

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

- **May 2022:** The FDA approved a label extension for Evrysdi® (risdiplam) to include infants younger than 2 months of age with SMA. The approval is based on interim efficacy and safety data from the RAINBOWFISH study in newborns, which showed the majority of pre-symptomatic infants treated with risdiplam achieved key milestones such as sitting and standing with half of them walking after 12 months of treatment. Risdiplam is now approved to treat SMA in children and adults of all ages. Of the infants with 2 or 3 copies of the *survival motor neuron 2* (*SMN2*) gene (N=6), 100% were able to sit after 1 year of

treatment with risdiplam, 67% could stand, and 50% of infants could walk independently. All infants were alive at 12 months without permanent ventilation. As part of the label extension, the risdiplam *Prescribing Information* has also been updated to include recent 2 year pooled data from the FIREFISH study, which demonstrate long-term efficacy and safety in symptomatic infants with type 1 SMA. The study enrolled infants 1-7 months of age, and after 2 years of treatment with risdiplam at the recommended dose (N=58), 60% of infants were able to sit without support for 5 seconds, 40% for 30 seconds, and 28% of infants were able to stand. Without treatment, infants do not achieve these milestones in the natural history of the disease. There were no treatment-related adverse events leading to withdrawal. The most common adverse reactions were respiratory tract infection, constipation, vomiting, and cough.

News:

- **June 2022:** Biogen presented new data from clinical studies RESPOND and DEVOTE at the SMA Research & Clinical Care Meeting hosted by Cure SMA. These studies are aimed at assessing remaining unmet needs for people living with SMA and evaluating the potential impact of Spinraza® (nusinersen) in different patient populations. In the Phase 4 RESPOND study the clinical benefit and safety of Spinraza® in infants and toddlers with SMA who have unmet needs following treatment with Zolgensma® (onasemnogene abeparvovec-xioi) is being evaluated. All enrolled study participants reported suboptimal clinical status across a variety of measures at baseline, with 13 of 16 showing this in multiple areas, including motor and respiratory functions and swallowing/feeding ability. The RESPOND study is currently enrolling participants at 20 sites worldwide. Additionally, data from part A of the ongoing, 3-part DEVOTE study evaluating the safety and tolerability of investigational, higher doses of nusinersen were presented. Results from part A, an open-label safety evaluation period in children and teens with later-onset SMA, suggest that a higher dosing regimen (28mg) of nusinersen leads to higher levels of the drug in the cerebrospinal fluid and is generally well-tolerated. The totality of Part A data supports further development of a higher dose of nusinersen. Part B and part C of DEVOTE evaluating an investigational, higher dose of nusinersen are enrolling at 52 sites worldwide.
- **August 2022:** The deaths of 2 children 4 and 28 months of age were reported after treatment with the SMA gene therapy Zolgensma® (onasemnogene abeparvovec-xioi). The 2 children, from Russia and Kazakhstan, died 6 to 7 weeks after receiving Zolgensma® from acute liver failure, a known side effect of Zolgensma® that is included in the *Prescribing Information* as a *Boxed Warning*. Both patients had

received corticosteroid taper to restore liver function. Clinical characteristics of the 2 fatal cases associated with Zolgensma® treatment included asymptomatic elevation of liver aminotransferases within the first 1 to 2 weeks post infusion, treated with an increased prednisolone dose. This was followed by hepatotoxicity including vomiting, weakness, and a second elevation of liver aminotransferases, starting between 5 to 6 weeks post infusion, approximately 1 to 10 days following the initiation of prednisolone taper. Finally, rapid deterioration in liver function, and progression to hepatic encephalopathy and multi-organ failure followed. The manufacturer, Novartis, advises health care providers to monitor liver function for at least 3 months after Zolgensma® infusion and at other times as clinically indicated. This is noted in the *Prescribing Information* as well as the recommendation to assess liver function prior to infusion, and the label is being updated to note that fatal cases of acute liver failure have been reported in treated patients.

Pipeline:

- **Apitegromab:** In April 2021, Scholar Rock announced positive top-line data from the TOPAZ Phase 2 clinical study evaluating apitegromab (previously known as SRK-015) in patients with type 2 and type 3 SMA. Apitegromab is a selective inhibitor of the activation of latent myostatin. Myostatin is expressed primarily by skeletal muscle cells and the absence of its gene is associated with an increase in muscle mass and strength. The TOPAZ Phase 2 proof-of-concept study enrolled 58 patients with type 2 and type 3 SMA across 16 study sites in the United States and Europe. The study evaluated the safety and efficacy of intravenous apitegromab dosed every 4 weeks (Q4W) over a 12-month treatment period in 3 patient cohorts. In the 3 cohorts, the patients received apitegromab either in conjunction with nusinersen, received apitegromab and had initiated nusinersen at 5 years of age or older, or received apitegromab and had initiated nusinersen at younger than 5 years of age. All 3 cohorts showed the patients maintained or improved their motor function from baseline, as reflected in Revised Hammersmith Scale (RHS). The results of TOPAZ informed the design of SAPPHIRE, a randomized, double-blind, placebo-controlled, Phase 3 clinical study. Approximately 156 patients 2 to 12 years of age with non-ambulatory type 2/3 SMA are anticipated to be enrolled in the main efficacy population of the study. Patients will receive either apitegromab or placebo Q4W for 12 months, which will be added on top of background treatment, either nusinersen or risdiplam. Separately from the main efficacy population, an exploratory population of approximately 48 patients 13 to 21 years of age with non-

ambulatory type 2/3 SMA will also be evaluated. Start-up activities for SAPPHIRE commenced in November 2021.

- **OAV-101 IT:** In August 2021, Novartis announced the FDA determined that OAV-101 intrathecal (IT) clinical trials for SMA patients could proceed, thereby lifting the partial clinical trial hold initiated in October 2019. The decision to lift the hold was based on data from Novartis' comprehensive nonclinical toxicology study in non-human primates (NHP) that addressed all issues identified, including questions of dorsal root ganglia (DRG) injury following IT administration. Following this decision and input from the FDA and European Medicines Agency (EMA), Novartis is initiating STEER, a global, pivotal Phase 3 study to evaluate the clinical efficacy, safety, and tolerability of OAV-101 IT in treatment naïve SMA patients who are between 2 and 18 years of age who are able to sit but have never walked. The primary objective of STEER is to evaluate the efficacy and safety of one-time IT administration of OAV-101 compared to sham controls over a 52-week period, at the end of which patients in the control arm will be treated with OAV-101. The therapeutic effect of OAV-101 will be evaluated using the Hammersmith Functional Motor Scale-Expanded (HFMSE). Secondary objectives include evaluating safety and efficacy of OAV-101 using the Revised Upper Limb Module (RULM) scale. More than 100 patients will be randomized to receive OAV-101 by IT injection or to receive a sham procedure. At the end of the 52-week period, all eligible patients who received the sham procedure will receive OAV-101 and all eligible patients who received OAV-101 will receive the sham procedure.

Recommendations

The College of Pharmacy recommends updating the approval criteria for Evrysdi® (risdiplam) based on the recent FDA approved age expansion (changes noted in red):

Evrysdi® (Risdiplam) Approval Criteria:

1. An FDA approved diagnosis of spinal muscular atrophy (SMA) ~~in members 2 months of age and older~~; and
2. Molecular genetic testing to confirm bi-allelic pathogenic variants in the *survival motor neuron 1* (*SMN1*) gene; and
3. Member is not currently dependent on permanent invasive ventilation (defined as ≥16 hours of respiratory assistance per day continuously for >21 days in the absence of an acute, reversible illness or a perioperative state); and
4. Evrysdi® must be prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA); and

5. Prescriber must agree to evaluate member's liver function prior to initiating Evrysdi® and must verify the member does not have severe hepatic impairment (Child-Pugh C); and
6. Pharmacy must confirm Evrysdi® will be constituted to an oral solution by a pharmacist prior to dispensing and must confirm Evrysdi® will be shipped via cold chain supply to adhere to the storage and handling requirements in the Evrysdi® *Prescribing Information*; and
7. Prescriber must confirm the member or caregiver has been counseled on the proper storage of Evrysdi® and has been instructed on how to prepare the prescribed daily dose of Evrysdi® prior to administration of the first dose; and
8. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
9. Female members of reproductive potential must be willing to use effective contraception during treatment with Evrysdi® and for at least 1 month after the last dose; and
10. Prescriber must verify male members of reproductive potential have been counseled on the potential effects on fertility and the potential of compromised male fertility is acceptable; and
11. Member will not be approved for concomitant treatment with Spinraza® (nusinersen); and
12. Member must not have previously received treatment with Zolgensma® (onasemnogene abeparvovec-xioi); and
13. A baseline assessment must be provided using a functionally appropriate exam [e.g., Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), Hammersmith Functional Motor Scale Expanded (HFMSE), Hammersmith Infant Neurological Exam (HINE), Upper Limb Module (ULM) Test]; and
14. Member's recent weight must be provided to ensure accurate dosing in accordance with Evrysdi® *Prescribing Information*; and
15. A quantity limit of 240mL per 36 days will apply.

Utilization Details of SMA Medications: Fiscal Year 2022

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM
RISDIPLAM PRODUCTS					
EVRYSDI SOL 0.75MG/ML	151	16	$3,105,500.65	9.44	$20,566.23
SUBTOTAL	**151**	**16**	**$3,105,500.65**	**9.44**	**$20,566.23**
NUSINERSEN PRODUCTS					
SPINRAZA INJ 12MG/5ML	24	12	$2,680,185.49	2	$111,674.40
SUBTOTAL	**24**	**12**	**$2,680,185.49**	**2**	**$111,674.40**
ONASEMNOGENE ABEPARVOVEC-XIOI PRODUCTS					
ZOLGENSMA INJ 1x5.5ML/2x8.3ML KIT	1	1	$2,125,011.41	1	$2,125,011.41
ZOLGENSMA INJ 2x5.5ML/3x8.3ML KIT	1	1	$2,125,011.41	1	$2,125,011.41

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM
SUBTOTAL	**2**	**2**	**$4,250,022.82**	**1**	**$2,125,011.41**
TOTAL	**177**	**28***	**$10,035,708.96**	**6.32**	**$56,698.92**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
INJ = injection; SOL = solution
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS+	TOTAL MEMBERS*	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM
NUSINERSEN INJ J2326	3	1	$510,000.00	3	$170,000.00
TOTAL	**3**	**1**	**$510,000.00**	**3**	**$170,000.00**

Costs do not reflect rebated prices or net costs.
+Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
INJ = injection
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

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[9] Novartis. Novartis Announces Lift of Partial Clinical Trial Hold and Plans to Initiate a New, Pivotal Phase 3 Study of Intrathecal OAV-101 in Older Patients with SMA. Available online at: https://www.novartis.com/news/media-releases/novartis-announces-lift-partial-clinical-trial-hold-and-plans-initiate-new-pivotal-phase-3-study-intrathecal-oav-101-older-patients-sma. Issued 08/03/2021. Last accessed 09/26/2022.

Appendix H

Fiscal Year 2022 Annual Review of Myeloproliferative Neoplasm (MPN) Medications and 30-Day Notice to Prior Authorize Besremi® (Ropeginterferon Alfa-2b-njft) and Vonjo® (Pacritinib)

Oklahoma Health Care Authority
October 2022

Introduction[1]

Myelofibrosis (MF), polycythemia vera (PV), and essential thrombocythemia (ET) are a group of heterogeneous disorders of the hematopoietic system collectively known as myeloproliferative neoplasms (MPN). The prevalence of these diseases is rare in the United States and is estimated to be approximately 295,000 collectively. MPN are characterized by a complicated clinical course with symptoms that vary based on subtype. The main symptoms include fatigue, pruritus, weight loss, and splenomegaly. The treatment of MPN has evolved since the identification of Janus kinase-signal transducer and activator of transcription (JAK-STAT) driver mutations. This has led to the development of targeted therapies resulting in significant improvements in disease-related symptoms and quality of life.

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. Must be used as a single agent.

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

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

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

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

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

1. Diagnosis of MF; and

2. Used in 1 of the following settings:
    a. Symptomatic lower-risk MF with no response or loss of response to peginterferon alfa-2a or hydroxyurea; or
    b. Intermediate to high-risk MF; and
3. Member must be 18 years of age or older.

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

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

Utilization of MPN Medications: Fiscal Year 2022

Fiscal Year Comparison: Pharmacy Claims

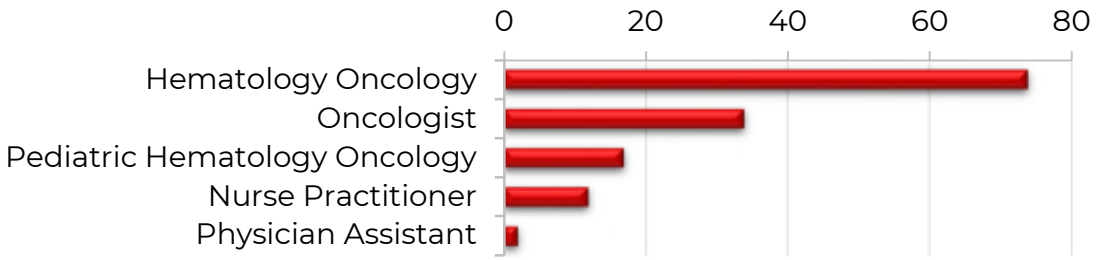
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	14	76	$1,100,091.90	$14,474.89	$410.48	4,693	2,680
2022	24	139	$2,168,007.17	$15,597.17	$484.47	8,542	4,475
% Change	**71.40%**	**82.90%**	**97.10%**	**7.80%**	**18.00%**	**82.00%**	**67.00%**
Change	**10**	**63**	**$1,067,915.27**	**$1,122.28**	**$73.99**	**3,849**	**1,795**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing MPN Medications: Pharmacy Claims

- Due to the limited number of members utilizing MPN medications during fiscal year 2022, detailed demographic information could not be provided.

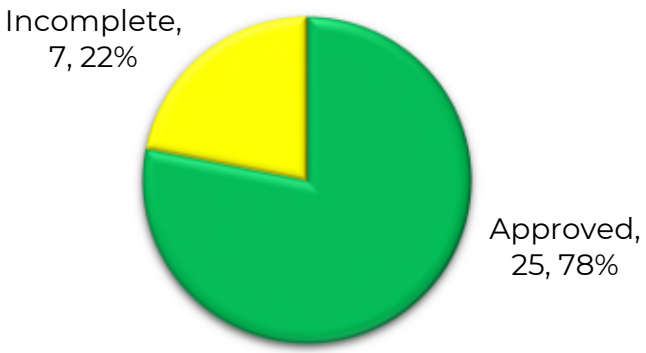
Top Prescriber Specialties of MPN Medications by Number of Claims: Pharmacy Claims



Prior Authorization of MPN Medications

There were 32 prior authorization requests submitted MPN medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



Market News and Updates[2,3]

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

- **November 2021:** The FDA approved Besremi® (ropeginterferon alfa-2b-njft) injection for the treatment of adults with PV. Besremi® can be used regardless of treatment history, and it is the first interferon therapy specifically approved for PV.
- **February 2022:** The FDA approved Vonjo® (pacritinib) for the treatment of adults with intermediate or high-risk primary or secondary (post-PV or post-ET) MF with a platelet count below 50 x 10^9/L. Vonjo® is a novel oral kinase inhibitor with specificity for Janus kinase 2 (JAK2) and interleukin-1 receptor-associated kinase 1 (IRAK1), without inhibiting JAK1.

Product Summaries[4,5]

Besremi® (Ropeginterferon Alfa-2b-njft):

- **Therapeutic Class:** Type I interferon
- **Indication(s):** Interferon alfa-2b indicated for the treatment of adults with PV
- **How Supplied:** 500mcg/mL solution in a single-dose prefilled syringe
- **Dose:**
  - Starting dose: 100mcg by subcutaneous (sub-Q) injection every 2 weeks or 50mcg if receiving hydroxyurea
  - Subsequent dosing: Dose may be increased by 50mcg every 2 weeks (up to a maximum of 500mcg) until hematological parameters are stabilized
- **Cost:** The Wholesale Acquisition Cost (WAC) is $7,288 per mL, resulting in a cost per month of $14,576 and an annual cost of $189,488 based on the maximum recommended dosing of 500mcg every 2 weeks.

Vonjo® (Pacritinib):

- **Therapeutic Class:** Kinase inhibitor
- **Indication(s):** Treatment of adults with intermediate or high-risk primary or secondary (post-PV or post-ET) MF with a platelet count below 50 x 10^9/L.
- **How Supplied:** 100mg oral capsules
- **Dose:** 200mg [(2) 100mg capsules] twice daily
- **Cost:** The WAC is $178.58 per capsule, resulting in a cost per month of $21,429.60 and an annual cost of $257,155.20 based on the recommended dosing of 200mg twice daily.

Recommendations

The College of Pharmacy recommends the prior authorization of Besremi® (ropeginterferon alfa-2b-njft) and Vonjo® (pacritinib) with the following criteria:

Besremi® (Ropeginterferon Alfa-2b-njft) Approval Criteria [Polycythemia Vera (PV) Diagnosis]:

1. Diagnosis of PV; and
2. Used as a single agent.

Vonjo® (Pacritinib) Approval Criteria [Myelofibrosis (MF) Diagnosis]:

1. Diagnosis of intermediate or high-risk primary or secondary MF; and
2. Platelet count <50 x 10^9/L.

Utilization Details of MPN Medications: Fiscal Year 2022

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	CLAIMS/ MEMBER	COST/ CLAIM
RUXOLITINIB PRODUCTS					
JAKAFI TAB 10MG	44	10	$712,203.22	4.4	$16,186.44
JAKAFI TAB 20MG	36	8	$550,914.76	4.5	$15,303.19
JAKAFI TAB 5MG	31	8	$472,450.71	3.88	$15,240.35
JAKAFI TAB 15MG	15	3	$231,187.15	5	$15,412.48
JAKAFI TAB 25MG	13	3	$201,251.33	4.33	$15,480.87
SUBTOTAL	**139**	**32**	**$2,168,007.17**	**5.79**	**$15,597.17**
TOTAL	**139**	**24***	**$2,168,007.17**	**5.79**	**$15,597.17**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
TAB = tablet
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

[1] National Comprehensive Cancer Network (NCCN). NCCN Guidelines. Myeloproliferative Neoplasms v 3.2022. Available online at: https://www.nccn.org/professionals/physician_gls/pdf/mpn.pdf. Last accessed 09/21/2022.
[2] U.S. Food and Drug Administration (FDA). FDA Approves Treatment for Rare Blood Disease. Available online at: https://www.fda.gov/news-events/press-announcements/fda-approves-treatment-rare-blood-disease. Issued 11/12/2021. Last accessed 09/20/2022.
[3] CTI BioPharma. CTI BioPharma Announces FDA Accelerated Approval of Vonjo® (Pacritinib) for the Treatment of Adult Patients with Myelofibrosis and Thrombocytopenia. *PR Newswire*. Available online at: https://www.prnewswire.com/news-releases/cti-biopharma-announces-fda-accelerated-approval-of-vonjo-pacritinib-for-the-treatment-of-adult-patients-with-myelofibrosis-and-thrombocytopenia-301492159.html. Issued 02/28/2022. Last accessed 09/20/2022.
[4] Besremi® (Ropeginterferon Alfa-2b-njft) Prescribing Information. PharmaEssentia. Available online at: https://us.pharmaessentia.com/wp-content/uploads/2021/11/BESREMi-USPI-November-2021-1.pdf. Last revised 11/2021. Last accessed 09/20/2022.
[5] Vonjo® (Pacritinib) Prescribing Information. CTI BioPharma. Available online at: https://www.ctibiopharma.com/VONJO_USPI.pdf. Last revised 02/2022. Last accessed 09/20/2022.

Appendix I

Fiscal Year 2022 Annual Review of Targeted Immunomodulator Agents and 30-Day Notice to Prior Authorize Sotyktu™ (Deucravacitinib), Spevigo® (Spesolimab-sbzo), and Tavneos® (Avacopan)

Oklahoma Health Care Authority
October 2022

Current Prior Authorization Criteria

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

Targeted Immunomodulator Agents Tier-2 Approval Criteria:

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

Targeted Immunomodulator Agents Tier-3 Approval Criteria:

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

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

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

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

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

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

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

Benlysta® (Belimumab) Approval Criteria:

1. The intravenous (IV) formulation will be covered as a medical only benefit while the subcutaneous (sub-Q) formulation will be covered as a pharmacy only benefit; and
2. An FDA approved indication of 1 of the following:
    a. The treatment of members 5 years of age and older with active, autoantibody-positive, systemic lupus erythematosus (SLE) already receiving standard therapy; or
    b. The treatment of members 18 years of age and older with active lupus nephritis (LN) who are receiving standard therapy; and
3. Documented inadequate response to at least 2 of the following medications appropriate to member's specific disease state:
    a. High-dose oral corticosteroids; or
    b. Methotrexate; or
    c. Azathioprine; or
    d. Mycophenolate; or
    e. Cyclophosphamide; or
    f. Hydroxychloroquine/chloroquine; and
4. Member must not have severe active central nervous system lupus; and

5. Benlysta® will not be approved for concomitant use with biologic therapies; and
6. Benlysta® will not be approved for concomitant use with IV cyclophosphamide (exception for induction treatment with IV cyclophosphamide for members with a diagnosis of LN).

Entyvio® (Vedolizumab) Approval Criteria:

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

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

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

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

1. Diagnosis of moderate-to-severe HS; and
2. Hurley Stage II or III disease; and
3. Member must have at least 3 abscesses or inflammatory nodules; and
4. Previous failure of at least 2 of the following categories:
    a. Topical or systemic antibiotics; or
    b. Oral or intralesional corticosteroids; or
    c. Dapsone; or
    d. Cyclosporine; or
    e. Antiandrogens (e.g., spironolactone, oral contraceptives); or

f. Finasteride; or
g. Surgery.

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

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

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

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

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

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

4. The following dosing requirements must be met:
    a. Dosing should not be more often than once every 8 weeks; and
    b. Weight-based dosing (the member's recent weight must be provided):
        i. Body weight >40kg: 150mg; or
        ii. Body weight 15kg to 40kg: 2mg/kg (if inadequate response, dose may be increased to 3mg/kg); and
5. Approvals will be for the duration of 1 year.

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

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

Inflectra® (Infliximab-dyyb) and Remicade® (Infliximab) Approval Criteria:

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

Orencia® ClickJect™ (Abatacept) Approval Criteria:

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

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

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

b. Colchicine; and
4. Quantity limits according to package labeling will apply.

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

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

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

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

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

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

Siliq® (Brodalumab) Approval Criteria:

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

Xeljanz® (Tofacitinib) Approval Criteria:

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

Xeljanz® (Tofacitinib Oral Solution) Approval Criteria:

1. Member must meet Tier-3 approval criteria; and
2. An age restriction of 2 years of age to 10 years of age will apply. Members older than 10 years of age require a patient-specific, clinically significant reason why the oral tablet formulation cannot be used.

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

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

Utilization of Targeted Immunomodulator Agents: Fiscal Year 2022

Comparison of Fiscal Years: Pharmacy Claims

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	1,255	8,604	$57,199,571.53	$6,648.02	$222.62	68,468	256,933
2022	1,983	12,353	$90,375,492.17	$7,316.08	$243.81	90,069	370,679
% Change	**58.00%**	**43.60%**	**58.00%**	**10.00%**	**9.50%**	**31.50%**	**44.30%**
Change	**728**	**3,749**	**$33,175,920.64**	**$668.06**	**$21.19**	**21,601**	**113,746**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

- The Targeted Immunomodulator Agents Product Based Prior Authorization (PBPA) category is heavily influenced by federal and supplemental rebates. These rebates are collected after reimbursement

for the medication and are not reflected in this report. The costs included in this report do not reflect net costs.

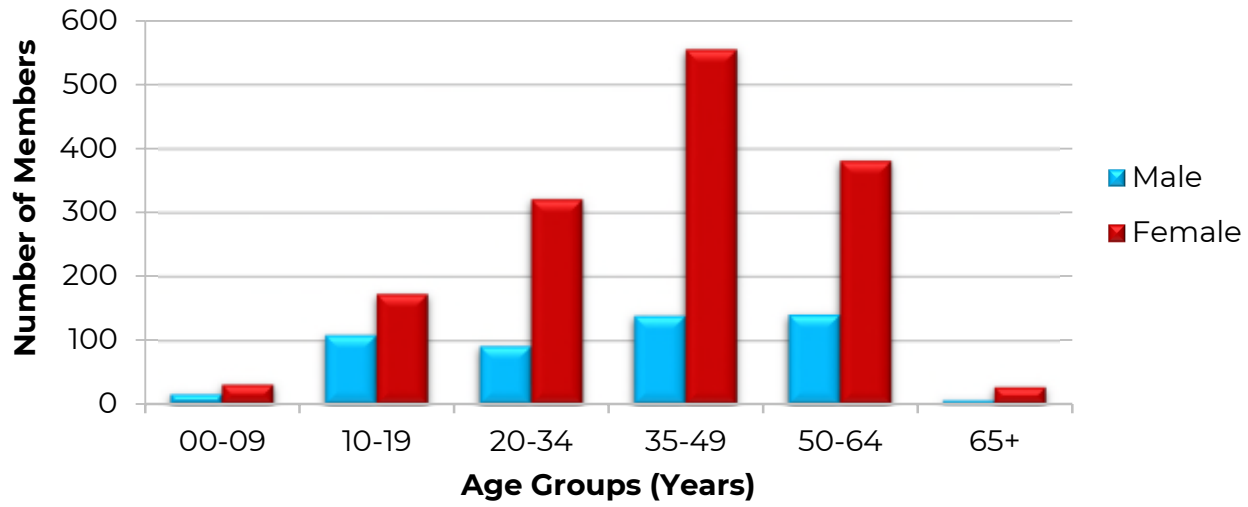
- Aggregate drug rebates collected during fiscal year 2022 for targeted immunomodulator agents: $50,855,995.92[Δ]

Comparison of Fiscal Years: Medical Claims

Fiscal Year	*Total Members	†Total Claims	Total Cost	Cost/ Claim	Total Units
2021	310	1,243	$5,986,111.72	$4,815.86	190,613
2022	530	2,064	$9,054,390.79	$4,386.82	289,374
% Change	**220**	**821**	**$3,068,279.07**	**-$429.04**	**98,761**
Change	**71.0%**	**66.0%**	**51.3%**	**-8.9%**	**51.8%**

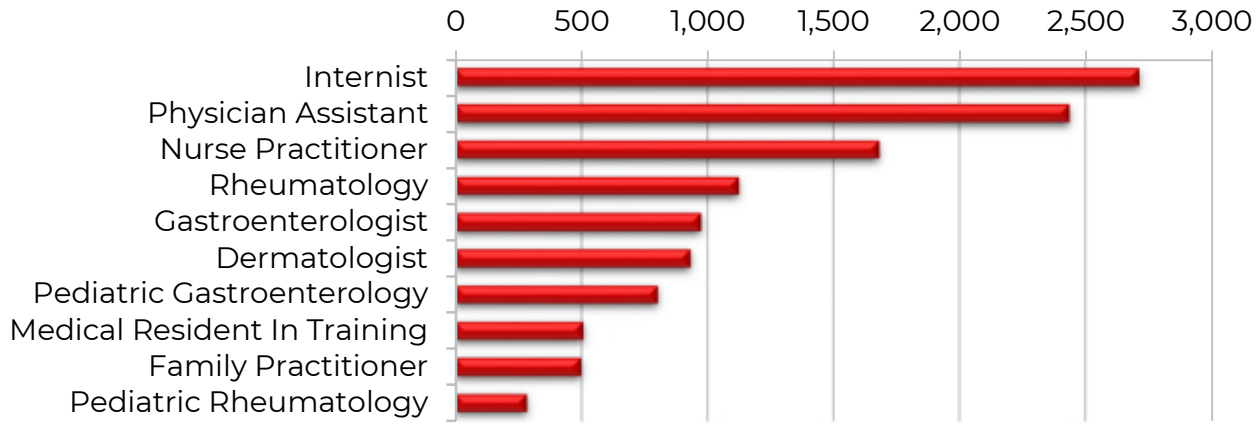
Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
†Total number of unduplicated claims.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Targeted Immunomodulator Agents: Pharmacy Claims



[Δ] Important considerations: Aggregate drug rebates are based on the date the claim is paid rather than the date dispensed. Claims data are based on the date dispensed.

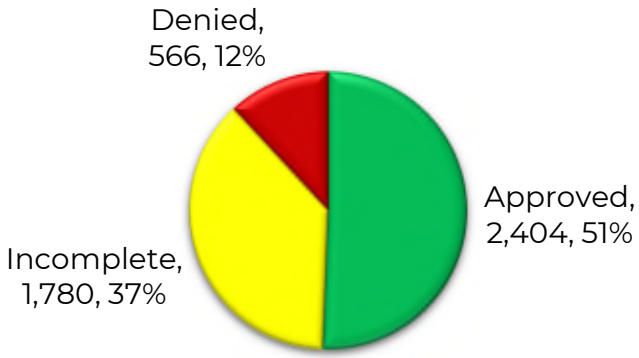
Top Prescriber Specialties of Targeted Immunomodulator Agents by Number of Claims: Pharmacy Claims



Prior Authorization of Targeted Immunomodulator Agents

There were 4,750 prior authorization requests submitted for targeted immunomodulator agents during fiscal year 2022. Computer edits are in place to detect lower tiered medications in a member's claims history and generate automated prior authorizations where possible. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



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

Anticipated Patent Expiration(s):

- Xeljanz® (tofacitinib oral solution and tablet): December 2025
- Otezla® (apremilast tablet): February 2028
- Tavneos® (avacopan capsule): February 2031
- Olumiant® (baricitinib tablet): November 2032
- Xeljanz® XR [tofacitinib extended-release (ER) tablet]: March 2034
- Rinvoq® (upadacitinib tablet): October 2036

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

- **October 2021:** The FDA approved Tavneos® (avacopan) as an adjunctive treatment of adult patients with severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis [granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)] in combination with standard therapy including corticosteroids. Tavneos® does not eliminate corticosteroid use.
- **December 2021:** The FDA approved Rinvoq® (upadacitinib) for a new indication for the treatment of adults with active psoriatic arthritis (PsA) who have had an inadequate response or intolerance to 1 or more tissue necrosis factor (TNF) blockers.
- **December 2021:** The FDA approved Xeljanz® (tofacitinib) for a new indication for the treatment of adults with active ankylosing spondylitis (AS) who have had an inadequate response or intolerance to 1 or more TNF blockers.
- **December 2021:** The FDA approved Orencia® (abatacept) for a new indication for the prophylaxis of acute graft versus host disease (aGVHD), in combination with a calcineurin inhibitor and methotrexate, in adult and pediatric patients 2 years of age and older undergoing hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor.
- **December 2021:** The FDA approved Cosentyx® (secukinumab) for a new indication for the treatment of active enthesitis-related arthritis (ERA) in patients 4 years of age and older. Additionally, the FDA expanded the PsA indication to allow for pediatric use for active PsA in patients 2 years of age and older. Previously, Cosentyx® was only indicated for PsA in adult patients.
- **January 2022:** The FDA approved Rinvoq® (upadacitinib) for a new indication for the treatment of adults and pediatric patients 12 years of age and older with refractory, moderate-to-severe atopic dermatitis (AD) whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies are inadvisable. Additionally, the FDA approved a new 30mg strength tablet for use in patients with AD.
- **January 2022:** The FDA approved Skyrizi® (risankizumab-rzaa) for a new indication for the treatment of active PsA in adults.
- **March 2022:** The FDA approved Rinvoq® (upadacitinib) for a new indication for the treatment of adults with moderately-to-severely active ulcerative colitis (UC) who have had an inadequate response or intolerance to 1 or more TNF blockers. Additionally, the FDA approved a new 45mg strength tablet for the initial induction dosing in patients with UC.

- **April 2022:** The FDA approved Rinvoq® (upadacitinib) for a new indication for the treatment of adults with active AS who have had an inadequate response or intolerance to 1 or more TNF blockers.
- **May 2022:** The FDA approved Olumiant® (baricitinib) for a new indication for the treatment of COVID-19 in hospitalized adults requiring supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO). Additionally, the FDA approved a new 4mg strength tablet for use with this indication.
- **June 2022:** The FDA approved Olumiant® (baricitinib) for a new indication for the treatment of adults with severe alopecia areata.
- **June 2022:** The FDA approved Skyrizi® (risankizumab-rzaa) for a new indication for the treatment of moderately-to-severely active Crohn's disease (CD) in adults. Additionally, the FDA approved a new intravenous (IV) formulation of Skyrizi® for the initial induction dosing in patients with CD and a new subcutaneous (sub-Q) on-body injector formulation for maintenance dosing in CD patients.
- **July 2022:** The FDA approved Stelara® (ustekinumab) for an expanded indication for pediatric patients with active PsA. Previously, Stelara® was only indicated for PsA in adult patients.
- **September 2022:** The FDA approved Spevigo® (spesolimab-sbzo) for the treatment of generalized pustular psoriasis (GPP) flares in adults. GPP is a rare autoinflammatory skin disease that is potentially life-threatening. Patients with GPP flares experience widespread eruption of sterile pustules with or without systemic symptoms such as pain, fever, malaise, and fatigue. In severe untreated cases, GPP can result in death due to septic shock or cardiorespiratory failure. Spevigo® is the first medication to be FDA approved for the treatment of GPP flares.
- **September 2022:** The FDA approved Sotyktu™ (deucravacitinib) for the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

Guideline Update(s):

- **April 2022:** The American College of Rheumatology (ACR) published updated guidelines for the treatment of juvenile idiopathic arthritis (JIA), specifically concerning therapeutic approaches for the treatment of oligoarthritis, temporomandibular joint (TMJ) arthritis, and systemic JIA [with and without macrophage activation syndrome (MAS)]. These guidelines are intended to complement previous ACR guidelines from 2019 for JIA which focused on therapeutic approaches for the treatment of non-systemic polyarthritis, sacroiliitis, enthesitis, and uveitis. Key recommendations for oligoarthritis and active TMJ arthritis include:

- Nonsteroidal anti-inflammatory drugs (NSAIDs) are conditionally recommended, and intraarticular corticosteroids are recommended (strongly for oligoarthritis and conditionally for TMJ arthritis) as part of initial therapy.
- Oral corticosteroids are conditionally recommended against as part of initial therapy.
- Conventional disease-modifying antirheumatic drugs (DMARDs) are strongly recommended if there is inadequate response to NSAIDs and/or intraarticular corticosteroids.
- Biologic DMARDs are recommended (strongly for oligoarthritis and conditionally for TMJ arthritis) if there is inadequate response to or intolerance of NSAIDs and/or intraarticular corticosteroids and at least 1 conventional synthetic DMARD (there is no preferred biologic DMARD).

Key recommendations for systemic JIA without MAS include:

- NSAIDs are conditionally recommended as initial monotherapy.
- Oral corticosteroids are conditionally recommended against as initial monotherapy.
- Biologic DMARDs inhibiting IL-1 and IL-6 are conditionally recommended as initial monotherapy (there is no preferred biologic DMARD).
- Biologic DMARDs inhibiting IL-1 and IL-6 are strongly recommended over a single or combination of conventional synthetic DMARDs in patients with inadequate response to or intolerance of NSAIDs and/or corticosteroids.

Key recommendations for systemic JIA with MAS include:

- Biologic DMARDs inhibiting IL-1 and IL-6 are conditionally recommended over calcineurin inhibitors alone to achieve inactive disease and resolution of MAS.
- Corticosteroids are conditionally recommended as part of initial treatment of systemic JIA with MAS.

Sotyktu™ (Deucravacitinib) Product Summary[18,19,20]

Indication(s): Deucravacitinib is a tyrosine kinase 2 (TYK2) inhibitor indicated for the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

- Limitations of Use: Not recommended for use in combination with other potent immunosuppressants

How Supplied: 6mg oral tablet

Dosing and Administration:

- Recommended dose is 6mg orally once daily, with or without food
- Tablets should not be chewed, cut, or crushed

Contraindications:

- Known hypersensitivity to deucravacitinib or any of the excipients in Sotyktu™

Safety:

- Hypersensitivity: Hypersensitivity reactions such as angioedema have been reported in patients receiving deucravacitinib. If a clinically significant hypersensitivity reaction occurs, deucravacitinib should be discontinued and appropriate therapy should be instituted.
- Infections: Deucravacitinib may increase the risk of infections. Serious infections have been reported in patients with psoriasis, including pneumonia and COVID-19. Use of deucravacitinib should be avoided in patients with active or serious infection. In patients with chronic or recurrent infection, previous exposure to tuberculosis (TB), a history of serious or opportunistic infection, or underlying conditions that may predispose them to infection, the risks and benefits of treatment with deucravacitinib should be considered. Patients should be closely monitored for signs and symptoms of infections during and after treatment with deucravacitinib and appropriate antimicrobial therapy should be initiated in patients who develop a new infection during treatment with deucravacitinib. If a patient develops a serious infection, deucravacitinib should be interrupted and should not be resumed until the infection resolves or is adequately treated.
- Viral Reactivation: Herpes virus reactivation was reported in clinical studies with deucravacitinib. The impact of deucravacitinib on chronic viral hepatitis reactivation is unknown. Consider viral hepatitis screening and monitor for reactivation in accordance with clinical guidelines before and during treatment with deucravacitinib. If signs of reactivation occur, a hepatitis specialist should be consulted. Deucravacitinib is not recommended for use in patients with active hepatitis B (HBV) or hepatitis C (HCV).
- TB: Four patients with latent TB who were treated with deucravacitinib and received appropriate TB prophylaxis did not develop active TB during a mean follow-up of 34 weeks. One patient who did not have latent TB developed active TB after 54 weeks of treatment with deucravacitinib. Patients should be evaluated for latent and active TB infection before beginning treatment with deucravacitinib, and deucravacitinib should not be administered to patients with active TB. Treatment for latent TB should be initiated prior to administering deucravacitinib.
- Malignancy Including Lymphomas: Malignancies, including lymphomas, were observed in clinical studies of deucravacitinib. The benefits and risks of treatment with deucravacitinib should be

considered, particularly in patients with a known malignancy (other than successfully treated non-melanoma skin cancer) and patients who develop a malignancy during treatment with deucravacitinib.

- Rhabdomyolysis and Elevated Creatine Phosphokinase (CPK): Cases of rhabdomyolysis were reported in patients treated with deucravacitinib, resulting in interruption or discontinuation of deucravacitinib. There was also an increased incidence of asymptomatic CPK and rhabdomyolysis relative to placebo. Deucravacitinib should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected.
- Laboratory Abnormalities: Treatment with deucravacitinib was associated with increases in triglyceride (TG) levels and liver enzyme elevations. Serum TG should be monitored periodically, and hyperlipidemia should be managed according to clinical guidelines. Liver enzymes should be evaluated at baseline and thereafter in patients with known or suspected liver disease. Deucravacitinib should be interrupted if treatment-related increases in liver enzymes occur and drug-induced liver injury is suspected.
- Immunizations: Consideration for completing all age-appropriate immunizations should be made prior to initiating treatment with deucravacitinib, including herpes zoster vaccination. Live vaccines should be avoided in patients treated with deucravacitinib. The response to live or non-live vaccines has not been evaluated in patients receiving deucravacitinib.
- Potential Risks Related to Janus Kinase (JAK) Inhibition: It is not known whether TYK2 inhibition may be associated with observed or potential adverse reactions of JAK inhibition.
- Pregnancy: The available data on deucravacitinib use during pregnancy are not sufficient to evaluate a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. In animal studies, no effects on embryo-fetal development were observed in rats and rabbits during organogenesis at doses ≥91 times the maximum recommended human dose (MRHD) of 6mg daily.
- Lactation: There are no data available on the presence of deucravacitinib in human milk, the effects on the breastfed infant, or the effects on milk production. Deucravacitinib is present in rat milk and would likely be present in human milk.
- Pediatric Use: The safety and efficacy of deucravacitinib in pediatric patients have not been established.

Mechanism of Action: Deucravacitinib is a TYK2 inhibitor. TYK2 is a member of the JAK family. JAK kinases, including TYK2, function as pairs of homo- or heterodimers in the JAK-signal transducers and activators of transcription (STAT) pathways. TYK2 pairs with JAK1 to mediate multiple cytokine pathways

and also pairs with JAK2 to transmit signals as shown in cell-based assays. The precise mechanism linking inhibition of TYK2 enzyme to therapeutic effectiveness in the treatment of adults with moderate-to-severe plaque psoriasis is not currently known.

Adverse Reactions: The most commonly reported adverse reactions in clinical studies (≥1% and >placebo) include upper respiratory tract infections, increased blood CPK, herpes simplex, mouth ulcers, folliculitis, and acne.

Efficacy: The safety and efficacy of deucravacitinib were established in 2 Phase 3 studies (PSO-1 and PSO-2) which were randomized, double-blind, placebo- and active-controlled studies. The studies enrolled a total of 1,684 patients 18 years of age or older with moderate-to-severe plaque psoriasis who were eligible for systemic therapy or phototherapy. Patients were required to have a body surface area (BSA) involvement of ≥10%, a Psoriasis Area and Severity Index (PASI) score of ≥12, and a static Physician's Global Assessment (sPGA) score of ≥3 (moderate or severe). Patients were randomized to receive deucravacitinib 6mg once daily, placebo, or apremilast 30mg twice daily.

- Primary Endpoint(s): In both studies, the 2 co-primary endpoints were the proportion of patients who achieved an sPGA score of 0 (clear) or 1 (almost clear) with at least a 2-point improvement from baseline relative to placebo at week 16 and the proportion of patients who achieved ≥75% improvement in PASI scores from baseline (PASI-75) relative to placebo at week 16.
- Results: In PSO-1, sPGA of 0 or 1 was achieved in 54% of patients in the deucravacitinib group and 7% of patients in the placebo group at week 16 [treatment difference: 47%; 95% confidence interval (CI): 40, 53, P<0.0001], and PASI-75 was achieved in 58% of patients in the deucravacitinib group and 13% of patients in the placebo group at week 16 (treatment difference: 46%; 95% CI: 39, 53, P<0.0001). In PSO-2, sPGA of 0 or 1 was achieved in 50% of patients in the deucravacitinib group and 9% of patients in the placebo group at week 16 (treatment difference: 41%; 95% CI: 35, 46, P<0.0001), and PASI-75 was achieved in 53% of patients in the deucravacitinib group and 9% of patients in the placebo group at week 16 (treatment difference: 44%; 95% CI: 38, 49, P<0.0001). Additional secondary endpoints assessed comparing deucravacitinib to apremilast showed treatment with deucravacitinib was associated with statistically significantly higher response rates for the endpoints assessed.

Cost: The Wholesale Acquisition Cost (WAC) of Sotyktu™ is $205.48 per 6mg tablet, resulting in an estimated cost of $6,164.40 per 30 days and $73,972.80 per year based on the recommended dose of 6mg once daily.

Spevigo® (Spesolimab-sbzo) Product Summary[21,22]

Indication(s): Spesolimab is an interleukin-36 (IL-36) receptor antagonist indicated for the treatment of GPP flares in adults.

How Supplied: 450mg/7.5mL solution in a single-dose vial (SDV)

Dosing and Administration:

- Administered as a single 900mg dose [using (2) 450mg/7.5mL SDVs] by IV infusion over 90 minutes
- If GPP flare symptoms persist, a second 900mg dose may be administered 1 week after the initial dose

Contraindications:

- Severe or life-threatening hypersensitivity to spesolimab or to any of the excipients

Safety:

- Infections: Spesolimab may increase the risk of infections. During a 1-week placebo-controlled portion of a Phase 2 study, infections were reported in 14% of patients who received spesolimab vs. 6% of patients who received placebo. In patients with chronic infection or a history of recurrent infections, the potential risks and benefits of treatment should be considered before initiating treatment with spesolimab. Treatment with spesolimab is not recommended in patients with any clinically significant active infection until the infection resolves or is adequately treated.
- Risk of Tuberculosis (TB): Patients should be evaluated for TB infection prior to initiation and spesolimab should not be initiated in patients with active TB infection. Treatment of latent TB should be considered prior to initiating treatment with spesolimab for patients with a history of TB in whom an adequate treatment course cannot be confirmed.
- Hypersensitivity and Infusion-Related Reactions: Immediate hypersensitivity reactions, such as anaphylaxis, and delayed hypersensitivity reactions, such as drug reaction with eosinophilia and systemic symptoms (DRESS), may be associated with spesolimab. DRESS has been reported in clinical studies of spesolimab in patients with GPP. Spesolimab should be discontinued immediately, and appropriate treatment should be initiated if a patient develops signs of anaphylaxis or other serious hypersensitivity.
- Vaccinations: The use of live vaccines should be avoided in patients treated with spesolimab. Studies have not been performed in patients treated with spesolimab who have recently received live viral or bacterial vaccines.
- Pregnancy: There are insufficient data available to inform a drug-related risk of adverse pregnancy-related outcomes with spesolimab.

Human immunoglobulin G (IgG) is known to cross the placental barrier, and spesolimab may be transmitted from the mother to the developing fetus.
- Lactation: There are no data available on the presence of spesolimab in human milk, the effects on the breastfed infant, or the effects on milk production. Spesolimab is expected to be present in human milk.
- Pediatric Use: The efficacy and safety of spesolimab in pediatric patients have not been established.

Mechanism of Action: Spesolimab is humanized monoclonal IgG subclass 1 (IgG1) antibody that binds to the IL-36 receptor and inhibits IL-36 signaling. This prevents downstream activation of pro-inflammatory and pro-fibrotic pathways. The precise mechanism linking reduced IL-36 receptor activity and the treatment of GPP flares is unclear.

Adverse Reactions: The most commonly reported adverse reactions in clinical studies (≥1% and >placebo) include asthenia and fatigue, nausea and vomiting, headache, pruritus and prurigo, infusion site hematoma and bruising, urinary tract infection (UTI), bacteremia, bacteriuria, cellulitis, herpes dermatitis and oral herpes, upper respiratory tract infection, dyspnea, eye edema, and urticaria.

Efficacy: The safety and efficacy of spesolimab were established in the Phase 2 Effisayil 1 study which was a randomized, double-blind, placebo-controlled study in 53 patients with GPP. Patients were required to have a moderate-to-severe GPP flare, defined as a Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score ≥3, presence of fresh pustules (new appearance or worsening of pustules), a GPPPGA pustulation sub-score ≥2, and ≥5% of body surface area (BSA) covered with erythema and the presence of pustules. Patients were randomized 2:1 to receive a single IV dose of spesolimab 900mg (N=35) or placebo (N=18).
- Primary Endpoint: The primary endpoint was the proportion of patients with a GPPPGA pustulation sub-score of 0 (no visible pustules) at week 1 after treatment.
- Results: At week 1, a GPPPGA pustulation sub-score of 0 was achieved in 19 (54%) patients who received spesolimab and 1 (6%) patient who received placebo (difference: 49%; 95% CI: 21, 67; P<0.001).

After the 1-week double-blinded period, patients in either treatment group who continued to experience GPP flare symptoms could receive a single open-label IV dose of spesolimab 900mg. At week 1, 12 (34%) patients previously treated with spesolimab and 15 (83%) patients who previously received placebo received open-label spesolimab. At week 2, among the patients who previously received spesolimab, a GPPPGA pustulation sub-score of 0 was achieved in 5 (42%) of the patients after their second dose.

Cost: The WAC of Spevigo® is $3,408.87 per milliliter, resulting in an estimated cost of $51,133.05 for a single 900mg dose or $102,266.10 if a second dose is required for the GPP flare.

Tavneos® (Avacopan) Product Summary[23,24]

Indication(s): Avacopan is a complement 5a receptor (C5aR) antagonist indicated as an adjunctive treatment of adult patients with severe active ANCA-associated vasculitis (GPA or MPA) in combination with standard therapy including corticosteroids. Avacopan does not eliminate corticosteroid use.

How Supplied: 10mg oral capsule

Dosing and Administration:

- The recommended dose is 30mg [(3) 10mg capsules] twice daily with food

Safety:

- Hepatotoxicity: Cases of serious hepatic injury have been observed in patients taking avacopan. In clinical studies, patients receiving avacopan had a higher incidence of transaminase elevations and hepatobiliary events, including serious and life-threatening events. Serum alanine aminotransferase (ALT), aspartate aminotransferase (AST), alkaline phosphatase, and total bilirubin should be obtained before starting avacopan, every 4 weeks after starting treatment for the first 6 months, and as clinically indicated thereafter.
- Hypersensitivity Reactions: In clinical studies, 2 cases of angioedema occurred including 1 serious event requiring hospitalization. Avacopan should be discontinued immediately if angioedema occurs and appropriate therapy should be provided; avacopan should not be re-administered unless another cause has been established.
- HBV Reactivation: HBV reactivation, including life-threatening HBV, was observed in clinical studies of avacopan. Patients should be screened for HBV before starting avacopan. For patients with evidence of prior HBV infection, physicians with expertise in managing HBV should be consulted, and HBV antiviral therapy should be considered before and during treatment with avacopan. Patients with evidence of current or prior HBV infection should be monitored for clinical and laboratory signs of hepatitis or HBV reactivation during treatment and for 6 months following treatment with avacopan.
- Serious Infections: Serious and fatal infections have been reported in patients receiving avacopan. The most common serious infections were pneumonia and UTIs. In patients with chronic or recurrent infection, previous exposure to TB, a history of serious or opportunistic infection,

who have resided or traveled in areas of endemic TB or endemic mycoses, or with underlying conditions that may predispose them to infection, the risks and benefits of treatment with avacopan should be considered. Patients should be closely monitored for signs and symptoms of infections during and after treatment with avacopan and appropriate antimicrobial therapy should be initiated in patients who develop a new infection during treatment with avacopan. If a patient develops a serious or opportunistic infection, avacopan should be interrupted and should not be resumed until the infection is controlled.

- Drug Interactions: Avacopan exposure is decreased when co-administered with strong CYP3A4 enzyme inducers (e.g., rifampin); coadministration of avacopan and moderate or strong CYP3A4 inducers should be avoided. Avacopan exposure is increased when co-administered with strong CYP3A4 enzyme inhibitors (e.g., itraconazole); the dose of avacopan should be decreased to 30mg once daily when co-administered with strong CYP3A4 inhibitors. Avacopan is a CYP3A4 inhibitor; dose reduction of sensitive CYP3A4 substrates with a narrow therapeutic window should be considered when co-administered with avacopan, and patients should be closely monitored for adverse reactions.
- Pregnancy: There are no adequate and well-controlled studies with avacopan in pregnant women to inform a drug-associated risk. In animal studies, administration of avacopan to pregnant hamsters and rabbits during the period of organogenesis produced no evidence of fetal harm with exposures up to approximately 5 and 0.6 times, respectively, the exposure at the MRHD of 30mg twice daily. Avacopan caused an increase in the number of abortions in rabbits at an exposure 0.6 times the MRHD.
- Lactation: There are no data available on the effects of avacopan on the breastfed child or on milk production. It is unknown whether avacopan is secreted in human milk. Avacopan was detected in the plasma of undosed hamster pups nursing from drug-treated dams.
- Pediatric Use: The efficacy and safety of avacopan in pediatric patients have not been established.

Mechanism of Action: Avacopan is a C5aR antagonist that inhibits the interaction between C5aR and the anaphylatoxin C5a. Avacopan blocks C5a-mediated neutrophil activation and migration. The precise mechanism by which avacopan exerts a therapeutic effect in patients with ANCA-associated vasculitis has not been definitively established.

Adverse Reactions: The most commonly reported adverse reactions in clinical studies (incidence ≥5% and >placebo) include nausea, headache,

hypertension, diarrhea, vomiting, rash, fatigue, upper abdominal pain, dizziness, increased blood creatinine, and paresthesia.

Efficacy: The safety and efficacy of avacopan were established in a double-blind, active-controlled, Phase 3 study in 330 patients with newly diagnosed or relapsed ANCA-associated vasculitis. Patients were randomized 1:1 to receive avacopan 30mg twice daily for 52 weeks (with prednisone-matching placebo for 20 weeks) or prednisone tapered from 60mg/day to 0mg/day over 20 weeks (with avacopan-matching placebo for 52 weeks). Patients in both groups additionally received 1 of 3 standard immunosuppressive regimens consisting of (1) IV cyclophosphamide/oral azathioprine (or mycophenolate mofetil if azathioprine was contraindicated), (2) oral cyclophosphamide/azathioprine (or mycophenolate mofetil if azathioprine was contraindicated), or (3) IV rituximab without azathioprine or mycophenolate mofetil.

- Primary Endpoint(s): The primary efficacy endpoints were disease remission at week 26 and sustained disease remission at week 52. Disease remission was defined as a Birmingham Vasculitis Activity Score (BVAS) of 0 and no use of corticosteroids for treatment of ANCA-associated vasculitis from week 22 to week 26 (for the assessment at week 26) or no use of corticosteroids for treatment of ANCA-associated vasculitis at week 48 to week 52 (for the assessment at week 52). The BVAS evaluates a composite of signs and symptoms of vasculitis in 9 organ systems. Scores range from 0 to 63, with higher scores indicating greater disease activity.
- Results: At week 26, remission was achieved in 72.3% of patients in the avacopan group and 70.1% of patients in the prednisone group (estimated treatment difference: 3.4%; 95% CI: -6.0, 12.8%). At week 52, sustained remission was achieved in 65.7% of patients in the avacopan group and 54.9% of patients in the prednisone group, a statistically significant difference (estimated treatment difference: 12.5%; 95% CI: 2.6, 22.3; P=0.013).

Cost: The WAC of Tavneos® is $80.27 per 10mg capsule, resulting in an estimated cost of $14,448.60 per 30 days and $173,383.20 per year based on the recommended dose of 30mg twice daily.

Recommendations

The College of Pharmacy recommends the prior authorization of Spevigo® (spesolimab-sbzo) and Tavneos® (avacopan) with the following criteria:

Spevigo® (Spesolimab-sbzo) Approval Criteria:

1. An FDA approved indication for the treatment of generalized pustular psoriasis (GPP) flares (GPP diagnosis should be verifiable in the member's diagnosis history); and
2. Prescriber must verify at least 1 of the following:
    a. Member has experienced >1 flare (relapsing GPP); or
    b. Member has symptoms persisting for >3 months (persistent GPP); and
3. Member must be currently experiencing a moderate-to-severe GPP flare meeting all the following criteria:
    a. Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score must be provided and must be ≥3; and
    b. Presence of fresh pustules (new appearance or worsening of pustules); and
    c. GPPPGA pustulation sub-score must be provided and must be ≥2; and
    d. ≥5% of body surface area (BSA) covered with erythema and the presence of pustules; and
4. Member must be 21 years of age or older; and
5. Must be prescribed by a dermatologist or other specialist with expertise in the treatment of GPP (or an advanced care practitioner with a supervising physician who is a dermatologist or other specialist with expertise in the treatment of GPP); and
6. Prescriber must submit documentation of negative tuberculosis (TB) test or initiation of anti-TB therapy for latent TB prior to initiation of therapy with Spevigo®; and
7. Prescriber must verify the member does not have any clinically significant active infections and the member will be monitored for active infections prior to each dose of Spevigo®; and
8. Approvals will be for 1 dose of Spevigo®. A second dose of Spevigo® may be approved 1 week after the first dose if the prescriber submits documentation that the member has been evaluated and continues to experience GPP flare symptoms; and
9. A quantity limit of 2 doses per year will apply (the safety and efficacy of additional doses of Spevigo® have not been assessed); and
    a. Requests for additional doses of Spevigo® to treat new GPP flares occurring within 1 year (after successful resolution of the previous flare) will be reviewed on a case-by-case basis and will require the prescriber to submit patient-specific, clinically significant information documenting the clinical necessity of additional

treatment despite the lack of adequate safety and efficacy data; and

10. Subsequent requests for new GPP flares (after 1 year) will require the member to meet all initial approval criteria, and information regarding the member's response to previous treatment with Spevigo® must be submitted. Members who did not experience resolution of pustules after previous treatment will not be approved for additional use of Spevigo®.

Tavneos® (Avacopan) Approval Criteria:

1. An FDA approved diagnosis as adjunctive treatment of adult members with severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis [granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)] in combination with standard therapy including corticosteroids; and
2. Member must be 18 years of age or older; and
3. Tavneos® must be used in combination with standard immunosuppressive therapy including corticosteroids; and
4. The prescriber must agree to monitor liver function tests prior to initiating Tavneos®, every 4 weeks after the start of therapy for the first 6 months of treatment, and as clinically indicated thereafter; and
5. The prescriber must agree to screen the member for hepatitis B virus (HBV) infection prior to initiating treatment with Tavneos®; and
6. The prescriber must verify the member has no active, serious infections, including localized infections and will closely monitor member for the development of signs and symptoms of infection during and after treatment with Tavneos®; and
7. A quantity limit of 180 tablets per 30 days will apply.

Next, the College of Pharmacy recommends additional criteria for Orencia® (abatacept) for the diagnosis of aGVHD and Rinvoq® (upadacitinib) for the diagnosis of AD based on the new FDA approvals for these indications:

Orencia® (Abatacept) Approval Criteria [Acute Graft Versus Host Disease (aGVHD) Prophylaxis in Hematopoietic Stem Cell Transplant (HSCT) Diagnosis]:

1. An FDA approved indication for the prophylaxis of aGVHD in members undergoing HSCT; and
2. Member must be 2 years of age or older; and
3. Member is undergoing HSCT with a matched or 1 allele-mismatched unrelated donor; and
4. Must be used in combination with a calcineurin inhibitor and methotrexate.

Rinvoq® (Upadacitinib) Approval Criteria [Atopic Dermatitis (AD) Diagnosis]:

1. An FDA approved diagnosis of moderate-to-severe AD not adequately controlled with other systemic drug products, including biologics, or when those therapies are not advisable; and
2. Member must be 12 years of age or older; and
3. Member must have a documented trial within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following topical therapies (or have a contraindication or documented intolerance):
   a. 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
   b. 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
4. Member must have a documented 16 week trial with Dupixent® (dupilumab) that resulted in inadequate response (or have a contraindication or documented intolerance); and
5. Requested medication must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
6. Rinvoq® will not be approved for use in combination with other Janus kinase (JAK) inhibitors, biologic immunomodulators, or with other immunosuppressant medications; and
7. Initial approvals will be for the duration of 3 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval; and
8. The maximum approvable dose for AD is 30mg once daily.

Additionally, the College of Pharmacy recommends the following additions and changes to the Targeted Immunomodulator Agents PBPA Tier chart based on net costs (shown in red in the following Tier chart):

1. Placing Sotyktu™ (deucravacitinib) into Tier-3; and
2. Removing the additional approval criteria for Orencia® ClickJect™.

Targeted Immunomodulator Agents*±		
Tier-1 (DMARDs appropriate to disease state)	**Tier-2***	**Tier-3**
6-mercaptopurine	adalimumab (Humira®)+	abatacept (Orencia®, Orencia® ClickJect™)≠¤
azathioprine	anakinra (Kineret®)	adalimumab-afzb (Abrilada™)±
hydroxychloroquine	apremilast (Otezla®)ß	adalimumab-atto (Amjevita™)±

Targeted Immunomodulator Agents*±		
Tier-1 (DMARDs appropriate to disease state)	**Tier-2***	**Tier-3**
leflunomide	etanercept (Enbrel®)	adalimumab-adbm (Cyltezo™)±
mesalamine	rituximab (Rituxan®)~	adalimumab-bwwd (Hadlima™)±
methotrexate		adalimumab-fkjp (Hulio®)±
minocycline		adalimumab-adaz (Hyrimoz™)±
NSAIDs		baricitinib (Olumiant®)
oral corticosteroids		brodalumab (Siliq®)**
sulfasalazine		canakinumab (Ilaris®)¥
		certolizumab pegol (Cimzia®)
		deucravacitinib (Sotyktu™)
		etanercept-szzs (Erelzi®)±
		etanercept-ykro (Eticovo™)±
		golimumab (Simponi®, Simponi Aria®)
		guselkumab (Tremfya®)
		infliximab (Remicade®)±
		infliximab-axxq (Avsola®)±
		infliximab-dyyb (Inflectra®)±
		infliximab-abda (Renflexis®)±
		ixekizumab (Taltz®)
		risankizumab-rzaa (Skyrizi®)
		rituximab-abbs (Truxima®)±
		rituximab-arrx (Riabni™)±
		rituximab-pvvr (Ruxience®)±
		sarilumab (Kevzara®)
		secukinumab (Cosentyx®)
		tildrakizumab-asmn (Ilumya®)
		tocilizumab (Actemra®)π
		tofacitinib (Xeljanz®, Xeljanz® XR, Xeljanz® oral solution)**
		upadacitinib (Rinvoq®)#
		ustekinumab (Stelara®)
		vedolizumab (Entyvio®)**

DMARDs = disease modifying anti-rheumatic drugs; NSAIDs = nonsteroidal anti-inflammatory drugs
*Tier structure based on supplemental rebate participation and/or National Average Drug Acquisition Costs (NADAC), Wholesale Acquisition Costs (WAC), or State Maximum Allowable Costs (SMAC). Products may be moved to a higher tier based on net cost if the manufacturer chooses not to participate in supplemental rebates. Appropriate laboratory monitoring must be verified by the prescriber prior to approval.
±Biosimilars or reference products preferred based on lowest net cost product. Authorization of higher net cost biosimilars or reference products requires a patient-specific, clinically significant reason why the member could not use the preferred formulation.
†Unique criteria applies for a diagnosis of hidradenitis suppurativa (HS) and noninfectious intermediate and posterior uveitis and panuveitis.
ß Unique criteria applies for a diagnosis of Behçet's disease (BD).
¥Unique criteria applies for a diagnosis of cryopyrin-associated periodic syndromes (CAPS), tumor necrosis factor receptor-associated periodic syndrome (TRAPS), hyperimmunoglobulin D syndrome

(HIDS)/mevalonate kinase deficiency (MKD), familial Mediterranean fever (FMF), systemic juvenile idiopathic arthritis (SJIA), or adult-onset Still's disease (AOSD).
~Unique criteria applies for a diagnosis of pemphigus vulgaris (PV). Unique criteria applies for a diagnosis of granulomatosis with polyangiitis (GPA) and microscopic polyangiitis (MPA).
ᵀᵀUnique criteria applies for a diagnosis of giant cell arteritis (GCA) and chimeric antigen receptor (CAR) T-cell-induced cytokine release syndrome (CRS).
ᵍUnique criteria applies for acute graft versus host disease (aGVHD) prophylaxis in hematopoietic stem cell transplant (HSCT) recipients.
#Unique criteria applies for a diagnosis of atopic dermatitis (AD).
~~**≠Orencia® ClickJect™ requires a patient-specific, clinically significant reason why the member cannot use the typical pre-filled syringe formulation.**~~
**Unique criteria applies to this medication for approval.

~~**Orencia® ClickJect™ (Abatacept) Approval Criteria:**~~

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

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

Avsola® (Infliximab-axxq) ~~Inflectra® (Infliximab-dyyb)~~ and Remicade® (Infliximab) Approval Criteria:

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

Utilization Details of Targeted Immunomodulator Agents: Fiscal Year 2022

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
TIER-2 PRODUCTS						
ADALIMUMAB PRODUCTS						
HUMIRA PEN INJ 40MG/0.4ML	4,517	774	$32,143,905.72	$7,116.21	5.84	35.57%
HUMIRA INJ 40MG/0.4ML	632	120	$4,216,963.19	$6,672.41	5.27	4.67%
HUMIRA PEN INJ 40MG/0.8ML	379	103	$2,889,421.93	$7,623.80	3.68	3.20%
HUMIRA KIT 40MG/0.8ML	232	49	$1,812,853.06	$7,814.02	4.73	2.01%
HUMIRA INJ 20MG/0.2ML	208	29	$1,412,329.93	$6,790.05	7.17	1.56%
HUMIRA PEN INJ 80MG/0.8ML	194	39	$2,385,133.20	$12,294.50	4.97	2.64%
HUMIRA PEN KIT CD/UC/HS 80MG/0.8ML	153	148	$2,743,686.28	$17,932.59	1.03	3.04%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
HUMIRA PEN KIT PS/UV 80MG/0.8ML & 40MG/0.4ML	110	107	$1,365,268.57	$12,411.53	1.03	1.51%
HUMIRA INJ 10MG/0.1ML	44	5	$261,614.18	$5,945.78	8.8	0.29%
HUMIRA PEN KIT PED UC 80MG/0.8ML	4	4	$100,836.01	$25,209.00	1	0.11%
HUMIRA PEN INJ PS/UV 40MG/0.8ML	2	2	$24,441.13	$12,220.57	1	0.03%
HUMIRA PED INJ CROHNS 80MG/0.8ML	2	2	$35,832.06	$17,916.03	1	0.04%
HUMIRA PEN INJ CD/UC/HS 40MG/0.8ML	2	2	$36,109.93	$18,054.97	1	0.04%
SUBTOTAL	**6,479**	**1,384**	**$49,428,395.19**	**$7,629.02**	**4.68**	**54.69%**
ETANERCEPT PRODUCTS						
ENBREL SRCLK INJ 50MG/ML	1,653	326	$10,205,645.84	$6,174.01	5.07	11.29%
ENBREL INJ 50MG/ML	303	78	$1,927,306.95	$6,360.75	3.88	2.13%
ENBREL MINI INJ 50MG/ML	117	24	$698,960.53	$5,974.02	4.88	0.77%
ENBREL INJ 25MG/0.5ML	70	13	$299,431.66	$4,277.60	5.38	0.33%
ENBREL INJ 25/0.5ML PFS	56	10	$208,557.01	$3,724.23	5.6	0.23%
ENBREL INJ 25MG/0.5ML	3	1	$8,756.40	$2,918.80	3	0.01%
SUBTOTAL	**2,202**	**452**	**$13,348,658.39**	**$6,062.06**	**4.87**	**14.77%**
APREMILAST PRODUCTS						
OTEZLA TAB 30MG	383	89	$1,482,121.66	$3,869.77	4.3	1.64%
OTEZLA TAB 10/20/30MG	37	34	$154,995.09	$4,189.06	1.09	0.17%
SUBTOTAL	**420**	**123**	**$1,637,116.75**	**$3,897.90**	**3.41**	**1.81%**
ANAKINRA PRODUCTS						
KINERET INJ 100MG/0.67ML	28	3	$130,622.12	$4,665.08	9.33	0.14%
SUBTOTAL	**28**	**3**	**$130,622.12**	**$4,665.08**	**9.33**	**0.14%**
TIER-2 SUBTOTAL	**9,129**	**1,492***	**$64,544,792.45**	**$7,070.30**	**6.12**	**71.42%**
TIER-3 PRODUCTS						
SECUKINUMAB PRODUCTS						
COSENTYX PEN INJ 300MG	301	56	$2,220,096.89	$7,375.74	5.38	2.46%
COSENTYX PEN INJ 150MG/ML	72	18	$539,458.41	$7,492.48	4	0.60%
COSENTYX INJ 300MG	42	12	$327,971.31	$7,808.84	3.5	0.36%
COSENTYX INJ 150MG/ML	9	5	$87,662.86	$9,740.32	1.8	0.10%
COSENTYX INJ 75MG/0.5ML	2	1	$15,883.82	$7,941.91	2	0.02%
SUBTOTAL	**426**	**92**	**$3,191,073.29**	**$7,490.78**	**4.63**	**3.53%**
ABATACEPT PRODUCTS						
ORENCIA INJ 125MG/ML	252	42	$1,196,748.19	$4,749.00	6	1.32%
ORENCIA CLICKJECT INJ 125MG/ML	82	12	$397,631.83	$4,849.17	6.83	0.44%
ORENCIA INJ 250MG	60	7	$157,866.70	$2,631.11	8.57	0.17%
ORENCIA INJ 50MG/0.4ML	1	1	$917.87	$917.87	1	0.00%
SUBTOTAL	**395**	**62**	**$1,753,164.59**	**$4,438.39**	**6.37**	**1.94%**
TOFACITINIB PRODUCTS						
XELJANZ TAB 5MG	254	49	$1,187,860.16	$4,676.61	5.18	1.31%
XELJANZ TAB 10MG	61	11	$310,899.45	$5,096.71	5.55	0.34%
XELJANZ XR TAB 11MG	59	11	$290,659.50	$4,926.43	5.36	0.32%
SUBTOTAL	**374**	**71**	**$1,789,419.11**	**$4,784.54**	**5.27**	**1.98%**

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
USTEKINUMAB PRODUCTS						
STELARA INJ 90MG/ML	280	65	$6,822,843.08	$24,367.30	4.31	7.55%
STELARA INJ 45MG/0.5ML	53	15	$657,872.21	$12,412.68	3.53	0.73%
STELARA INJ 45MG/0.5ML	24	7	$274,214.95	$11,425.62	3.43	0.30%
STELARA INJ 5MG/ML	3	3	$13,674.38	$4,558.13	1	0.02%
SUBTOTAL	**360**	**90**	**$7,768,604.62**	**$21,579.46**	**4**	**8.60%**
IXEKIZUMAB PRODUCTS						
TALTZ INJ 80MG/ML	234	40	$1,857,073.96	$7,936.21	5.85	2.05%
TALTZ INJ 80MG/ML	37	3	$227,402.97	$6,146.03	12.33	0.25%
SUBTOTAL	**271**	**43**	**$2,084,476.93**	**$7,691.80**	**6.3**	**2.31%**
UPADACITINIB PRODUCTS						
RINVOQ TAB 15MG ER	190	47	$1,009,423.07	$5,312.75	4.04	1.12%
RINVOQ TAB 30MG ER	2	1	$11,357.34	$5,678.67	2	0.01%
RINVOQ TAB 45MG ER	1	1	$10,593.65	$10,593.65	1	0.01%
SUBTOTAL	**193**	**49**	**$1,031,374.06**	**$5,343.91**	**3.94**	**1.14%**
INFLIXIMAB PRODUCTS						
REMICADE INJ 100MG	160	24	$1,142,553.74	$7,140.96	6.67	1.26%
INFLECTRA INJ 100MG	6	1	$9,814.50	$1,635.75	6	0.01%
AVSOLA INJ 100MG	2	1	$5,022.82	$2,511.41	2	0.01%
RENFLEXIS INJ 100MG	1	1	$1,844.26	$1,844.26	1	0.00%
SUBTOTAL	**169**	**27**	**$1,159,235.32**	**$6,859.38**	**6.26**	**1.28%**
CERTOLIZUMAB PRODUCTS						
CIMZIA PREFL KIT 200MG/ML	148	23	$920,400.64	$6,218.92	6.43	1.02%
CIMZIA START KIT 200MG/ML	10	10	$141,695.34	$14,169.53	1	0.16%
SUBTOTAL	**158**	**33**	**$1,062,095.98**	**$6,722.13**	**4.79**	**1.18%**
TOCILIZUMAB PRODUCTS						
ACTEMRA INJ ACTPEN 162MG/0.9ML	83	15	$289,127.17	$3,483.46	5.53	0.32%
ACTEMRA INJ 162MG/0.9ML	57	9	$179,099.48	$3,142.10	6.33	0.20%
ACTEMRA INJ 400MG/20ML	11	2	$26,238.71	$2,385.34	5.5	0.03%
ACTEMRA INJ 80MG/4ML	2	1	$1,987.38	$993.69	2	0.00%
ACTEMRA INJ 200MG/10ML	1	1	$2,317.21	$2,317.21	1	0.00%
SUBTOTAL	**154**	**28**	**$498,769.95**	**$3,238.77**	**5.5**	**0.55%**
GUSELKUMAB PRODUCTS						
TREMFYA INJ 100MG/ML	75	25	$941,839.76	$12,557.86	3	1.04%
TREMFYA INJ 100MG/ML	35	12	$469,421.49	$13,412.04	2.92	0.52%
SUBTOTAL	**110**	**37**	**$1,411,261.25**	**$12,829.65**	**2.97**	**1.56%**
SARILUMAB PRODUCTS						
KEVZARA INJ 200MG/1.14ML	79	13	$300,257.62	$3,800.73	6.08	0.33%
KEVZARA INJ 200MG/1.14ML	8	2	$30,581.20	$3,822.65	4	0.03%
SUBTOTAL	**87**	**15**	**$330,838.82**	**$3,802.75**	**5.8**	**0.37%**
VEDOLIZUMAB PRODUCTS						
ENTYVIO INJ 300MG	67	13	$404,059.82	$6,030.74	5.15	0.45%
SUBTOTAL	**67**	**13**	**$404,059.82**	**$6,030.74**	**5.15**	**0.45%**

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
CANAKINUMAB PRODUCTS						
ILARIS INJ 150MG/ML	59	15	$886,773.58	$15,030.06	3.93	0.98%
SUBTOTAL	**59**	**15**	**$886,773.58**	**$15,030.06**	**3.93**	**0.98%**
GOLIMUMAB PRODUCTS						
SIMPONI INJ 50MG/0.5ML	53	12	$280,225.11	$5,287.27	4.42	0.31%
SIMPONI ARIA SOL 50MG/4ML	5	1	$28,651.15	$5,730.23	5	0.03%
SIMPONI INJ 100MG/ML	1	1	$19,235.26	$19,235.26	1	0.02%
SUBTOTAL	**59**	**14**	**$328,111.52**	**$5,561.21**	**4.21**	**0.36%**
RISANKIZUMAB PRODUCTS						
SKYRIZI PEN INJ 150MG/ML	38	18	$695,842.50	$18,311.64	2.11	0.77%
SKYRIZI INJ 150MG/ML	18	6	$321,527.48	$17,862.64	3	0.36%
SKYRIZI INJ 150MG	4	3	$68,088.72	$17,022.18	1.33	0.08%
SUBTOTAL	**60**	**27**	**$1,085,458.70**	**$18,090.98**	**2.22**	**1.20%**
BARICITINIB PRODUCTS						
OLUMIANT TAB 2MG	18	3	$44,275.38	$2,459.74	6	0.05%
SUBTOTAL	**18**	**3**	**$44,275.38**	**$2,459.74**	**6**	**0.05%**
BRODALUMAB PRODUCTS						
SILIQ INJ 210MG/1.5ML	2	1	$7,888.02	$3,944.01	2	0.01%
SUBTOTAL	**2**	**1**	**$7,888.02**	**$3,944.01**	**2**	**0.01%**
TIER-3 SUBTOTAL	**2,963**	**536***	**$24,836,880.94**	**$8,382.34**	**5.53**	**27.48%**
BELIMUMAB PRODUCTS						
BENLYSTA INJ 200MG/ML	262	55	$993,818.78	$3,793.20	4.76	1.10%
BELIMUMAB SUBTOTAL	**262**	**55**	**$993,818.78**	**$3,793.20**	**4.76**	**1.10%**
TOTAL	**12,353**	**1,983***	**$90,375,492.17**	**$7,316.08**	**6.23**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CD = Crohn's disease; ER = extended-release; HS = hidradenitis suppurativa; INJ = injection; PED = pediatric; PREFL = prefilled; PS = psoriasis; SRCLK = SureClick; TAB = tablet; UC = ulcerative colitis; UV = uveitis
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
REMICADE INJ (J1745)	466	105	$926,166.74	$1,987.48	4.44
BENLYSTA INJ (J0490)	446	78	$1,846,368.33	$4,139.84	5.72
RITUXAN INJ (J9312)	386	159	$2,833,443.05	$7,340.53	2.43
ENTYVIO INJ (J3380)	194	55	$1,268,232.00	$6,537.28	3.53
SIMPONI ARIA INJ (J1602)	193	60	$679,450.57	$3,520.47	3.22
ORENCIA INJ (J0129)	167	31	$647,826.36	$3,879.20	5.39
ACTEMRA INJ (J3262)	104	21	$334,028.00	$3,211.81	4.95
STELARA INJ (J3358)	26	24	$122,651.10	$4,717.35	1.08
RENFLEXIS INJ (Q5104)	25	13	$67,215.54	$2,688.62	1.92
INFLECTRA INJ (Q5103)	14	6	$45,108.20	$3,222.01	2.33
STELARA INJ (J3357)	13	3	$199,854.00	$15,373.38	4.33
AVSOLA INJ (Q5121)	13	7	$26,315.70	$2,024.28	1.86

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
CIMZIA INJ (J0717)	9	4	$21,964.00	$2,440.44	2.25
TRUXIMA INJ (Q5115)	6	2	$28,603.20	$4,767.20	3
SAPHNELO INJ (J0491)	1	1	$4,863.00	$4,863.00	1
SAPHNELO INJ (C9086)	1	1	$2,301.00	$2,301.00	1
TOTAL	**2,064⁺**	**530***	**$9,054,390.79**	**$4,386.82**	**3.89**

Costs do not reflect rebated prices or net costs.
⁺Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
INJ = injection
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

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Appendix J

Fiscal Year 2022 Annual Review of Anemia Medications and 30-Day Notice to Prior Authorize Enjaymo™ (Sutimlimab-jome), Pyrukynd® (Mitapivat), and Zynteglo® (Betibeglogene Autotemcel)

Oklahoma Health Care Authority
October 2022

Current Prior Authorization Criteria

Adakveo® (Crizanlizumab-tmca) Approval Criteria:

1. An FDA approved indication to reduce the frequency of vaso-occlusive crises (VOCs) in adult members and in pediatric members 16 years of age and older with sickle cell disease (SCD); and
2. Member must have a history of vaso-occlusive crises; and
3. Adakveo® must be prescribed by, or in consultation with, a hematologist or a specialist with expertise in treatment of sickle cell disease (or an advanced care practitioner with a supervising physician who is a hematologist or specialist with expertise in treating sickle cell disease); and
4. Prescriber must verify Adakveo® will be administered by a trained health care provider. The prior authorization request must indicate how Adakveo® will be administered; and
    a. Adakveo® must be shipped via cold chain supply to the facility where the member is scheduled to receive treatment; or
    b. Adakveo® must be shipped via cold chain supply to the member's home and administered by a home health provider, and the member or member's caregiver must be trained on the proper storage of Adakveo®; and
5. A recent (within the last 3 months) weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
6. Approval quantities will be dependent on the member's weight and will include loading doses at week 0 and 2, then subsequent doses every 4 weeks in accordance with package labeling; and
7. Initial approvals will be for the duration of 3 months. Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

Aranesp® (Darbepoetin Alfa) Approval Criteria:

1. An FDA approved diagnosis of anemia due to chemotherapy in members with non-myeloid malignancies; or

2. An FDA approved diagnosis of anemia associated with chronic renal failure; and
    a. For the diagnosis of anemia associated with chronic renal failure: member must not be receiving dialysis [erythropoietin stimulating agents (ESAs) are included in the bundled dialysis payment if member is on any form of dialysis and cannot be billed separately]; and
3. Recent hemoglobin levels must be provided; and
4. Approvals will be for the duration of 16 weeks of therapy. Recent hemoglobin levels must be provided with continuation requests, and further approval may be granted if the member's recent hemoglobin level is <11g/dL.

Endari® (L-Glutamine) Approval Criteria:

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

Epogen® (Epoetin Alfa), Procrit® (Epoetin Alfa), and Retacrit® (Epoetin Alfa-epbx) Approval Criteria:

1. An FDA approved indication of 1 of the following:
    a. Treatment of anemia due to chemotherapy in members with non-myeloid malignancies; or
    b. Treatment of anemia in zidovudine-treated human immunodeficiency virus (HIV)-infected members; or
    c. Reduction of allogeneic blood transfusion(s) in members undergoing surgery; or
    d. Treatment of anemia associated with chronic renal failure; and
        i. For the diagnosis of anemia associated with chronic renal failure: member must not be receiving dialysis [erythropoietin stimulating agents (ESAs) are included in the bundled dialysis payment if member is on any form of dialysis and cannot be billed separately]; and
2. Recent hemoglobin levels must be provided; and

3. Approvals will be for the duration of 16 weeks of therapy. Recent hemoglobin levels must be provided with continuation requests, and further approval may be granted if the member's recent hemoglobin level is <11g/dL.

Oxbryta® (Voxelotor) Approval Criteria:

1. An FDA approved indication for the treatment of sickle cell disease (SCD) in members 12 years of age and older; and
2. Member must have a history of vaso-occlusive crises (VOCs); and
3. Member must have baseline hemoglobin ≥5.5 to ≤10.5g/dL; and
4. Oxbryta® must be prescribed by, or in consultation with, a hematologist or a specialist with expertise in treatment of SCD (or an advanced care practitioner with a supervising physician who is a hematologist or specialist with expertise in treating SCD); and
5. Member must not be taking concomitant strong CYP3A4 inhibitors (e.g., fluconazole, ketoconazole) or the prescriber must verify the dose of Oxbryta® will be reduced during concomitant use according to package labeling; and
6. Member must not be taking concomitant strong or moderate CYP3A4 inducers (e.g., rifampin) or the prescriber must verify the dose of Oxbryta® will be adjusted during concomitant use according to package labeling; and
7. Prescriber must verify that the dose of Oxbryta® will be reduced in accordance with package labeling for members with severe hepatic impairment; and
8. A quantity limit of 3 tablets per day will apply; and
9. Initial approvals will be for the duration of 6 months. Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

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

1. An FDA approved indication for the treatment of adult members with beta thalassemia who require regular red blood cell (RBC) transfusions; and
2. Member must require regular RBC transfusions (no transfusion-free period >35 days during the prior 6 month period); and
3. Reblozyl® must be prescribed by, or in consultation with, a hematologist or a specialist with expertise in treatment of beta thalassemia (or an advanced care practitioner with a supervising physician who is a hematologist or specialist with expertise in treating beta thalassemia); and
4. Prescriber must verify the member's hemoglobin will be monitored prior to each Reblozyl® administration; and

5. Prescriber must verify Reblozyl® will be administered by a trained health care provider; and
6. A recent (within the last 3 months) weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
7. Approval quantities will be dependent on member's weight and every 3 week dosing in accordance with package labeling; and
8. Initial approvals will be for the duration of 4 months. Further approvals will not be granted if the member does not experience a decrease in transfusion burden after 9 weeks of treatment (administration of 3 doses) at the maximum dose of 1.25mg/kg (allows for initial dosing of 6 weeks at 1mg/kg). Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

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

1. An FDA approved indication for the treatment of adult members with very low-to-intermediate risk MDS with ring sideroblasts (MDS-RS) or myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T) with anemia failing an erythropoiesis stimulating agent (ESA) and requiring ≥2 red blood cell (RBC) units over 8 weeks; and
2. Member must have had an inadequate response to prior treatment with an ESA, be intolerant of ESAs, or have a serum erythropoietin level >200U/L; and
3. Member must not have been previously treated with a disease modifying agent for the treatment of MDS; and
4. Prescriber must verify the member does not have deletion 5q (del 5q); and
5. Complete blood counts (CBC) and verification that levels are acceptable to the prescriber and in accordance with package labeling; and
6. Reblozyl® must be prescribed by, or in consultation with, a hematologist, oncologist, or a specialist with expertise in treatment of myelodysplastic syndromes (or an advanced care practitioner with a supervising physician who is a hematologist, oncologist, or specialist with expertise in treating myelodysplastic syndromes); and
7. Prescriber must verify the member's hemoglobin will be monitored prior to each Reblozyl® administration; and
8. Prescriber must verify Reblozyl® will be administered by a trained health care provider; and
9. A recent (within the last 3 months) weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and

10. Approval quantities will be dependent on member's weight and every 3 week dosing in accordance with package labeling; and
11. Initial approvals will be for the duration of 6 months. Further approvals will not be granted if the member does not experience a decrease in transfusion burden after 9 weeks of treatment (administration of 3 doses) at the maximum dose of 1.75mg/kg or if unacceptable toxicity occurs at any time. Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

Siklos® (Hydroxyurea Tablets) Approval Criteria:

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

Utilization of Anemia Medications: Fiscal Year 2022

Comparison of Fiscal Years: Erythropoietin Stimulating Agents (Pharmacy Claims)

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	20	153	$57,335.42	$374.74	$30.18	162	1,900
2022	21	120	$63,522.56	$529.35	$33.57	249	1,892
% Change	**5.0%**	**-21.6%**	**10.8%**	**41.3%**	**11.2%**	**53.7%**	**-0.4%**
Change	**1**	**-33**	**$6,187.14**	**$154.61**	**$3.39**	**87**	**-8**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Comparison of Fiscal Years: Erythropoietin Stimulating Agents (Medical Claims)

Fiscal Year	*Total Members	+Total Claims	Total Cost	Cost/ Claim	Claims/ Member
2021	18	52	$45,630.58	$877.51	2.89
2022	27	97	$71,652.70	$738.69	3.59
% Change	**50%**	**86.54%**	**57.03%**	**-15.82%**	**24.22%**
Change	**9**	**45**	**$26,022.12**	**-$138.82**	**0.7**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
+Total number of unduplicated claims.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Comparison of Fiscal Years: Sickle Cell Disease and Beta Thalassemia Medications (Pharmacy Claims)

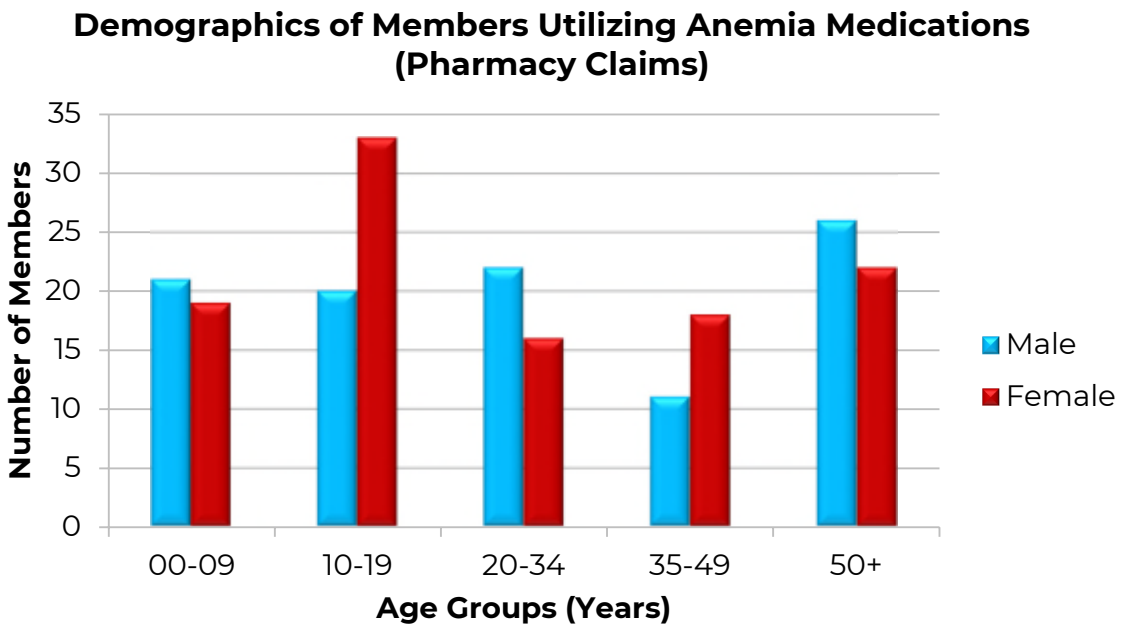
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	147	712	$528,199.52	$741.85	$22.35	47,803	23,632
2022	188	934	$850,874.23	$911.00	$27.47	64,776	30,972
% Change	**27.90%**	**31.20%**	**61.1%**	**22.80%**	**22.90%**	**35.50%**	**31.10%**
Change	**41**	**222**	**$322,674.71**	**$169.15**	**$5.12**	**16,973**	**7,340**

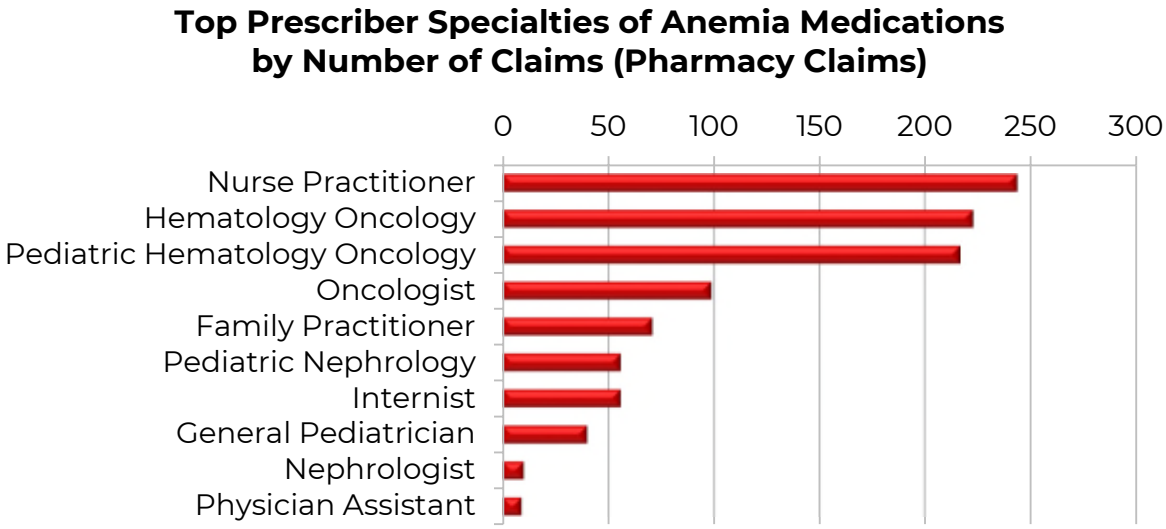
Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022
Please note: There were no pharmacy claims for beta thalassemia medications during fiscal year 2021 and 2022.

Comparison of Fiscal Years: Sickle Cell Disease and Beta Thalassemia Medications (Medical Claims)

Fiscal Year	*Total Members	+Total Claims	Total Cost	Cost/ Claim	Claims/ Member
2021	13	60	$556,675.88	$9,033.07	4.62
2022	24	127	$1,177,699.99	$9,273.23	5.29
% Change	**84.62%**	**111.67%**	**111.56%**	**2.66%**	**14.50%**
Change	**11**	**67**	**$621,024.11**	**$240.16**	**0.67**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
+Total number of unduplicated claims.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

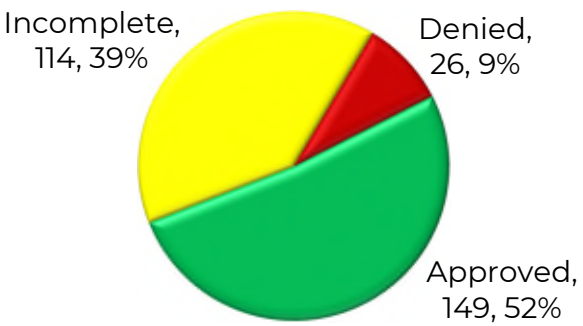




Prior Authorization of Anemia Medications

There were 289 prior authorization requests submitted for anemia medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



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

Anticipated Patent Expiration(s):

- Oxbryta® (voxelotor tablets): October 2027
- Pyrukynd® (mitapivat tablets) November 2038

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

- **December 2021:** The FDA approved Oxbryta® (voxelotor) to include use in children 4 to 11 years of age. Voxelotor was previously FDA approved in 2019 for sickle cell disease (SCD) in patients 12 years of age and older. The approved age expansion was based on data from a Phase 2 trial in 45 children that showed 36% of patients had an increase in hemoglobin (Hgb) >1g/dL by week 24. With this new approval, an oral tablet for suspension is now also available. Global Blood Therapeutics is also currently studying voxelotor in patients 9 months of age and older.
- **February 2022:** The FDA approved Enjaymo™ (sutimlimab-jome) to decrease the need for red blood cell (RBC) transfusions due to hemolysis in adults with cold agglutinin disease based on a study in 24 adults with cold agglutinin disease who had a blood transfusion within the past 6 months. Cold agglutinin disease is an autoimmune disorder characterized by RBC destruction, which leads to anemia and cold-induced circulatory symptoms, such as pain and discoloration of fingers or toes. The disease is called “cold” agglutinin disease because the RBC destruction occurs at cold temperatures. Patients with cold agglutinin disease have a range in severity of anemia symptoms, which include fatigue, weakness, shortness of breath, tachycardia, dizziness, and chest pain. Many patients with cold agglutinin disease need RBC transfusions to manage their disease. The disease is rare, affecting about 1 person per million annually, and mostly develops in individuals between 40 and 80 years of age.

- **February 2022:** Pyrukynd® (mitapivat) was approved for hemolytic anemia in adults with pyruvate kinase (PK) deficiency. PK deficiency is an inherited disorder that causes premature RBC destruction leading to anemia. Patients with PK deficiency have a range in severity of symptoms, which include fatigue, unusually pale skin, jaundice, shortness of breath, and a fast heart rate. Patients can also develop an enlarged spleen, iron overload from repeated blood transfusions, and gallstones. PK deficiency is rare with approximately 3 to 9 cases per 1 million people; however, it is often misdiagnosed or underdiagnosed.
- **August 2022:** Zynteglo® (betibeglogene autotemcel) was approved as the first cell-based gene therapy for the treatment of adult and pediatric patients with beta thalassemia who require regular RBC transfusions. Beta thalassemia is a type of inherited blood disorder that causes a reduction of normal Hgb and RBCs in the blood, through mutations in the beta-globin subunit, leading to insufficient delivery of oxygen in the body. The reduced levels of RBCs can lead to a number of health issues including dizziness, weakness, fatigue, bone abnormalities, and more serious complications. Transfusion-dependent beta thalassemia (TDT), the most severe form of the condition, generally requires life-long RBC transfusions as the standard course of treatment. These regular transfusions can be associated with multiple health complications of their own, including problems in the heart, liver, and other organs due to an excessive build-up of iron in the body. Zynteglo® is a one-time gene therapy product administered as a single dose; each dose of Zynteglo® is a customized treatment created using the patient's own stem cells that are genetically modified to produce functional beta-globin.

News:

- **March 2022:** The FDA declined marketing approval for the hypoxia-inducible factor prolyl hydroxylase inhibitor (HIF-PHI) vadadustat. This makes it the second HIF-PHI to be turned down for an approval from the FDA. In August 2021, the FDA rejected the New Drug Application (NDA) for roxadustat. Both FDA rejections were due to unresolved concerns about safety. The FDA issued a complete response letter (CRL) for vadadustat due to failure to meet non-inferiority in major adverse cardiovascular events in nondialysis patients and the increased risk of thromboembolic events in dialysis patients.

Pipeline:

- **Exagamglogene Autotemcel (Exa-cel):** Vertex Pharmaceuticals and CRISPR Therapeutics are collaborating on a gene therapy for patients with TDT or severe SCD. Two of the trials, CLIMB-111 and CLIMB-121, are in Phase 3 and fully enrolled. The manufacturers plan to submit a biologics license application (BLA) by the end of 2022.

Enjaymo™ (Sutimlimab-jome) Product Summary[11]

Indication(s): Enjaymo™ is a classical complement inhibitor indicated to decrease the need for RBC transfusion due to hemolysis in adults with cold agglutinin disease.

How Supplied: 1,100mg/22mL (50mg/mL) single dose vial

Dosing and Administration:

- Weight-based dosing weekly for 2 weeks then every 2 weeks thereafter
  - 39kg to <75kg: 6,500mg by intravenous (IV) infusion
  - ≥75kg: 7,500mg by IV infusion
- Vaccination against encapsulated bacteria should be completed at least 2 weeks prior to treatment.

Mechanism of Action: Sutimlimab-jome is an immunoglobulin G (IgG), subclass 4 (IgG4) monoclonal antibody (mAb) that inhibits the classical complement pathway (CP) and specifically binds to complement protein component 1, s subcomponent (C1s), a serine protease which cleaves C4. Sutimlimab-jome does not inhibit the lectin and alternative pathways. Inhibition of the classical CP at the level of C1s prevents deposition of complement opsonins on the surface of RBCs, resulting in inhibition of hemolysis in patients with cold agglutinin disease.

Contraindication(s):

- Known hypersensitivity to sutimlimab-jome or any of the inactive ingredients

Safety:

- Serious Infections: Enjaymo™ may increase susceptibility to serious infections caused by encapsulated bacteria (e.g., *Neisseria meningitides*, *Streptococcus pneumoniae*, *Haemophilus influenzae*). Patients should be vaccinated against encapsulated bacteria according to the most current Advisory Committee on Immunization Practices (ACIP) recommendations. Patients should be vaccinated at least 2 weeks prior to receiving the first dose of Enjaymo™ or as soon as possible.
- Infusion-Related Reactions: Patients should be monitored for infusion-related reactions and treatment should be interrupted if reaction occurs. Enjaymo™ should be discontinued and appropriate supportive measures should be instituted if signs of hypersensitivity reactions, such as cardiovascular instability or respiratory compromise, occur.
- Risk of Autoimmune Disease: Enjaymo™ may potentially increase the risk for developing autoimmune disease. Patients should be monitored for signs and symptoms and managed medically.

- Recurrent Hemolysis after Enjaymo™ Discontinuation: If treatment with Enjaymo™ is interrupted, patients should be closely monitored for signs and symptoms of recurrent hemolysis [e.g., elevated levels of total bilirubin or lactate dehydrogenase (LDH) accompanied by a decrease in Hgb; reappearance of symptoms such as fatigue, dyspnea, palpitations, or hemoglobinuria]. Consideration should be given to restarting Enjaymo™ if signs and symptoms of hemolysis occur after discontinuation.

Adverse Reactions: The most frequent (incidence ≥10%) adverse reactions in clinical trials were respiratory tract infection, viral infection, diarrhea, dyspepsia, cough, arthralgia, arthritis, and peripheral edema.

Efficacy: The safety and efficacy of Enjaymo™ was studied in a Phase 3 open-label 6-month trial in 24 adult patients with confirmed cold agglutinin disease, recent history of a RBC transfusion within 6 months of study enrollment, Hgb ≤10g/dL, and symptomatic disease.

- Primary Endpoint: The composite primary endpoint was defined as an increase from baseline in Hgb level ≥2g/dL or a Hgb level ≥12g/dL at the treatment assessment time point, no RBC transfusion from week 5 through week 26, and no treatment for cold agglutinin disease (i.e., rituximab with or without cytotoxic agents) beyond what was allowed per protocol.
- Results: Overall, 13 of 24 patients [54.2%; 95% confidence interval (CI): 32.8%, 74.4%] of patients were deemed a responder based on the primary composite endpoint. The results of each of the components of the composite endpoint were also reported: 63% had a Hgb level ≥12g/dL or increase in level ≥2g/dL, 71% of patients did not receive RBC transfusions from week 5 to week 26, and 92% did not receive protocol prohibited cold agglutinin disease medications. Of the 11 patients who did not meet the primary endpoint, 6 showed evidence of a treatment response.

Cost: The Wholesale Acquisition Cost (WAC) of Enjaymo™ is $81.82 per mL, or $1,800.04 per 1,100mg/22mL vial, resulting in an estimated annual cost of $327,607.28 at the maximum recommended dose of 7,500mg every 2 weeks.

Pyrukynd® (Mitapivat) Product Summary[12]

Indication(s): Pyrukynd® is a PK activator indicted for the treatment of hemolytic anemia in adults with PK deficiency.

How Supplied: 5mg, 20mg, and 50mg oral tablets

Dosing and Administration:

- Pyrukynd® tablets should be swallowed whole and may be taken with or without food.

- The recommended starting dose is 5mg orally twice daily with a maximum recommended dose of 50mg twice daily.
- Pyrukynd® should be titrated every 4 weeks based on Hgb levels and transfusion requirements.
- Pyrukynd® should be discontinued if no benefit has been observed by 24 weeks.
- Refer to the *Prescribing Information* for the full recommended titration and maintenance dosing information.

Mechanism of Action: Mitapivat is a PK activator that acts by allosterically binding to the PK tetramer and increasing PK activity. The RBC form of PK (PK-R) is mutated in PK deficiency, which leads to reduced adenosine triphosphate (ATP), shortened RBC lifespan, and chronic hemolysis.

Contraindication(s): None

Safety:
- Acute Hemolysis with Abrupt Treatment Interruption: Abrupt discontinuation of Pyrukynd® should be avoided due to possible acute hemolysis. Pyrukynd® should be gradually tapered to discontinue treatment.
- Pediatric Use: The safety and effectiveness in pediatric patients have not been established.
- Geriatric Use: Studies of Pyrukynd® did not include sufficient numbers of patients 65 years of age and older.
- Hepatic Impairment: Pyrukynd® undergoes extensive hepatic metabolism and should be avoided in patients with moderate-to-severe hepatic impairment.

Adverse Reactions: The most frequent (incidence ≥10%) adverse reactions in clinical trials were decreased estrone (males), increased urate, back pain, decreased estradiol (males), and arthralgia.

Efficacy: Pyrukynd® was studied in 2 trials, ACTIVATE and ACTIVATE-T. ACTIVATE was a randomized, double-blind trial in adults with PK deficiency who were not regularly transfused, defined as having no more than 4 transfusions in the 52-week period prior to treatment and no transfusions in the 3-month period prior to treatment. Of the 80 patients enrolled, 40 were randomized to receive Pyrukynd® up to 50mg twice daily for 12 weeks following a dose titration. ACTIVATE-T was an open-label study in 27 adults with PK deficiency who had a minimum of 6 transfusion episodes in the 52-week period prior to enrollment.

- **ACTIVATE:**
  - Primary Endpoint: Percentage of patients who achieved a Hgb response, defined as ≥1.5g/dL increase in Hgb from baseline

sustained at 2 or more assessments during the fixed-dose period without transfusions
    - Results: Pyrukynd® demonstrated a statistically significant increase in Hgb where 40% (n=16) of patients randomized to Pyrukynd® achieved a Hgb response, compared to 0 patients randomized to placebo (2-sided p<0.0001). Of those 16 patients, 15 continued in a long-term extension study and 13 maintained increases in Hgb from baseline without requiring transfusions.
- **ACTIVATE-T:**
    - Primary Endpoint: Reduction in the patient's transfusion burden, defined as ≥33% reduction in the number of RBC units transfused during the fixed-dose period compared with the patient's historical transfusion burden
    - Results: In ACTIVATE-T, 9 (33%) patients who received Pyrukynd® achieved the primary endpoint for a reduction in transfusion burden showing statistical significance. This included 6 patients who did not require any transfusions during the 24-week fixed dose treatment period. All 6 patients who were transfusion-free remained that way in a long-term extension study.

Cost: The WAC of Pyrukynd® is $460 per tablet regardless of strength, resulting in an annual cost of $331,200 at the recommended dosing regimen of 1 tablet twice daily.

Zynteglo® (Betibeglogene Autotemcel) Product Summary[13]

Indication(s): Zynteglo® is an autologous hematopoietic stem cell-based gene therapy indicated for the treatment of adult and pediatric patients with beta thalassemia who require regular RBC transfusions.

How Supplied: A cell suspension for intravenous (IV) infusion
- A single dose of Zynteglo® contains a minimum of 5 x 10^6 CD34+ cells/kg of body weight, in 1 or more infusion bags.

Dosing and Administration:
- Patients are required to undergo hematopoietic stem cell (HSC) mobilization followed by apheresis to obtain CD34+ cells for Zynteglo® manufacturing. A back-up collection of CD34+ cells is also required.
- Dosing of Zynteglo® is based on the number of CD34+ cells in the infusion bag(s) per kg of body weight.
- The minimum recommended dose is 5 x 10^6 CD34+ cells/kg.
- Full myeloablative conditioning must be administered before infusion of Zynteglo®.
- Patient's identity should be verified to match the unique patient identification information on the Zynteglo® infusion bag(s) prior to infusion.

- Zynteglo® should not be sampled, altered, or irradiated.
- An in-line blood filter or an infusion pump should not be used.
- Each infusion bag of Zynteglo® should be administered via IV infusion over a period of less than 30 minutes.

Mechanism of Action: Zynteglo® adds functional copies of a modified β-globin gene into patients' HSCs through transduction of autologous CD34+ cells with BB305 lentiviral vector (LVV). After Zynteglo® infusion, transduced CD34+ HSCs engraft in the bone marrow and differentiate to produce RBCs containing biologically active βA-T87Q-globin (a modified β-globin protein) that will combine with α-globin to produce functional adult Hgb containing βA-T87Q-globin (HbAT87Q). βA-T87Q-globin can be quantified relative to other globin species in peripheral blood using high-performance liquid chromatography. βA-T87Q-globin expression is designed to correct the β/α-globin imbalance in erythroid cells of patients with beta thalassemia and has the potential to increase functional adult Hgb (HbA) and total Hgb to normal levels and eliminate dependence on regular RBC transfusions.

Contraindication(s): None

Safety:
- Delayed Platelet Engraftment: Delayed platelet engraftment has been observed with Zynteglo® treatment; bleeding risk is increased prior to platelet engraftment and may continue after engraftment in patients with prolonged thrombocytopenia. Platelet counts should be monitored until platelet engraftment and recovery are achieved. Patients should also be monitored for thrombocytopenia and bleeding.
- Risk of Neutrophil Engraftment Failure: There is a potential risk of neutrophil engraftment failure after treatment with Zynteglo® [defined as failure to achieve 3 consecutive absolute neutrophil counts (ANC) ≥500cells/mcL obtained on different days by day 43 after Zynteglo® infusion]. ANC should be monitored after Zynteglo® infusion, and if neutrophil engraftment does not occur, rescue treatment with the back-up collection of CD34+ cells should be provided.
- Risk of Insertional Oncogenesis: There is a potential risk of LVV-mediated insertional oncogenesis after treatment with Zyntelgo®; patients treated with Zyntelgo® may develop hematologic malignancies and should be monitored lifelong. Patients should be monitored at month 6, month 12, and at least annually for hematologic malignancies for at least 15 years after Zyntelgo® infusion.
- Hypersensitivity Reactions: The dimethyl sulfoxide (DMSO) in Zyntelgo® may cause hypersensitivity reactions, including anaphylaxis. Patients should be monitored for hypersensitivity reactions during the infusion.
- Anti-Retroviral and Hydroxyurea Use: Patients should not take prophylactic human immunodeficiency virus (HIV) anti-retroviral

medications or hydroxyurea prior to mobilization (for at least 1 month prior to mobilization or for the expected duration for elimination of the medications) and until all cycles of apheresis are completed. If a patient requires anti-retrovirals for HIV prophylaxis, a negative test for HIV should be confirmed before beginning mobilization and apheresis of CD34+ cells.

- Iron Chelation: Drug-drug interactions between iron chelating agents and the myeloablative conditioning agent must be considered. Iron chelating agents should be discontinued at least 7 days prior to initiation of conditioning. After Zyntelgo® infusion, iron chelating agents should be avoided for 6 months. If iron chelation is needed, administration of non-myelosuppressive iron chelating agents should be considered, and phlebotomy can be used in lieu of iron chelation, when appropriate.
- Interference with Serology Testing: Patients who have received Zyntelgo® are likely to test positive by polymerase chain reaction (PCR) assays for HIV due to integrated BB305 LVV proviral DNA, resulting in a false-positive test for HIV; therefore, patients who have received Zyntelgo® should not be screened for HIV infection using a PCR-based assay.
- Pregnancy: There is no available data on the administration of Zyntelgo® in pregnant women. The risks associated with myeloablative conditioning should be considered on pregnancy and fertility. No reproductive and developmental toxicity studies in animals have been conducted with Zyntelgo® to assess whether it can cause fetal harm when administered to a pregnant woman, and it is not known whether Zyntelgo® has the potential to be transferred to the fetus. Therefore, Zyntelgo® should not be administered to women who are pregnant, and pregnancy after Zyntelgo® infusion should be discussed with the treating physician.
- Lactation: There is no information regarding the presence of Zyntelgo® in human milk, the effect on the breastfed infant, and the effects on milk production. Therefore, Zyntelgo® is not recommended for women who are breastfeeding, and breastfeeding after Zyntelgo® infusion should be discussed with the treating physician.
- Females and Males of Reproductive Potential: A negative serum pregnancy test should be confirmed prior to the start of mobilization and should be re-confirmed prior to conditioning procedures and before Zyntelgo® administration. Women of childbearing potential and men capable of fathering a child should use an effective method of contraception [intrauterine device (IUD) or combination of hormonal and barrier contraception] from start of mobilization through at least 6 months after administration of Zyntelgo®. Patients should also be

advised of the risks of infertility associated with myeloablative conditioning.

- Pediatric Use: The safety and efficacy of Zyntelgo® have been established in pediatric patients with beta thalassemia requiring regular transfusions. Use of Zyntelgo® is supported by two Phase 3 studies that included 27 pediatric patients in the following age groups: 16 children (younger than 12 years) and 11 adolescents (age 12 years to younger than 18 years). The safety and efficacy of Zyntelgo® in children younger than 4 years of age have not been established.
- Geriatric Use: Zyntelgo® has not been studied in patients older than 65 years of age. HSC transplantation must be appropriate for a patient to be treated with Zyntelgo®.
- Patients Seropositive for HIV: Zyntelgo® has not been studied in patients with HIV-1, HIV-2, or human T-lymphotrophic virus 1 or 2 (HTLV-1 or HTLV-2). A negative serology test for HIV is necessary to ensure acceptance of apheresis material for Zynteglo® manufacturing. Apheresis material from patients with a positive test for HIV will not be accepted for Zynteglo® manufacturing.
- Renal Impairment: Zynteglo® has not been studied in patients with renal impairment. Patient should be assessed for renal impairment (defined as creatinine clearance ≤70mL/min/1.73m^2) to ensure HSC transplantation is appropriate.
- Hepatic Impairment: Zynteglo® has not been studied in patients with hepatic impairment. Patients should be assessed for hepatic impairment to ensure HSC transplantation is appropriate.

Adverse Reactions:

- The most frequent non-laboratory (incidence ≥20%) adverse reactions in clinical trials were mucositis, febrile neutropenia, vomiting, pyrexia, alopecia, epistaxis, abdominal pain, musculoskeletal pain, cough, headache, diarrhea, rash, constipation, nausea, decreased appetite, pigmentation disorder, and pruritus.
- The most frequent grade 3 or 4 laboratory (incidence >50%) adverse reactions in clinical trials were neutropenia, thrombocytopenia, leukopenia, anemia, and lymphopenia.

Efficacy: The safety and efficacy of Zynteglo® were studied in 2 Phase 3 open-label 24-month trials, Northstar-2 and Northstar-3. The trials included a total of 41 patients ranging from 4 to 34 years of age with beta thalassemia requiring regular transfusions, defined as a history of ≥100mL/kg/year of packed RBCs or ≥8 transfusions of RBCs per year in the 2 years preceding enrollment. All patients were administered granulocyte colony stimulating factor (G-CSF) and plerixafor to mobilize HSCs prior to apheresis. All patients also received full myeloablative conditioning with busulfan prior to treatment with Zynteglo®.

- Primary Endpoint: The primary endpoint was the proportion of patients who gained transfusion independence defined as Hgb ≥9g/dL without any RBC transfusions for a continuous period of ≥12 months at any time during the study after drug product infusion.
- Results: Between the 2 trials, there was an overall result of 32 of 36 evaluable patients (89%; 95% CI: 74, 97) who received Zynteglo® achieved transfusion independence. All patients who achieved independence have remained transfusion-free at this time. There is also an ongoing long-term follow-up study to monitor safety and efficacy for those who have received Zynteglo® through 15 years post treatment. Currently, no patients who have received Zynteglo® have developed a hematologic malignancy.

Cost: The WAC of Zynteglo® is $2.8 million per one-time treatment.

Recommendations

The College of Pharmacy recommends the following changes to the Oxbryta® (voxelotor) prior authorization criteria based on the new FDA approved age expansion (changes noted in red):

Oxbryta® (Voxelotor) Approval Criteria:

1. An FDA approved indication for the treatment of sickle cell disease (SCD) in members 4 ~~12~~ years of age and older; and
~~2. Member must have a history of vaso-occlusive crises (VOCs); and~~
3. Member must have baseline hemoglobin ~~≥5.5 to~~ ≤10.5g/dL; and
4. Oxbryta® must be prescribed by, or in consultation with, a hematologist or a specialist with expertise in treatment of SCD (or an advanced care practitioner with a supervising physician who is a hematologist or specialist with expertise in treating SCD); and
~~5. Member must not be taking concomitant strong CYP3A4 inhibitors (e.g., fluconazole, ketoconazole) or the prescriber must verify the dose of Oxbryta® will be reduced during concomitant use according to package labeling; and~~
6. Member must not be taking concomitant strong or moderate CYP3A4 inducers (e.g., rifampin) or the prescriber must verify the dose of Oxbryta® will be adjusted during concomitant use according to package labeling; and
7. Prescriber must verify that the dose of Oxbryta® will be reduced in accordance with package labeling for members with severe hepatic impairment; and
8. For members younger than 12 years of age, the member's recent weight (kg) must be provided on the prior authorization request to ensure accurate dosing in accordance with Oxbryta® *Prescribing Information*; and

9. Oxbryta® tablets for oral suspension will have an age restriction of 4 to 10 years of age; and
    a. Members older than 10 years of age requesting Oxbryta® tablets for oral suspension will require a patient-specific, clinically significant reason why the member cannot use Oxbryta® oral tablets; and
10. The following quantity limits ~~A quantity limit of 3 tablets per day~~ will apply: ~~; and~~
    a. (3) 500mg tablets per day; and
    b. (5) 300mg tablets for oral suspension per day; and
11. Initial approvals will be for the duration of 6 months. Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

The College of Pharmacy also recommends the prior authorization of Enjaymo™ (sutimlimab-jome) with the following criteria:

Enjaymo™ (Sutimlimab-jome) Approval Criteria:

1. An FDA approved diagnosis of primary cold agglutin disease confirmed by the following:
    a. Chronic hemolysis; and
    b. Positive direct antiglobulin (Coombs) test for C3d; and
    c. Cold agglutin titer of ≥64 at 4° Celsius; and
2. Member must have 1 or more symptoms associated with cold agglutinin disease (i.e., symptomatic anemia, acrocyanosis, Raynaud's phenomenon, hemoglobinuria, a major adverse vascular event); and
3. Member has a history of at least 1 documented red blood cell (RBC) transfusion within 6 months of initiation; and
4. Member has a hemoglobin (Hgb) level ≤10g/dL; and
5. Member has a bilirubin level above the normal reference range; and
6. Enjaymo™ must be prescribed by a hematologist (or an advanced care practitioner with a supervising physician who is a hematologist); and
7. Member has not received rituximab within 3 months of initiation and will not be using rituximab concomitantly with Enjaymo™; and
8. Prescriber must verify the member has been vaccinated against encapsulated bacteria (e.g., *Neisseria meningitides, Streptococcus pneumoniae, Haemophilus influenzae*) at least 2 weeks prior to initiation of treatment; and
9. Enjaymo™ must be administered in a health care setting by a health care provider prepared to manage anaphylaxis; and
10. Prescriber must agree to monitor the member for at least 2 hours following the initial infusion for signs or symptoms of an infusion and/or hypersensitivity reaction and for 1 hour following completion of subsequent infusions; and
11. Prescriber must verify the member has no chronic systemic infections [e.g., hepatitis B, hepatitis C, human immunodeficiency virus (HIV)]; and

12. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
13. Initial approvals will be for 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to therapy, as confirmed by at least 1 of the following:
    a. Member has had an increase in Hgb level ≥2g/dL from baseline; or
    b. Member has had normalization of Hgb level to ≥12g/dL; or
    c. Member has had a decreased number of RBC transfusions since initiation of therapy.

Additionally, the College of Pharmacy recommends the prior authorization of Pyrukynd® (mitapivat) with the following criteria:

Pyrukynd® (Mitapivat) Approval Criteria:

1. An FDA approved indication of hemolytic anemia in adults with pyruvate kinase (PK) deficiency confirmed by the following:
    a. Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (*PKLR*) gene, with at least 1 missense variant; and
        i. Hemoglobin (Hgb) ≤10g/dL; or
        ii. Member has received ≥6 red blood cell (RBC) transfusions in the past year; and
2. Pyrukynd® must be prescribed by a hematologist (or an advanced care practitioner with a supervising physician who is a hematologist); and
3. Member must not have moderate or severe hepatic impairment; and
4. If Pyrukynd® is to be discontinued, prescriber must verify dose will be tapered gradually according to Pyrukynd® *Prescribing Information* and member will be monitored for signs of acute hemolysis and worsening anemia; and
5. Prescriber must agree to monitor Hgb levels and follow dose titration and maintenance according to Pyrukynd® *Prescribing Information*; and
6. Approvals will be for the duration of 3 months, after which time the prescriber must provide Hgb levels to support a dose increase or continuation of current dose; and
7. Pyrukynd® should be discontinued in members who do not show evidence of therapeutic benefit (i.e., Hgb increase of ≥1.5mg/dL from baseline, reduction in number of transfusions) by week 24.

Further, the College of Pharmacy recommends the prior authorization of Zynteglo® (betibeglogene autotemcel) with the following criteria:

Zynteglo® (Betibeglogene Autotemcel) Approval Criteria:

1. An FDA approved indication for the treatment of adult and pediatric members with beta thalassemia who require regular red blood cell (RBC) transfusions; and

2. Member must be 4 years of age or older; and
3. Member must weigh ≥6kg; and
4. Member must require regular RBC transfusions as demonstrated by the following:
    a. History of ≥100mL/kg/year transfusions of packed RBCs in the last 2 years; or
    b. ≥8 transfusions of packed RBCs per year in the last 2 years; and
5. Zynteglo® must be prescribed by a hematologist with expertise in the treatment of beta thalassemia and the administration of Zynteglo®; and
6. Member must not have a known and available human leukocyte antigen (HLA)-matched sibling donor; and
7. Member must not have a prior history of hematopoietic stem cell transplantation (HSCT); and
8. Member must have a negative serology test for human immunodeficiency virus (HIV) prior to apheresis; and
9. Prescriber must verify the member is clinically stable and eligible to undergo HSCT (HSCT must be appropriate for a member to be treated with Zynteglo®); and
10. Female members must not be pregnant and must have a negative pregnancy test prior to the start of mobilization, prior to conditioning procedures, and prior to Zynteglo® administration; and
11. Male and female members of reproductive potential must use an effective method of contraception from the start of mobilization through at least 6 months after administration of Zynteglo®; and
12. Prescriber must verify male and female members of reproductive potential have been counseled on the potential effects of myeloablative conditioning on fertility and the potential risk of infertility is acceptable to the member; and
13. Prescriber must evaluate the potential for drug interactions, according to package labeling, prior to and after administration of Zynteglo®; and
14. Member will not be approved for treatment with Reblozyl® (luspatercept-aamt) following Zynteglo® infusion (current authorizations for luspatercept-aamt will be discontinued upon Zynteglo® approval); and
15. Prescriber must verify member will be monitored for hematologic malignancies lifelong, with a complete blood count (with differential) performed at month 6 and month 12 after treatment with Zynteglo®, then at least annually thereafter for at least 15 years, and with integration site analysis at months 6, 12, and as warranted; and
16. Zynteglo® must be administered at a Zynteglo® qualified treatment center, and the receiving facility must have a mechanism in place to track the patient-specific Zynteglo® dose from receipt to storage to administration; and
17. Approvals will be for 1 dose per member per lifetime.

Finally, the College of Pharmacy recommends the following changes to the Reblozyl® (luspatercept-aamt) prior authorization criteria for beta thalassemia based on FDA approval of Zynteglo® (betibeglogene autotemcel) (changes noted in red):

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

1. An FDA approved indication for the treatment of adult members with beta thalassemia who require regular red blood cell (RBC) transfusions; and
2. Member must require regular RBC transfusions (no transfusion-free period >35 days during the prior 6 month period); and
3. Member must not have previously received treatment with Zynteglo® (betibeglogene autotemcel); and
4. Reblozyl® must be prescribed by, or in consultation with, a hematologist or a specialist with expertise in treatment of beta thalassemia (or an advanced care practitioner with a supervising physician who is a hematologist or specialist with expertise in treating beta thalassemia); and
5. Prescriber must verify the member's hemoglobin will be monitored prior to each Reblozyl® administration; and
6. Prescriber must verify Reblozyl® will be administered by a trained health care provider; and
7. A recent (within the last 3 months) weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
8. Approval quantities will be dependent on member's weight and every 3 week dosing in accordance with package labeling; and
9. Initial approvals will be for the duration of 4 months. Further approvals will not be granted if the member does not experience a decrease in transfusion burden after 9 weeks of treatment (administration of 3 doses) at the maximum dose of 1.25mg/kg (allows for initial dosing of 6 weeks at 1mg/kg). Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

Utilization Details of Anemia Medications: Fiscal Year 2022

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
HYDROXYUREA PRODUCTS					
HYDROXYUREA CAP 500MG	673	155	$16,965.88	$25.21	4.34
DROXIA CAP 300MG	93	25	$4,327.22	$46.53	3.72
DROXIA CAP 400MG	55	13	$3,230.27	$58.73	4.23

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
DROXIA CAP 200MG	20	5	$651.45	$32.57	4.00
SIKLOS TAB 1000MG	3	1	$12,160.63	$4,053.54	3.00
SUBTOTAL	**844**	**199**	**$37,335.45**	**$44.24**	**4.24**
EPOETIN ALFA PRODUCTS					
PROCRIT INJ 20,000/ML	56	9	$23,922.62	$427.19	6.22
EPOGEN INJ 20,000/ML	42	8	$29,656.52	$706.11	5.25
EPOGEN INJ 10,000/ML	9	2	$3,902.09	$433.57	4.50
EPOGEN INJ 2,000/ML	8	3	$2,379.32	$297.42	2.67
RETACRIT INJ 10,000/ML	3	1	$1,347.33	$449.11	3.00
EPOGEN INJ 4,000/ML	1	1	$541.97	$541.97	1.00
RETACRIT INJ 40,000/ML	1	1	$1,772.71	$1,772.71	1.00
SUBTOTAL	**120**	**21**	**$63,522.56**	**$529.35**	**5.71**
VOXELOTOR PRODUCTS					
OXBRYTA TAB 500MG	71	13	$726,459.99	$10,231.83	5.46
OXBRYTA TAB 300MG	6	3	$62,570.46	$10,428.41	2.00
SUBTOTAL	**77**	**16**	**$789,030.45**	**$10,247.15**	**4.81**
GLUTAMINE PRODUCTS					
ENDARI POW 5GM	13	3	$24,508.33	$1,885.26	4.33
SUBTOTAL	**13**	**3**	**$24,508.33**	**$1,885.26**	**4.33**
TOTAL	**1,054**	**209***	**$914,396.79**	**$867.55**	**4.41**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
CAP = capsule; INJ = injection; POW = powder; TAB = tablet
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Medical Claims

PRODUCT UTILIZED	TOTAL CLAIMS†	TOTAL MEMBERS*	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER
ADAKVEO INJ J0791	111	23	$1,003,206.99	$9,037.90	4.83
ARANESP INJ J0881	55	15	$59,999.99	$1,090.91	3.67
PROCRIT INJ J0885	42	12	$11,652.71	$277.45	3.5
REBLOZYL INJ	16	1	$174,493.00	$10,905.81	16
TOTAL	**224**	**51**	**$1,249,352.69**	**$5,577.47**	**4.39**

Costs do not reflect rebated prices or net costs.
†Total number of unduplicated claims.
*Total number of unduplicated utilizing members.
INJ = injection
Fiscal Year 2022 = 07/01/2021 to 06/30/2022

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Appendix K

Fiscal Year 2022 Annual Review of Hepatitis C Medications

Oklahoma Health Care Authority
October 2022

Current Prior Authorization Criteria

Mavyret® (glecaprevir/pibrentasvir) is the preferred direct-acting antiviral (DAA) for the treatment of chronic hepatitis C virus (HCV) based on net cost after supplemental rebate participation and value-based agreement (VBA). DAAs for the treatment of chronic HCV are preferred based on the lowest net cost product(s) and may be moved to non-preferred if the net cost changes in comparison to the other available DAAs. Effective July 2022, as a result of the VBA and as part of an initiative by the Oklahoma Health Care Authority (OHCA) to cure HCV in the SoonerCare population, Mavyret® (glecaprevir/pibrentasvir) no longer requires prior authorization. Use of an alternative DAA medication for the treatment of HCV requires prior authorization and a patient-specific, clinically significant reason why the preferred DAA is not appropriate for the member. Mavyret® (glecaprevir/pibrentasvir) oral pellets are covered for pediatric members 3 to 11 years of age requiring that dosage formulation. The following is a template for standard prior authorization criteria for the non-preferred HCV DAA medications. The criteria for each medication is based on FDA approved regimens and American Association for the Study of Liver Diseases (AASLD) and Infectious Diseases Society of America (IDSA) guidance-recommended regimens. Specific HCV medication criteria will vary based on product labeling, FDA approved indications, AASLD/IDSA guidance recommendations, drug interaction potential, and use in specific populations.

Hepatitis C Medication Approval Criteria:

1. An FDA approved age appropriate to the requested medication; and
2. An FDA approved diagnosis of chronic hepatitis C (CHC) and an FDA-indicated genotype (GT) appropriate to the requested medication; and
3. Requested hepatitis C medication must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated for hepatitis C treatment by a gastroenterologist, infectious disease specialist, or transplant specialist within the last 3 months; and
4. Hepatitis C virus (HCV) GT testing must be confirmed and indicated on the prior authorization request; and
5. Member has chronic HCV infection defined by:

a. If the member has a liver fibrosis score ≥F1 (METAVIR equivalent), then only 1 detectable and quantifiable HCV RNA (>15 IU/mL) test within the last 12 months is required; or
b. If the member has a liver fibrosis score <F1 (METAVIR equivalent), then the following must be met:
    i. Positive (i.e., reactive) HCV antibody test that is at least 6 months old and has a detectable and quantifiable HCV RNA (>15 IU/mL) test 6 months after date of positive HCV antibody test; or
    ii. Two detectable and quantifiable HCV RNA (>15 IU/mL) tests at least 6 months apart; and

6. FDA approved regimens and requirements based on cirrhosis status, viral GT, treatment history, and viral load thresholds will apply; and
7. Member must sign and submit the Hepatitis C Intent to Treat Contract; and
8. Member's pharmacy must submit the Hepatitis C Therapy Pharmacy Agreement for each member on therapy; and
9. Prescriber must verify that they will provide SoonerCare with all necessary labs to evaluate hepatitis C therapy efficacy including sustained virologic response (SVR-12); and
10. Prescriber must agree to counsel members on the potential harms of illicit intravenous (IV) drug use or alcohol use and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and
11. Documentation of initiation of immunization with the hepatitis A and B vaccines must be provided; and
12. Decompensated cirrhosis or moderate or severe hepatic impairment (Child-Pugh B or C) restrictions based on FDA approvals and safety recommendations will apply; and
13. Member must not have a limited life expectancy (<12 months) that cannot be remediated by treating HCV, liver transplantation, or another directed therapy; and
14. Female members must not be pregnant and must have a negative pregnancy test immediately prior to therapy initiation. Male and female members must be willing to use 2 forms of non-hormonal birth control while on therapy; and
15. Member must not be taking any medications not recommended for use with the requested hepatitis C medication; and
16. All other clinically significant issues must be addressed prior to starting therapy including but not limited to the following: neutropenia, anemia, thrombocytopenia, surgery, depression, psychosis, epilepsy, obesity, weight-management, severe concurrent medical diseases, such as but not limited to, retinal disease, or autoimmune thyroid disease; and

17. Prescriber must verify that they will work with the member to ensure the member remains adherent to hepatitis C therapies; and
18. Member must be adherent for continued approval. Treatment gaps of therapy longer than 3 days/month will result in denial of subsequent requests for continued therapy; and
19. Approvals for treatment regimen initiation for 8 or 12 weeks of therapy will not be granted prior to the 10th of a month, and for 16 weeks of therapy prior to the 15th of a month in order to prevent prescription limit issues from affecting the member's compliance.

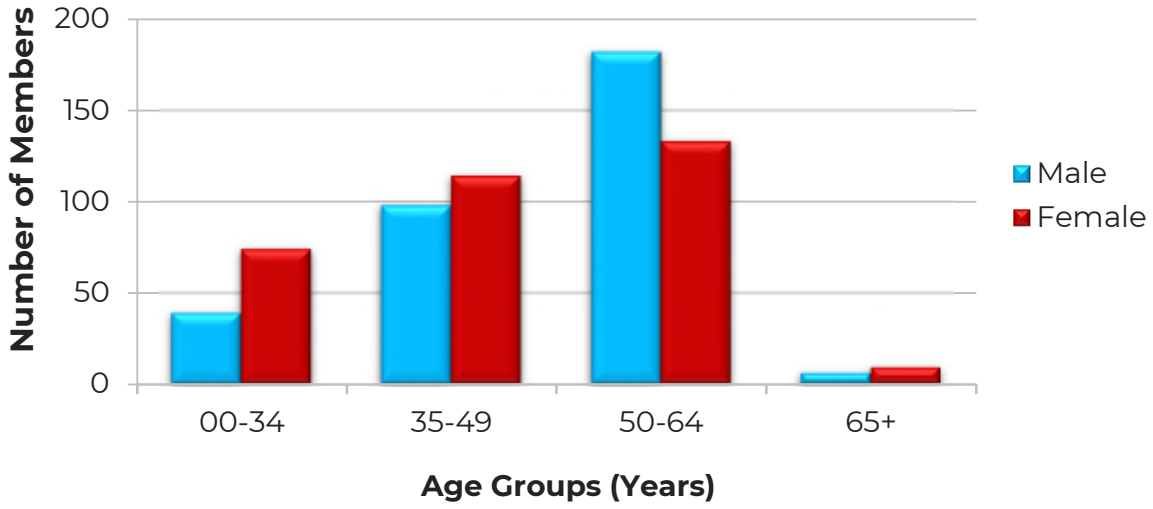
Utilization of Hepatitis C Medications: Fiscal Year 2022

Comparison of Fiscal Years

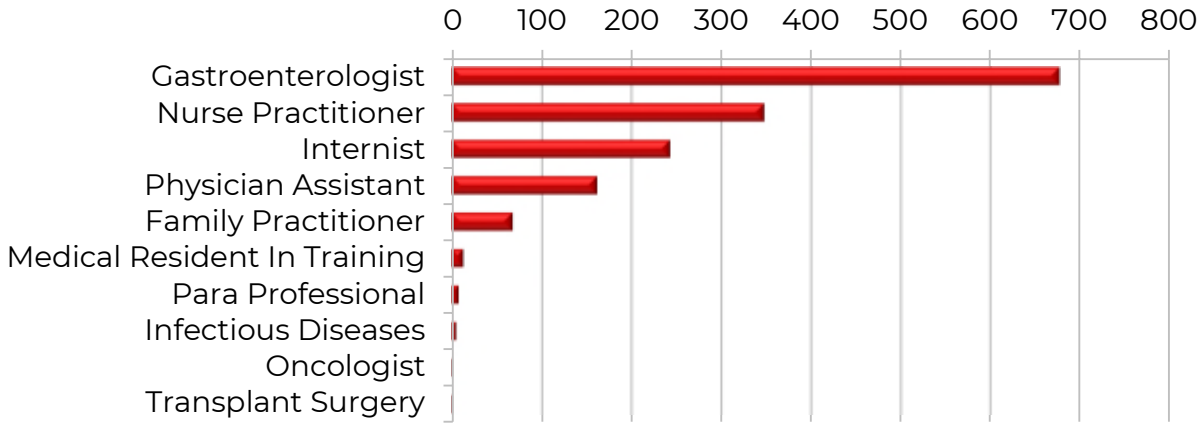
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2021	337	767	$14,865,542.63	$19,381.41	$692.00	33,070	21,482
2022	655	1,526	$14,712,276.49	$9,641.07	$343.92	67,992	42,778
% Change	**94.4%**	**99.0%**	**-1.0%**	**-50.3%**	**-50.3%**	**105.6%**	**99.1%**
Change	**318**	**759**	**-$153,266.14**	**-$9,740.34**	**-$348.08**	**34,922**	**21,296**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated utilizing members.
Fiscal Year 2021 = 07/01/2020 to 06/30/2021; Fiscal Year 2022 = 07/01/2021 to 06/30/2022

Demographics of Members Utilizing Hepatitis C Medications



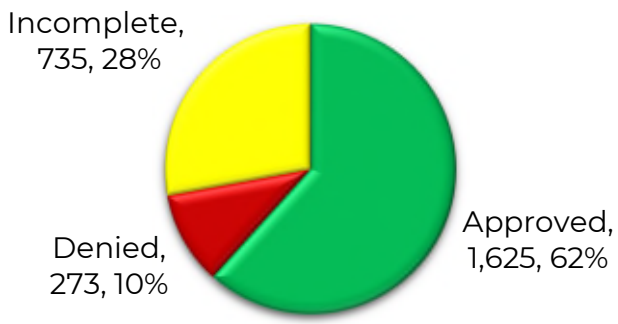
Top Prescriber Specialties of Hepatitis C Medications by Number of Claims



Prior Authorization of Hepatitis C Medications

There were 2,633 prior authorization requests submitted for hepatitis C medications during fiscal year 2022. The following chart shows the status of the submitted petitions for fiscal year 2022.

Status of Petitions



Market News and Updates[1,2,3,4,5,6,7,8]

Anticipated Patent Expiration(s):

- Zepatier® (elbasvir/grazoprevir tablets): May 2031
- Solvadi® (sofosbuvir pellets and tablets): June 2031
- Harvoni® (ledipasvir/sofosbuvir pellets): March 2033
- Epclusa® (sofosbuvir/velpatasvir pellets and tablets): July 2034
- Harvoni® (ledipasvir/sofosbuvir tablets): July 2034
- Mavyret® (glecaprevir/pibrentasvir pellets): December 2035
- Mavyret® (glecaprevir/pibrentasvir tablets): December 2036
- Vosevi® (sofosbuvir/velpatasvir/voxilaprevir tablets): December 2037

Guideline Update(s):

- **September 2021:** The AASLD/IDSA released updated guidance for the identification and management of chronic hepatitis C. The following changes were made:
  - The monitoring section was updated to include guidance for patients with incomplete adherence to therapy.
  - The patients with human immunodeficiency virus (HIV)/HCV coinfection section was updated with drug-drug interaction information for newer antiretroviral agents and ribavirin was removed.
  - The initial treatment of adults with HCV infection was updated to recommend Zepatier® (elbasvir/grazoprevir) as an alternative regimen for genotype 1a, due to ribavirin use.
  - The renal impairment section was updated to include information based on FDA approval of sofosbuvir-based regimens for patients with renal disease.
  - The HCV in children section was updated based on FDA approval of DAA therapy in patients 3 years of age and older.

News:

- **August 2022:** The Centers for Disease Control and Prevention (CDC) released a new *Vital Signs* report that found less than 1 in 3 people with health insurance receive DAA treatment for HCV within a year of diagnosis. The study used a nationwide administrative claims database to identify more than 47,600 adults diagnosed with HCV infection from January 30, 2019 to October 31, 2020. Of those identified, 79% had Medicaid, 7% had Medicare, and 14% had private insurance. The research found that only 23% of Medicaid patients, 28% of Medicare patients, and 35% of patients with private insurance received DAA treatment within a year of receiving a positive HCV test result. Among those with Medicaid, those who lived in states with treatment restrictions were 23% less likely to receive timely treatment compared to those living in states with no restrictions. The report recommends removing eligibility restrictions and preauthorization requirements that make it difficult for people to access treatment, providing treatment where people are already accessing care (i.e., primary care offices, community clinics, syringe services programs), providing treatment in as few visits as possible, and expanding the number of primary care providers treating HCV.
- **June 2022:** The World Health Organization (WHO) published updated guidance on hepatitis C infection with new recommendations on the treatment of adolescents and children, simplified service delivery, and diagnostics.

Recommendations

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

Utilization Details of Hepatitis C Medications: Fiscal Year 2022

Pharmacy Claims

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	COST/ CLAIM	CLAIMS/ MEMBER	% COST
SOFOSBUVIR/VELPATASVIR PRODUCTS						
SOF/VEL TAB 400-100MG	1,066	426	$8,510,615.78	$7,983.70	2.50	57.85%
EPCLUSA TAB 400-100MG	10	4	$249,290.10	$24,929.01	2.50	1.69%
EPCLUSA TAB 200-50MG	2	1	$99,702.82	$49,891.41	2	0.68%
SUBTOTAL	**1,078**	**431**	**$8,859,608.70**	**$8,218.56**	**2.50**	**60.22%**
GLECAPREVIR/PIBRENTASVIR PRODUCTS						
MAVYRET TAB 100-40MG	403	215	$5,293,574.88	$13,135.42	1.87	35.98%
SUBTOTAL	**403**	**215**	**$5,293,574.88**	**$13,135.42**	**1.87**	**35.98%**
SOFOSBUVIR/LEDIPASVIR PRODUCTS						
HARVONI TAB 90-400MG	3	2	$94,534.23	$31,511.41	1.50	0.64%
HARVONI PEL 45-200MG	2	1	$63,022.82	$31,511.41	2	0.43%
SUBTOTAL	**5**	**3**	**$157,557.05**	**$31,511.41**	**1.67**	**1.07 %**
RIBAVIRIN PRODUCTS						
RIBAVIRIN TAB 200MG	18	7	$1,743.52	$96.86	2.57	0.01%
RIBAVIRIN CAP 200MG	6	4	$937.78	$156.30	1.50	0.01%
SUBTOTAL	**24**	**11**	**$2,681.3**	**$111.72**	**2.18**	**0.02%**
SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR PRODUCTS						
VOSEVI TAB 400-100-100MG	16	7	$398,854.56	$24,928.41	2.29	2.71%
SUBTOTAL	**16**	**7**	**$398,854.56**	**$24,928.41**	**2.29**	**2.71%**
TOTAL	**1,526**	**655***	**$14,712,276.49**	**$9,641.07**	**2.33**	**100%**

Costs do not reflect rebated prices or net costs.
*Total number of unduplicated members.
CAP = capsule; PEL = pellet; SOF/VEL = sofosbuvir/velpatasvir; TAB = tablet
Fiscal Year 2022 = 07/01/2021 to 06/30/2022
Please note: During fiscal year 2022, generic sofosbuvir/velpatasvir and Mavyret® were the preferred DAA products for SoonerCare, as reflected in the above data.

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[7] Hicks L. Few Hepatitis C Patients Receive Timely Treatment: CDC. *Medscape*. Available online at: https://www.medscape.com/viewarticle/979154. Issued 08/12/2022. Last accessed 09/23/2022.
[8] World Health Organization (WHO). WHO Publishes Updated Guidance on Hepatitis C Infection – With New Recommendations on Treatment of Adolescents and Children, Simplified Service Delivery and Diagnostics. Available online at: https://www.who.int/news/item/24-06-2022-WHO-publishes-updated-guidance-on-hepatitis-C-infection. Last revised 06/24/2022. Last accessed 09/23/2022.

Appendix L

30-Day Notice to Prior Authorize Xenpozyme™ (Olipudase Alfa-rpcp)

Oklahoma Health Care Authority
October 2022

Introduction[1,2,3,4]

Acid sphingomyelinase deficiency (ASMD) is a rare genetic disease that causes premature death in pediatric and adult patients. It is caused by a mutation in the sphingomyelin phosphodiesterase-1 (*SMPD1*) gene and is inherited in an autosomal recessive manner. Sphingomyelin is a complex lipid that accumulates in the liver, spleen, lung, and brain. Patients with ASMD lack the enzyme, acid sphingomyelinase (ASM), needed to break down sphingomyelin. This causes an accumulation of sphingomyelin in various tissues. Patients with ASMD have enlarged abdomens that can cause pain, vomiting, feeding difficulties, and falls. The severe, infantile form of ASMD is known as Niemann-Pick disease type A. Individuals with later onset ASMD can develop symptoms from infancy to adulthood, known as Niemann-Pick disease type B. There is also an intermediate form known as type A/B which affects patients from infancy to childhood. Patients who are severely affected have profound neurological symptoms and do not survive past 2 to 3 years of age. Other patients may survive into adulthood but die early from respiratory failure. Symptoms vary between patients and can range from mild to severe.

ASMD is diagnosed when the activity of the ASM enzyme is reduced or absent. A diagnosis is confirmed when a suspected blood sample demonstrates <10% ASM enzyme activity than that of a control sample. Molecular genetic testing can also confirm a diagnosis of ASMD. The current treatment for ASMD is directed towards specific symptom relief.

It is estimated that approximately 1 in 250,000 individuals in the general population are affected by ASMD, typically affecting males and females equally. In the United States, it is estimated that there are fewer than 120 patients diagnosed with ASMD and two-thirds of those patients are pediatric.

In August 2022, the U.S. Food and Drug Administration (FDA) approved Xenpozyme™ (olipudase alfa-rpcp) for the treatment of ASMD in adult and pediatric patients. Xenpozyme™ is the first approved medication to treat symptoms that are not related to the central nervous system (CNS) in patients with ASMD.

Xenpozyme™ (Olipudase Alfa-rpcp) Product Summary[5]

Indication(s): Hydrolytic lysosomal sphingomyelin-specific enzyme indicated for treatment of non-CNS manifestations of ASMD in adult and pediatric patients

How Supplied: 20mg lyophilized powder in a single-dose vial (SDV) for reconstitution

Dosing and Administration:

- Prior to initiating treatment, pregnancy status should be verified in females of reproductive potential and baseline transaminase levels should be obtained
- Pretreatment with antihistamines, antipyretics, and/or corticosteroids should be considered
- Recommended starting dose:
  - Adults: 0.1mg/kg administered as an intravenous (IV) infusion
  - Pediatrics: 0.03mg/kg administered as an IV infusion
- Recommended maintenance dosage for all patients is 3mg/kg via IV infusion
- Refer to the full *Prescribing Information* for the recommended titration and maintenance dosing algorithm

Boxed Warning: Severe Hypersensitivity Reactions

- Xenpozyme™ can cause hypersensitivity reactions, including anaphylaxis.
  - Appropriate medical support measures, including cardiopulmonary resuscitation equipment, should be readily available during Xenpozyme™ administration.
- If a severe hypersensitivity reaction occurs, Xenpozyme™ should be discontinued.
- In patients with severe hypersensitivity reaction, a desensitization procedure to Xenpozyme™ may be considered.

Warnings and Precautions:

- Infusion-Associated Reactions: Antihistamines, antipyretics, and/or corticosteroids may be given prior to Xenpozyme™ administration to reduce the risk of IARs; however, IARs may still occur in patients after receiving pretreatment. If severe IARs occur, Xenpozyme™ should be discontinued and appropriate medical treatment should be initiated. The risks and benefits should be considered of re-administering Xenpozyme™ following severe IARs.
- Elevated Transaminase Levels: Xenpozyme™ may be associated with elevated transaminases [alanine aminotransferase (ALT), aspartate

aminotransferase (AST), or both] within 24 to 48 hours after infusion. ALT and AST should be assessed within 1 month prior to initiation of Xenpozyme™, within 72 hours prior to any infusion during dose escalation, or prior to next scheduled infusion upon resuming treatment following a missed dose. If the pre-infusion transaminase levels are elevated above baseline and >2 times the upper limit of normal (ULN) prior to the next scheduled administration, the Xenpozyme™ dose can be reduced or Xenpozyme™ can be temporarily withheld until the liver transaminases return to the patient's baseline value.

- Risk of Fetal Malformations During Dosage Initiation or Escalation in Pregnancy: There is no evidence that olipudase alfa-rpcp crosses the human placenta; however, published literature reports that early embryonic exposure to a metabolite of sphingomyelin (ceramide) or the S1P receptor modulator fingolimod can produce exencephaly in chicks and mice, respectively. Xenpozyme™ dosage initiation or escalation, at any time during pregnancy, is not recommended as it may lead to elevated sphingomyelin metabolite levels that may increase the risk of fetal malformations. The decision to continue or discontinue Xenpozyme™ maintenance dosing in pregnancy should consider the female's need for Xenpozyme™, the potential drug-related risks to the fetus, and the potential adverse outcomes from untreated maternal ASMD disease. The pregnancy status of females of reproductive potential should be verified prior to initiating Xenpozyme™ treatment. Females of reproductive potential should be advised to use effective contraception during treatment and for 2 weeks after the last dose if Xenpozyme™ is discontinued.

Mechanism of Action: Xenpozyme™ provides an exogenous source of ASM. The deficiency of ASM causes an accumulation of sphingomyelin in various tissues. Xenpozyme™ is not expected to cross the blood-brain barrier or modulate the CNS manifestations of ASMD.

Contraindication(s): None

Use in Specific Populations:

- Pregnancy: Based on animal data, Xenpozyme™ may cause embryo-fetal harm when administered to a pregnant female. There is no human data on the use of Xenpozyme™ to evaluate for a drug associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes.
- Lactation: The presence of olipudase alfa-rpcp in human milk, the effects on the breastfed infant, or the effects on milk production are unknown.

- Females and Males of Reproductive Potential: Females of reproductive potential should be advised to use effective contraception until 2 weeks after the last dose.
- Pediatric Use: The safety and effectiveness of Xenpozyme™ for the treatment of non-CNS manifestations of ASMD have been established in pediatric patients down to birth. Compared to adults, a higher percentage of pediatric patients experienced treatment-related serious adverse reactions, anaphylaxis, hypersensitivity reactions, and IARs that occurred within 24 hours of infusion.
- Geriatric Use: Clinical trials of Xenpozyme™ included an insufficient number of patients 65 years of age and older to determine whether they respond differently from younger adult patients.

Adverse Reactions:

- The most common (>7%) adverse reactions in adult patients include headache, cough, diarrhea, hypotension, ocular hyperemia, erythema, asthenia, pharyngitis, dyspnea, urticaria, papule, myalgia, throat irritation, and abnormal C-reactive protein.
- The most common (≥13%) adverse reactions in pediatric patients include pyrexia, cough, diarrhea, rhinitis, abdominal pain, vomiting, headache, urticaria, nausea, rash, arthralgia, pruritus, fatigue, pharyngitis, increased C-reactive protein, hypotension, anaphylactic reaction, hypersensitivity, and infusion site swelling.

Efficacy:

- The approval of Xenpozyme™ was based on data from the ASCEND and ASCEND-Peds clinical trials, which showed clinically relevant improvement in lung function, platelet count, and reduction of spleen and liver volumes with use of Xenpozyme™.
- **ASCEND** was a multicenter, randomized, double-blinded, placebo-controlled, repeat dose Phase 2/3 trial in adult patients with ASMD type B and type A/B. Patients were randomized to receive either Xenpozyme™ or placebo as an IV infusion once every 2 weeks for 52 weeks. All patients were started on 0.1mg/kg of Xenpozyme™ or placebo and titrated up to the 3mg/kg maintenance dose. It was dosed as follows: 0.1mg/kg (day 1, week 0), 0.3mg/kg (weeks 2 and 4), 0.6mg/kg (weeks 6 and 8), 1mg/kg (week 10), 2mg/kg (week 12), and then a maintenance dose of 3mg/kg (week 14 onwards).
    - Primary Endpoint: The primary efficacy endpoints included assessment of percent predicted diffusion capacity of the lungs for carbon monoxide (DLco), spleen volume, liver volume, and platelet count.
    - Results: A greater proportion of patients showed improvement in the primary endpoint at week 52 compared to placebo. There was an increase of 21% in mean percent change in percent predicted

DLco in Xenpozyme™-treated patients compared to placebo [95% confidence interval (CI): 10.6, 31.2; P=0.0003] and a 39% reduction in spleen volume (95% CI: -47.6, -31.2; P<0.0001). Additionally, there was a decrease in mean liver volume (95% CI: -33.4, -16.1; P<0.0001) and an increase in mean platelet count (95% CI: 1.8, 29.4; P=0.0280) at 52 weeks with Xenpozyme™-treatment compared to placebo.

- **ASCEND-Peds** was a multicenter, open-label, repeated-dose trial of Xenpozyme™ given IV once every 2 weeks for 64 weeks in pediatric patients younger than 18 years of age with a diagnosis of ASMD type B and A/B. Xenpozyme™ was dosed as follows: 0.03mg/kg (day 1, week 0), 0.1mg/kg (weeks 2), 0.3mg/kg (weeks 4 and 6), 0.6mg/kg (weeks 8 and 10), 1mg/kg (week 12), 2mg/kg (week 14), and then a maintenance dose of 3mg/kg (week 16 onwards).
  - Primary Endpoint: The primary endpoints were related to organomegaly, pulmonary and liver functions, and linear growth which were all evaluated at week 52.
  - Results: Treatment with Xenpozyme™ resulted in improvements in mean percent change in percent predicted DLco (95% CI: -12.5, 104.3), spleen volume (95% CI: -55.5, -37.9), liver volumes (95% CI: -44.1, -32.0), platelet counts (95% CI: 8.5, 66.7), and linear growth progressions (95% CI: 0.2, 0.8) at week 52 as compared to baseline.

Cost: The Wholesale Acquisition Cost (WAC) of Xenpozyme™ is $7,142 per 20mg SDV, resulting in an estimated cost of $157,124 per month and $2,042,612 per year, based on the maximum recommended maintenance dose of 3mg/kg every 2 weeks for an adult member weighing 70kg.

Recommendations

The College of Pharmacy recommends the prior authorization of Xenpozyme™ (olipudase alfa-rpcp) with the following criteria:

Xenpozyme™ (Olipudase Alfa-rpcp) Approval Criteria:

1. An FDA approved diagnosis of acid sphingomyelinase deficiency (ASMD) type A, B, or A/B confirmed by:
   a. Documented lab results verifying <10% of acid sphingomyelinase (ASM) activity from baseline; or
   b. Molecular genetic testing confirming a mutation in the *SMPD1* gene; and
2. Documentation of baseline AST and ALT within 1 month prior to treatment initiation or within 72 hours prior to treatment escalation; and
3. Member's weight (kg) and body mass index (BMI) within the last 3 weeks must be provided to ensure accurate weight-based dosing; and
   a. BMI ≤30: The dosage is based on actual body weight (kg); or

   b. BMI >30: The dosage is based on adjusted body weight; and
4. Female members of reproductive potential must have a negative pregnancy test prior to initiation and must agree to use effective contraception during treatment and for 2 weeks after the final dose of Xenpozyme™; and
5. Prescriber must verify ALT and AST will be assessed to manage the risk of elevated transaminases as directed by the Xenpozyme™ *Prescribing Information*; and
6. Xenpozyme™ must be administered by a health care provider prepared to manage anaphylaxis. Approvals will not be granted for self-administration. Prior authorization requests must indicate how Xenpozyme™ will be administered; and
   a. Xenpozyme™ must be shipped via cold chain supply to the health care facility where the member is scheduled to receive treatment; or
   b. Xenpozyme™ must be shipped via cold chain supply to the member's home and administered by a home health care provider prepared to manage anaphylaxis, and the member or member's caregiver must be trained on the proper storage of Xenpozyme™; and
      i. For consideration of home administration by a home health care provider, prescriber must verify member is receiving the maintenance dose and is tolerating the Xenpozyme™ infusion well; and
7. 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.

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[2] U.S. Food and Drug Administration (FDA). FDA Approves First Treatment for Acid Sphingomyelinase Deficiency, a Rare Genetic Disease. Available online at: https://www.fda.gov/news-events/press-announcements/fda-approves-first-treatment-acid-sphingomyelinase-deficiency-rare-genetic-disease. Issued 08/31/2022. Last accessed 09/19/2022.
[3] Sanofi. Xenpozyme™ (Olipudase Alfa-rpcp) Approved by FDA as First Disease-Specific Treatment for ASMD (Non-CNS Manifestations). Available online at: https://www.sanofi.com/en/media-room/press-releases/2022/2022-08-31-18-30-00-2507978. Last revised 08/31/2022. Last accessed 09/19/2022.
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[5] Xenpozyme™ (Olipudase Alfa-rpcp) Prescribing Information. Sanofi. Available online at: https://products.sanofi.us/xenpozyme/xenpozyme.pdf. Last revised 08/2022. Last accessed 09/29/2022.

Appendix M

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

FDA NEWS RELEASE

For Immediate Release: September 29, 2022

FDA Approves New Treatment Option for Patients with ALS

The FDA approved Relyvrio™ (sodium phenylbutyrate/taurursodiol) to treat patients with amyotrophic lateral sclerosis (ALS), commonly referred to as Lou Gehrig's disease. ALS is a rare disease that attacks and kills the nerve cells that control voluntary muscles that produce movements such as chewing, walking, breathing, and talking. ALS causes the nerves to lose the ability to activate specific muscles, which causes the muscles to become weak and leads to paralysis. ALS is a progressive disease that continues to get worse over time. Most cases will result in death from respiratory failure, usually within 3 to 5 years from when the symptoms first appear. Approximately 5,000 individuals in the United States are diagnosed with ALS annually, and approximately 20,000 Americans are currently living with the disease.

Relyvrio™ can be taken orally by combining 1 packet in 8 ounces of room temperature water, and it can also be administered through a feeding tube. The recommended dosage for the first 3 weeks is 1 packet (3 grams sodium phenylbutyrate/1 gram taurursodiol) daily. After 3 weeks, the dosage increases to 1 packet twice a day. The medication can be taken before a snack or meal.

The efficacy of Relyvrio™ for the treatment of ALS was demonstrated in a 24-week, multicenter, randomized, double-blind, placebo-controlled, parallel-group trial. In the trial, 137 adult patients with ALS were randomized to receive either Relyvrio™ or placebo. The patients treated with Relyvrio™ experienced a slower rate of decline on a clinical assessment of daily functioning compared to those receiving a placebo. Additionally, longer overall survival was observed in a post hoc, long-term analysis of patients who originally received Relyvrio™ versus those who originally received placebo.

The most common adverse reactions experienced with Relyvrio™ were diarrhea, abdominal pain, nausea ,and upper respiratory tract infection. Relyvrio™ contains taurursodiol, a bile acid, which may cause worsening diarrhea in patients with disorders that interfere with bile acid circulation. These patients should consider consulting with a specialist before taking Relyvrio™. The *Prescribing Information* includes additional information on risks associated with Relyvrio™.

The FDA granted this application Priority Review and Orphan Drug designations. The FDA granted the approval of Relyvrio™ to Amylyx Pharmaceuticals Inc.

FDA NEWS RELEASE

For Immediate Release: September 27, 2022

Coronavirus (COVID-19) Update: FDA Updates COVID-19 Test Policy, Encourages Developers to Seek Traditional Premarket Review for Most Test Types

The FDA updated its COVID-19 test policy to ensure continued access to tests while encouraging the transition of these important public health tools to traditional premarket review pathways. The updated policy describes the FDA's intent to review only a small subset of new emergency use authorization (EUA) requests for diagnostic tests and encourages developers of all test types interested in marketing authorization to

pursue authorization through the de novo classification or 510(k) clearance pre-market review pathways.

Since the start of the pandemic, the FDA has adapted its regulatory approach to address the public's testing needs and has worked closely with test developers to adjust as those needs have changed. These efforts have helped increase testing capacity and broaden public access to rapid tests, including those purchased over-the-counter (OTC). The U.S. currently has the capacity for authorized manufacturers to produce hundreds of millions of tests per month, although the number of tests available for use at any given time will depend on demand and other factors.

To date, more than 430 distinct COVID-19 tests have been issued EUAs. The available information indicates that these tests are providing sufficient testing capacity for COVID-19 tests throughout the United States. Recognizing the current testing capacity, at this time, the agency believes most future submissions are best suited for traditional premarket review pathways. Therefore, the FDA is revising its policy to update the types of COVID-19 tests for which the agency intends to review EUA requests and discuss the use of the traditional premarket review pathways for COVID-19 tests. Tests for which EUA authorization requests are pending prior to this announcement will remain in the queue. Moving forward, the FDA generally intends to focus its review on EUA requests and supplemental EUA requests from experienced developers for:

- Diagnostic tests that are likely to have a significant benefit to public health (such as those that employ new technologies);
- Diagnostic tests that are likely to fulfill an unmet need (such as diagnosing infection with a new variant or subvariant);
- Supplemental EUA requests for previously authorized tests when the request is intended to fulfill a condition of authorization or includes a modification that will significantly benefit public health or fulfill an unmet need; and
- Tests for which the EUA request is from (or supported by) a U.S. government stakeholder, such as tests funded by the Biomedical Advanced Research and Development Authority (BARDA) or the National Institutes of Health's Rapid Acceleration of Diagnostics (RADx).

The FDA believes these priorities are appropriate to address the public health needs at the current stage of the COVID-19 public health emergency and may adjust these priorities as public health needs change. The FDA encourages test developers to consider these priorities and to otherwise shift their focus to traditional premarket review pathways for tests already authorized under EUA and new tests of the same types as those already available under EUA.

FDA NEWS RELEASE

For Immediate Release: September 23, 2022

New FDA Draft Guidance Aims to Protect Children who Participate in Clinical Trials

The FDA issued a draft guidance that, when finalized, will provide the agency's perspective on the ethical considerations for including and protecting children in clinical trials. The draft guidance is intended to assist industry, sponsors, and institutional review boards (IRBs) when considering the enrollment of children in clinical investigations of drugs, biological products, and medical devices. Historically, children were not included in clinical trials because of a misperception that excluding them from research was in fact protecting them. This resulted in many FDA-approved, licensed, cleared, or authorized drugs, biological products, and medical devices lacking pediatric-specific labeling information. If the medical product was the best available treatment option for the child,

doctors were left with no choice but to use a product that had not been reviewed by the FDA for safety and effectiveness in children. It became clear that children can be better protected by including them in clinical research.

The draft guidance, "Ethical Considerations for Clinical Investigations of Medical Products Involving Children," describes the ethical framework for protecting children in clinical research, which includes risk and benefit considerations. The draft guidance outlines and explains fundamental concepts for the ethical framework that IRBs, sponsors, and industry should consider when reviewing or conducting clinical trials involving children, including: scientific necessity of conducting a clinical investigation in children, risk categories for interventions or procedures that do not offer a prospect of direct benefit to the child, how to evaluate whether an intervention or procedure offers a prospect of direct benefit to the child, assessment of risk for interventions or procedures with a prospect of direct benefit, component analysis of the risks of interventions or procedures, potential for review, under a regulatory provision, of research that is not otherwise approvable by an IRB, and parental or guardian permission and child assent.

FDA NEWS RELEASE

For Immediate Release: September 7, 2022

Monkeypox Update: FDA Takes Significant Action to Help Expand Access to Testing

The FDA announced steps to further increase monkeypox testing capacity and accessibility nationwide as part of its continued commitment to addressing the ongoing outbreak. The agency is also providing voluntary templates that test developers may use when validating a test or when submitting an EUA request. These templates include recommendations, not requirements, for how a developer could validate a test to help ensure it is appropriately accurate and reliable. The FDA intends to update its recommendations, as needed, in response to the developing emergency.

As explained in the guidance, the FDA does not intend to enforce requirements for certain tests developed by laboratories that are used without submission of an EUA request where they are appropriately validated and the laboratories notify the FDA within 30 days, among other things. The agency's intent is to facilitate the development of additional tests to address local availability and accessibility concerns not addressed by current testing capabilities. The FDA will monitor the situation and may adjust its policies as appropriate to address testing needs. The FDA also may decide, on a case-by-case basis, not to object to individual labs offering tests using different specimen types or technologies to address patient care needs.

Commercial manufacturers who intend to make a diagnostic test for monkeypox and want to seek authorization through the more streamlined EUA process should inform the FDA of their plans within 30 days, as well.

Current Drug Shortages Index (as of September 29, 2022):

Amifostine Injection	***Currently in Shortage***
Amino Acids	***Currently in Shortage***
Amoxapine Tablets	***Currently in Shortage***
Atropine Sulfate Injection	***Currently in Shortage***
Azacitidine for Injection	***Currently in Shortage***
Azithromycin (Azasite) Ophthalmic Solution 1%	***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***
Belladonna and Opium Suppositories	***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***
Cefixime Oral Capsules	***Currently in Shortage***
Cefotaxime Sodium Injection	***Currently in Shortage***
Cefotetan Disodium Injection	***Currently in Shortage***
Chlordiazepoxide Hydrochloride Capsules	***Currently in Shortage***
Chloroprocaine Hydrochloride Injection	***Currently in Shortage***
Conivaptan Hydrochloride (Vaprisol) in 5% Dextrose Plastic Container	***Currently in Shortage***
Conjugated Estrogens/Bazedoxifene (Duavee) Tablet, Film Coated	***Currently in Shortage***
Cortisone Acetate Tablets	***Currently in Shortage***
Cyclopentolate 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***
Dextrose 10% Injection	***Currently in Shortage***
Dextrose 25% Injection	***Currently in Shortage***
Dextrose 5% Injection	***Currently in Shortage***
Dextrose 50% Injection	***Currently in Shortage***
Diazepam Rectal Gel	***Currently in Shortage***
Diflunisal Tablets	***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***
Erythromycin Ophthalmic Ointment	***Currently in Shortage***

Fentanyl Citrate (Sublimaze) Injection	***Currently in Shortage***
Floxuridine for Injection	***Currently in Shortage***
Fludarabine Phosphate Injection	***Currently in Shortage***
Fluorescein Injection	***Currently in Shortage***
Flurazepam Hydrochloride Capsules	***Currently in Shortage***
Fluvoxamine ER Capsules	***Currently in Shortage***
Furosemide Injection	***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***
Hydromorphone Hydrochloride Injection	***Currently in Shortage***
Hydroxypropyl (Lacrisert) Cellulose Ophthalmic Insert	***Currently in Shortage***
Ibutilide Fumarate Injection	***Currently in Shortage***
Indigotindisulfonate Sodium Injection	***Currently in Shortage***
Iodixanol Injection	***Currently in Shortage***
Iohexol Injection	***Currently in Shortage***
Iomeprol Injection	***Currently in Shortage***
Iopromide (Ultravist) Injection	***Currently in Shortage***
Isoniazid Injection	***Currently in Shortage***
IV Fat Emulsion	***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***
Lithium Oral Solution	***Currently in Shortage***
Lorazepam Injection	***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***
Metronidazole Injection	***Currently in Shortage***
Midazolam Injection	***Currently in Shortage***
Morphine Sulfate Injection	***Currently in Shortage***
Multi-Vitamin Infusion (Adult and Pediatric)	***Currently in Shortage***
Nizatidine Capsules	***Currently in Shortage***

Oxytocin 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***
Pentostatin Injection	***Currently in Shortage***
Physostigmine Salicylate Injection	***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***
Remifentanil Injection	***Currently in Shortage***
Rifampin Capsules	***Currently in Shortage***
Rifampin Injection	***Currently in Shortage***
Rifapentine Tablets	***Currently in Shortage***
Ropivacaine Hydrochloride Injection	***Currently in Shortage***
Semaglutide (Ozempic) Injection	***Currently in Shortage***
Semaglutide (Wegovy) Injection	***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 14.6% Injection	***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***
Streptozocin (Zanosar) Sterile Powder	***Currently in Shortage***
Sufentanil Citrate Injection	***Currently in Shortage***
Sulfasalazine Tablets	***Currently in Shortage***
Technetium TC-99M Mebrofenin Injection	***Currently in Shortage***
Technetium Tc99m Succimer Injection (DMSA)	***Currently in Shortage***
Teprotumumab-trbw	***Currently in Shortage***
Thiothixene Capsules	***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***
Vandetanib Tablets	***Currently in Shortage***
Vecuronium Bromide for Injection	***Currently in Shortage***